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What is burnout?

PERSPECTIVES

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Burnout among doctors is concerning for their health and patient care, but the term is imprecise and lacks a universally agreed definition. Greater clarity is needed in order to understand burnout in a meaningful way.

In recent years, various international studies have shown a high prevalence of burnout among doctors (1). Recent Norwegian data show an increase among general practitioners (GPs) from 6 % to 22 % in the period 2012–24 (2). Despite the absence of up-to-date data for other doctors in Norway, there is reason to assume that burnout is a significant problem. Studies also show that job satisfaction is declining, while stress is increasing (3, 4).

Burnout is closely linked to factors in the workplace, but the term has proved difficult to define clearly. This lack of clarity has likely contributed to its failure to be established as a distinct diagnosis – more than 50 years after the term was introduced into modern psychology.

Definition of burnout

Narratives of burnout, particularly among doctors, can be traced back centuries, and the phenomenon has traditionally been regarded as an inherent occupational hazard, described as early as the 9th century in *Adab al-Tabib*, an Arabic textbook on medical ethics (5).

The term 'burnout', as it is understood today, was first introduced in 1974 by the American psychologist Herbert Freudenberger (1926–99) (6). He defined it as a state of physical and mental exhaustion arising from workplace stress. Freudenberger described the risk of burnout among healthcare personnel in his own clinic and highlighted preventive measures that staff should focus on to reduce this risk.

The American psychologist Christina Maslach and her colleagues have been leading figures in research in this field since the 1970s (7). To measure burnout, they developed the Maslach Burnout Inventory (MBI), and although specialists in other fields have developed similar instruments, the MBI is regarded as the reference standard (8). The instrument defines burnout as 'a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do "people work" of some kind' (9). In the MBI, this is operationalised through three dimensions: emotional exhaustion, mental distancing (depersonalisation/cynicism) and reduced personal accomplishment (also called reduced professional efficacy).

There are several definitions of burnout, and the lack of standardisation was discussed in 2021 by the Network on the Coordination and Harmonisation of European Occupational Cohorts (OMEGA-NET) (10). The expert panel, comprising representatives from 29 countries, agreed on a revised definition of burnout: 'In a worker, occupational burnout or occupational physical AND emotional exhaustion state is an exhaustion due to prolonged exposure to work-related problems.'

No further explanation is given of the term 'prolonged exposure', but in other medical contexts a period exceeding three months is generally assumed. Defining burnout solely in terms of emotional exhaustion, without including the other two dimensions, meant that the panel did not draw on a theory of how burnout develops. Instead, they adopted a pragmatic approach, seeking a common denominator across existing definitions. Mental distancing is primarily understood in several of the definitions as a coping strategy for managing exhaustion, while reduced personal accomplishment is considered a consequence of exhaustion (11).

Exhaustion is a symptom of a wide range of conditions and is therefore not specific to burnout (8). In both clinical practice and research, distinguishing symptoms of burnout from depression or depressive symptoms is challenging. There is also no correlation between how burnout is defined and how it is measured. The development of burnout and the symptoms that should be included as diagnostic criteria remain a matter of debate. A distinction is also made between burnout as an individual problem, where treatment may include cognitive behavioural therapy or medication, and burnout from an organisational perspective, where interventions are aimed at the workplace.

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In the International Classification of Primary Care (ICPC), which is used in general practice, burnout is classified as a symptom rather than a diagnosis (P29) (12). Meanwhile, ICD-11 classifies burnout as an occupational phenomenon under the chapter 'Factors influencing health status or contact with health services' (13), and defines it as follows: 'Burnout is a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed. It is characterised by three dimensions: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and 3) a sense of ineffectiveness and lack of accomplishment. Burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life'.

The ICD-11 definition is more consistent with Maslach's conceptualisation than with the expert consensus from 2021. Its focus is on chronic workplace stress and distinguishes burnout from other conditions characterised by exhaustion, such as chronic fatigue syndrome (CFS)/myalgic encephalomyelitis (ME). We therefore anticipate that the ICD definition will eventually become the most widely used operational definition of burnout, despite the extensive work carried out by the expert panel in 2021. However, it raises questions for many clinicians working with burnout. Experience from clinical practice suggests that burnout can rarely be understood solely in terms of workplace factors; it tends to reflect an interplay between stressors both within and outside the workplace – a form of cumulative life stress – that contributes to the development of chronic stress.

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The field is further complicated by the fact that the American Psychiatric Association adopts a different approach in its classification system, DSM-5 (14). In DSM-5, burnout is subsumed within the category 'Trauma- and Stressor-Related Disorders', which also includes adjustment disorders and post-traumatic stress disorder (PTSD).

