EDITORIAL

Should all ICU clinicians regularly be tested for burnout? No

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Screening for a disease or condition requires several assumptions. First, the screened condition should be associated with harm to the individual and/or society. Second, it requires a valid, reliable screening tool. Third, screening an individual must not be harmful. Fourth, there should be a treatment or intervention to make results actionable. Finally, screening should, other things being equal, be cost-effective. In this counterpoint, we argue that routinely testing clinicians for burnout only fulfills the first of these assumptions.

Burnout can be understood as a syndromic psychological response to a hostile workplace environment [1–5]. While burnout has been recognized for decades, its impact on the individual and in-work performance has only recently been addressed [6, 7]. Burnout is clearly bad—contributing to depression, poor work performance, and likely even medical errors. The first of our criteria is thus clearly met. Despite rising interest in burnout and its implications for health care and clinicians, a standard screening process is premature for a variety of reasons. We highlight the risk that introducing a screening process prematurely may cause net harm.

Our second criterion is only very partially met. An instrument, the Maslach Burnout Inventory (MBI) [1, 8], has been used to diagnose burnout for some decades. However, this instrument may not fulfill all criteria allowing its use on a regular basis for several reasons (Fig. 1). Its test–retest reliability and related risks of test fatigue are not well worked out. Similarly, the time horizon for

which it applies (e.g., whether it may reflect transient stressful events in the workplace) is not well understood. The risks of comorbid or independent post-traumatic stress disorder—a syndrome requiring distinct interventions—are also not well understood [9]. We also do not know whether the MBI can be used for progress in treatment for burnout, which ties back to the lack of clear evidence for appropriate responses to a positive MBI.

On a related note, we do not currently have any meaningful maps between specific scores on MBI subscales and interventions and implications, even as they likely are superior to dichotomized scores [10]. What do specific scores mean for a clinician's patients and/or institution? In general, the minimal clinically important difference (MCID) is used to define relevant responses,

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but even an MCID is unavailable for the MBI. If the MBI is used in a dichotomous manner, how will it be used for evaluation of progress or triaging more severe cases for more intensive support [10]?

Our third criterion worries us greatly. Mandatory screening for burnout may have unintended consequences, including even harm. Based on our admittedly anecdotal experience, a major contributor to clinician burnout derives from the overwhelming burden of regulatory oversight, training, and scrutiny. Excessive bureaucracy and its anonymous surveillance systems may precisely lead to depersonalization. Many clinicians are exhausted by seemingly endless requirements imposed on them by regulatory bodies and administration, almost none of which appears directly meaningful or relevant to patient care. Adding another mandatory test will consume time (the MBI takes 5–10 min) and may further contribute to the feeling of excessive bureaucracy and workload. By focusing the attention on the individual clinician, mandatory screening may distract attention from the fact that burnout is often a marker of poor administration rather than defective clinicians. Any broad application of burnout screening must, in our view, start from the assumption that toxic workplaces must be addressed primarily [2–5]. If the test is not deemed mandatory, low response rates are to be expected [10], which may underestimate the burden of burnout. The bias will be worse if burned-out physicians are less prone to answer the questionnaire. If screening results are used punitively or are not associated with helpful interventions, broad screening may increase conflict in a workplace, thus further worsening burnout. A vicious cycle may likely ensue if responses to screening are suboptimal [2–4]. Thus, healthcare administrators and managers must, in our view, implement meaningful systems of change to avoid creating new burnout and worsening the workplace environment as part of a screening strategy.

Our fourth criterion identifies yet another crucial gap in contemporary knowledge that militates against burnout screening. What should one do if a clinician is tested positive for burnout? There are no evidence-based treatments for burnout at the individual level, although research is underway. Most if not all the possible interventions will require additional resources. Attempts to implement interventions cheaply may worsen burnout overall by shifting additional work onto other clinicians. No quality improvement program is free. Costs come not only from clinician time diverted but also administrative costs for data collection, analysis, and reporting. Indeed, an evaluation system without a feedback and/or corrective action cannot survive for the reasons cited above [11].

In terms of our final criterion, while back-of-the-envelope calculations may suggest that staff turnover is expensive and medical errors are costly, we are unaware of any detailed data to allow actual estimates of the cost-effectiveness of burnout screening in clinicians. By definition, screening costs resources, but the potential resource benefits have not been well measured and may depend substantially on the perspective taken. Benefits could be realized from patients', managers', and clinicians' perspectives. From a patient perspective, less burned-out physicians might deliver better, more human care; for the manager, one could speculate lower levels of absenteeism and more judicious resource use. For the clinician, a better quality of life could be expected. We again call attention to the fact that screening cannot stand alone; it must be coupled with effective interventions, and those interventions will also require resources.

In conclusion, we strongly believe that burnout is an important problem in the modern ICU and that it deserves careful thought and additional research to determine the best models. It would be foolhardy now to begin mandatory screening for burnout. We would never approve a laboratory biomarker for screening in a similar circumstance based on present evidence; we should not implement a survey-based screening tool, no matter how important the problem of burnout is. The path to hell is paved with good intentions, as the old saying goes.

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