Letters to the Editor

Anxiety Levels Among Physician Mothers During the COVID-19 Pandemic

TO THE EDITOR: Physicians experience burnout and anxiety in the course of their work. Public health emergencies may exacerbate burnout and anxiety. Recent research from China has found that anxiety among health care workers during the COVID-19 pandemic was disproportionately experienced by women (1). Previous studies consistently demonstrate higher levels of burnout among women (2). Scholars have emphasized the importance of investigating the experiences of women and mothers (3) because work-related and childcare disruptions from the pandemic may disproportionately affect women.

To quantify the mental health impact of the COVID-19 pandemic on a predominantly U.S. cohort of physician mothers, we surveyed the Physician Moms Group on Facebook from April 18 to April 29, 2020, after receiving approval from the institutional review board at Stanford University. We used standard scoring for the Generalized Anxiety Disorder 7-item scale (GAD-7) and defined frontline workers as those who had cared in person for a patient with presumed or confirmed SARS-CoV-2 infection within the last 14 days.

In a multivariable linear regression model of anxiety, we included the following theoretically relevant covariates: frontline worker status, whether the respondent was an informal caregiver (defined as having provided regular care or assistance to a friend or family member who had a health problem or disability in the past 30 days), and key demographic variables (race, ethnicity, age, child younger than age 6, age of youngest child, and medical specialty).

Of 1,809 participants, 41% scored above the cutoff points for moderate or severe anxiety as measured by the GAD-7, with 18% reporting severe anxiety. The median GAD-7 score was 8.0 (interquartile range=6.0–13.0). Multivariable analysis revealed that anxiety was higher among frontline workers than among those who were not frontline workers (46% compared with 37%, respectively; $\beta=0.80$, $p=0.01$) and informal caregivers ($\beta=0.873$, $p=0.02$) and lower among Asian respondents ($\beta=-1.1$, $p<0.004$). No other key demographic variables were associated with differences in anxiety levels.

In summary, rates of anxiety among physician mothers in this study appear substantial; for context, in the general U.S. population in normal circumstances, about 19% of adults had any anxiety disorder in the past year (4).

Although this study is limited by the possibility of bias due to nonresponse and its focus on an online group of physician mothers, it offers intriguing evidence to motivate further research. More research is necessary to determine anxiety among nonparents and other genders during the COVID-19 pandemic. Nevertheless, given that half of the U.S. medical student class is now female and that women constitute the majority of young U.S. physicians in most racial groups (5), this study calls attention to the mental health needs of physician mothers, particularly in a time of public health crisis.

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Psychiatrist Burnout

TO THE EDITOR: In the October 2020 issue of the *Journal*, Summers et al. (1) estimated the prevalence of burnout in 2,084 North American psychiatrists to be 78%. Because there are no consensual, clinically valid identification criteria for burnout, we argue that the authors' estimate is unreliable. The high estimate is likely a function of their assessment method.

Employing the Oldenburg Burnout Inventory (OLBI), Summers et al. operationally defined anyone with a score ≥35 as burned out. With 16 Likert-type items, an OLBI score of 35 translates at an item-level to 2.19. Thus, for instance, the OLBI item "Usually, I can manage the amount of my work well," with response choices "Strongly agree" [1] to "Strongly disagree" [4], a score of 2.19 is fractionally higher than "Agree," a low threshold for identifying a serious condition like burnout. Using such a low threshold, there is a high risk that many of the psychiatrists classified as burned out may have experienced nothing other than normal fluctuations in job stress. The threshold chosen is all the more questionable given that it does not have any robust clinical or theoretical underpinning.

A second problem is that the authors ignored the fact that the OLBI comprises two subscales covering exhaustion and disengagement (2). Exhaustion is the core of burnout. Disengagement, which refers to distancing oneself from colleagues and patients, is a strategy to cope with exhaustion. The authors provided no justification for combining exhaustion and disengagement items as part of a single syndrome.

Third, the study fails to differentiate exhaustion from depression. Depression, largely treated categorically, should have also been treated dimensionally. Mounting evidence indicates that depression is better conceptualized as dimensional (3), with individuals experiencing clinical depression found at the upper end of the dimension. Because there is evidence that burnout fundamentally reflects a depressive condition (4), it would have been preferable if the authors had employed advanced factor analytical techniques before making claims about burnout's putative distinctiveness.

High scorers on burnout inventories are at risk for clinical depression and should be offered treatment. And it is important to address depressogenic work-environment factors (e.g., reduced autonomy). It is not be helpful, however, to estimate the prevalence of a condition with no clear identification criteria. The impressive estimate provided can hardly be interpreted in a context in which what constitutes a case of burnout remains so elusive.

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Psychiatrist Burnout: Response to Schonfeld and Bianchi

TO THE EDITOR: We appreciate the comments by Drs. Schonfeld and Bianchi as they highlight some of the main points of our article and allow us to provide further clarification of the study findings. Our major conclusion is that burnout is prevalent among psychiatrists and is associated