Since 2005, the Swedish version of ICD-10 has included burnout as a separate diagnosis: exhaustion disorder (15), and the prevalence of this has increased considerably in Sweden (16). The diagnosis is not limited to workplace stress and is likely to encompass a range of different conditions. Critics have therefore argued that there is still insufficient scientific evidence to regard the Swedish diagnosis as a distinct clinical entity and that its diagnostic criteria are too broad to be clinically useful.

The absence of a model for the pathophysiological processes underlying disease development, together with the variability in diagnostic criteria, makes it difficult to argue that burnout constitutes a distinct disease entity. Nevertheless, there is little doubt that burnout represents a real and burdensome condition. The disagreement is largely academic and relates to how burnout is conceptualised within the biopsychosocial model of illness (7). Progress will require a common classification framework, but no consensus has yet been achieved within the field. Consequently, official health statistics do not capture the prevalence of burnout, and current knowledge is based largely on research studies with differing inclusion criteria, study populations and observation periods.

How should burnout be measured?

The original MBI questionnaire has been adapted for different populations (17). One version, the Human Services Survey (MBI-HSS), was developed specifically for healthcare personnel in patient-facing roles and comprises 22 of the original 25 items (9). Other variants have also been developed for different occupational groups, such as the MBI Educators Survey (MBI-ES) for teachers and educators working with school pupils.

The MBI-HSS version was originally rated on two dimensions for each item: a frequency scale (how often) and an intensity scale (how strongly). In subsequent versions, only a seven-point frequency scale, ranging from 'never' to 'every day', has been used (18). Each item in the MBI is scored from 0 to 6, but Maslach and her colleagues did not establish cut-off values to distinguish between burnout and non-burnout across the three dimensions of emotional exhaustion, depersonalisation and reduced personal accomplishment. Instead, the instrument was used to demonstrate high, moderate or low risk of burnout on the basis of responses within a given population. Researchers have subsequently introduced different thresholds, resulting in different definitions of burnout, making it difficult to compare studies and populations.

Some studies regard emotional exhaustion as synonymous with burnout. For example, in follow-up studies by the American Medical Association, 45 % of doctors reported at least one symptom of burnout in 2023 (19). However, it is important to consider all three dimensions as a whole. This facilitates differentiation between burnout and depression and better reflects individual differences in response patterns. Some people become more emotionally blunted and detached, whereas others are predominantly exhausted and withdrawn. These differences should be reflected in scoring instruments and

diagnostic criteria. For example, a high score on at least two MBI-HSS dimensions may indicate a high risk of burnout. This could also potentially serve as a diagnostic criterion. Several studies have interpreted high scores in at least two dimensions as indicating burnout (20). Using such cut-off values could yield more reliable prevalence estimates and contribute to the development of diagnostic criteria. Nevertheless, threshold values have yet to be established for the three dimensions, a need that Falkum highlighted 25 years ago (17). Consequently, many studies continue to rely on non-validated cut-off values. The absence of standardised threshold values is also problematic for clinicians with regard to diagnosis, treatment planning and assessment of treatment outcomes.

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Other validated burnout scales include the Copenhagen Burnout Inventory (CBI), the Oldenburg Burnout Inventory (OLBI), the Burnout Assessment Tool (BAT) and the Bergen Burnout Inventory (BBI) from Norway. A systematic review published in 2016 found that a version of the MBI scale was used in 85 % of the studies on burnout among doctors, and that as many as 47 different definitions of burnout were applied (18). The authors accordingly emphasised the need for a standardised definition and measurement tool.

We support the view that a definition of burnout should encompass all three dimensions and that cut-off values based on validated instruments are required for diagnosis. This would make it possible to monitor individual trajectories over time and to identify both individual and workplace factors that impact prevalence. At present, the lack of clear criteria limits the potential for targeted interventions, and the effectiveness of much of the advice given is unknown. For those working in high-pressure environments with heavy workloads, advice such as 'learning to say no' can have limited relevance.

The ICD-11 definition of burnout emphasises its association with *chronic workplace stress*. Where burnout among doctors is closely linked to working conditions, interventions should likewise be targeted at the workplace. Placing responsibility on the individual doctor can be perceived as an additional burden.

Several studies indicate that lack of autonomy in their daily work is a key factor in burnout among doctors (21). Nevertheless, interventions have largely been aimed at the individual, focusing on stress management, physical activity and relaxation techniques. A clearer definition with diagnostic criteria, together with evidence of effective interventions, would enable more targeted strategies that reflect the role of the working environment in burnout, including in the Norwegian health service.

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