Q&A: Clearing up confusion on physician burnout and depression

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It is important to differentiate between physician burnout and depression. While burnout has often been misconstrued to be directly related to depression and suicidal ideation, that is not the case. Yet confusion about these critical distinctions remains, even among some physicians.

During a recent interview, AMA Vice President of Professional Satisfaction Christine Sinsky, MD, cleared up some of the muddle surrounding burnout, depression and suicide while detailing how to better help physicians overcome the COVID-19 pandemic's powerful stressors.

AMA: You and colleagues recently co-wrote a JAMA Network Open study looking at this question of physician burnout and suicidal ideation. Why do you think burnout is so commonly grouped with depression?

Dr. Sinsky: There has been confusion and uncertainty about the relationships between depression and burnout in the past. We now have data that supports our understanding that burnout is not the same as depression—they are not the same condition. We also understand that it is depression, but not burnout, that puts a physician at higher risk of suicidal ideation.

AMA: What are some of the important facts to consider about depression, burnout and suicide?

Dr. Sinsky: It is important to understand that burnout and depression are different conditions altogether. Burnout is an occupational syndrome related to the external environment in which people work whereas depression is a medical illness that has many contributors, including biology, one's social structure and the environment in which we live and work.

We know that burnout is not the same as depression. We also know the consequences of these two conditions are different. Burnout leads to a higher rate of medical errors. Depression by itself doesn't seem to lead to a higher rate of medical errors. On the other hand, depression leads to greater

suicidal ideation, whereas burnout by itself does not appear to lead to greater risk of suicidal ideation. We have to be really cautious if we think that a physician's burnout contributes to suicidal thoughts. That's not really a complete story.

AMA: Can burnout develop into depression and lead to suicide?

Dr. Sinsky: That is a tricky question. It is important not to medicalize burnout because it is not a medical condition—it is an occupational syndrome. Burnout is a really specific thing, and it has to do with your work, whereas depression manifests itself in many parts of your life: in your work, in your family life, in your personal self-care, in your view toward the future and your actions that plan for the future. So, depression is this much broader concept. It’s also important to note that the majority of people who experience burnout don’t also have depression.

> It is possible that burnout can contribute to depression in some physicians. In turn, we know that depression is a risk factor for suicidal ideation, so burnout could indirectly increase the risk of suicide by contributing to depression. But most physicians who experience burnout do not experience depression.

A significant portion of those who screen positive for depression will have burnout, but a very smaller portion of those with burnout will screen positive for depression. That's consistent with the fact that burnout and depression are very different entities, but also suggests that for some, burnout can lead to depression.

AMA: How can we clear up the confusion out there about burnout, depression and suicide?

Dr. Sinsky: It is best to avoid using medical terms for burnout. We have to avoid medicalizing the experience of burnout, or to use another word we should avoid pathologizing it—making it into pathology. Burnout is actually a normal reaction to a chaotic and stressful work environment. Burnout is not a medical illness. It is a reaction to the environment.

> Although burnout manifests in individuals, it originates in health systems. Depression doesn't originate in health systems. Instead, depression is a much broader thing, again, with biological, genetic predisposition with many other factors and that fact that it's a medical illness. So, we can use medical terms for depression, but when people talk about addressing burnout through mental health channels, that gives the wrong impression that burnout is the same as depression—which it is not.

One wouldn't necessarily need to see their primary care physician or a psychiatrist because of burnout. One needs to do other things such as work on connection with colleagues and improving the

workflow in the practice setting. Leaders have an opportunity to change the culture within an organization and all of those things can help burnout, but those aren't medical interventions, those are occupational interventions. So—different origins, different consequences and different interventions to alleviate the suffering that people are experiencing either from burnout or from depression.

AMA: How do we continue to protect doctors and address increased physician stress during the COVID-19 pandemic?

Dr. Sinsky: We know that stress levels have increased with the COVID-19 pandemic. We don't yet know what impact COVID has had on rates of physician burnout or rates of physician depression. We are studying this in the fourth triennial national burnout survey that is currently in the field. Regardless, many things are key for organizations to protect the people within. That's what we're describing as it's important for organizations to become more resilient as organizations because resilient organizations can protect the individuals within during stressful times.

There are many different frameworks for that. Tait Shanafelt, MD, published the paper, " Understanding and Addressing Sources of Anxiety Among Health Care Professionals During the COVID-19 Pandemic," explaining the needs of health professionals, which are hear me, protect me, prepare me, support me and care for me.

One is for leaders to listen and understand what the needs are of the workforce during this time of stress. Another is transparency and just being completely honest about—this is what we know, this is what we don't know, and this is what we're doing to find out. I have talked to a number of physicians as part of an initiative I did for the AMA Accelerating Change in Medical Education initiative, asking them about their experiences during the height of the most stressful time.

One person said that just hearing every day who among the workforce was sick, how many were in the hospital and how many have died—having that transparency helped with the fear that the workforce was experiencing.

Also, when health systems measure the stress level among their workforce, they can identify: Where are the hotspots? What are the top issues? And then they can start to address those.

> One thing we've learned from our research is that when physicians and others feel highly valued by their leaders, their rates of stress and burnout appear to be less. Taking on that explicit role of expressing appreciation for the staff is important. It doesn't mean you can't express appreciation through words, but it's when you express appreciation through deeds that it really matters.

So, by respecting the front lines, listening to their needs and responding to them, leaders can provide much needed and targeted support.

Child care stipends, for example, have been given by some institutions as a way to show appreciation for workers who were stepping up and doing extraordinary things. There are other ways of doing that too. Johns Hopkins has moral resiliency rounds where people can talk about some of the ethical dilemmas that they've faced, and they can do that with peers. We support Mark Greenawald, MD, with his PeerRXMeD way of forming buddy systems and having meaningful conversations. There are many ways that organizations can support physicians during this time of higher stress.

AMA: How do we take appropriate steps to remove the stigma around burnout and depression?

Dr. Sinsky: There are two ways. One is to just continue to reiterate the core message that depression is an illness, just like many other illnesses, and burnout is an occupational syndrome—it is not an illness. The problem is that what needs fixing is the workplace, not the worker and the locus of the problem is in the environment rather than in the individual, so continuing with that message.

Then there is stigma around depression, and some states are starting to change that. For example, Virginia changed the questions on their state licensing application forms to no longer ask about a history of mental illness, but only ask about current impairment. In addition, they have created Safe Haven, which is a process where physicians can receive confidential mental health care. These changes were in response to the suicide during COVID of Dr. Lorna Breen, an emergency physician, and to the positive actions of her family through the Dr. Lorna Breen Heroes Foundation. Those are ways that things can change.

> Every single state has the opportunity to update their medical licensing questions so that they ask about current impairment from any mental or medical illness, but that they not ask about past history of any mental illness or not ask about current history of mental illness if there's no impairment.

We did do a study that was published in 2017 looking at burnout and the way medical license questions are asked. Lotte Dyrbye, MD, was the lead author and only one-third of the states had appropriately worded questions on their initial renewal application forms.

Several states have changed since then, but clearly there are other states that can update their language on the license application or renewal forms so that they are asking about current impairment rather than asking about whether or not the physician has a history of mental illness. That is an ongoing effort to get every state to change this language in their application forms.

We can reduce stigma around burnout by not conflating it with depression and other mental illness.