which might be contributing factors to adverse events.[4,5] Sensor-wear-related symptoms were recorded as adverse events in the IMPACT trial if the effects were severe and lasted for more than 7 days, or if the patient required prescription medication for the event to resolve. Adverse event severities were recorded on the basis of a health-care professionals assessment of mild, moderate, or severe events.

According to the study protocol, individuals with known sensitivity to medical-grade adhesives were excluded from participation. However, we reasonably expected that a few participants might have been unaware of their sensitivity until they had exposure to the product for longer than a few days. For participants with adverse events involving skin symptoms during this trial, symptoms (including severe) were resolved by use of barrier products (eg, Cavilon spray) or drug therapy (eg, zinc ointment, Fenistil gel, or hydrocortisone cream) as prescribed, or simply by relocating the device to another area of the skin such that the effects were maintained at a tolerable, background level. In other cases, although the adverse events were generally mild or moderate, the longevity of the symptoms, despite use of treatment, contributed to the participant's decision to withdraw from the trial. None of the participants withdrew because of health-care professional advice to stop wearing the sensor.

Since completion of the IMPACT trial, minor design changes have been made to FreeStyle Libre. These changes are expected to improve breathability of the skin that is in contact with the sensor and to facilitate the exclusion of moisture between the sensor–skin interface.

We conclude that although some individuals might be intolerant to using devices with medical-grade adhesive, others might have manageable skin symptoms from sensor wear. Overall, we believe that the benefits of using such a system generally outweigh the risks. Ultimately, the decision to continue or discontinue the use of a medical device when localised skin symptoms occur has to be made in consultation with the patient.

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Physician burnout is better conceptualised as depression

Ronald Epstein and Michael Privitera (Nov 5, p 2216)[1] reported that burnout affects more than half of practising physicians. The authors additionally warned against confusing burnout with depression. We are concerned with the validity of these conclusions.

First, there is now robust evidence that burnout is a depressive condition.[2,3] The misunderstanding surrounding burnout–depression overlap might reflect both a neglect of the stress–depression association and a difficulty coordinating dimensional and categorical approaches to depression in burnout research. The issue is not about interchanging one term with the other. By cultivating the idea that burnout is not a depressive condition, despite evidence to the contrary, investigators inhibit themselves from exploiting the accumulated knowledge on treating and preventing (job-induced) depression when helping sufferers of burnout.

Second, the published estimates of burnout's prevalence rely on clinically groundless criteria, cobbled together without any rationale.[4] In one study,[5] depending on how burnout was identified, the prevalence of burnout went from 69% to 10%, showing a worrying malleability. Because estimates of prevalence of burnout do not have a nosological frame and are adjustable at convenience, they can be easily challenged by anyone willing to discourage public health initiatives intended to enhance working conditions and alleviate job stress. Recognising burnout–depression overlap would help resolve the problem. By contrast to burnout, depression, in its different forms, is diagnosable in a consensual and clinically valid way.

Promoting occupational health is a difficult job. The major organisational changes recommended by Epstein and Privitera[1] are unlikely to be implemented without resistance. Switching from a the construct of burnout to depression would strengthen research validity and public health decision-making authority.

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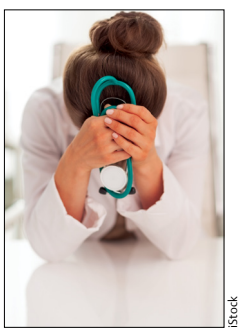
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Authors' reply

We agree with Renzo Bianchi and colleagues that the public health significance of job-related distress is large—and costly in both human and financial terms[1]—and that the variability of definitions and thresholds for burnout in the literature have been problematic. West and colleagues' review in *The Lancet*[2] addressed that issue partly by using one definition of burnout (high emotional exhaustion or depersonalisation) and also supplying data on individual domains and numerical Maslach burnout inventory scale scores. Importantly, these scores, taken as continuous or dichotomous variables, have been clearly linked with clinically relevant outcomes and are responsive to both institutional and individual interventions. Although there is still a need for conceptual clarification now that physician distress is finally recognised as a serious problem, discarding the construct of burnout altogether seems unwarranted.

Recognition of major depression is important. We do not agree, however, that there is robust evidence that burnout is merely depression.[3] Although there is substantial overlap between the two conditions, and physicians with the highest amount of burnout are more likely to develop major depression, workers often have one without the other. Maslach and colleagues, addressed this issue early in development of the burnout construct and assessment scale[4] and again recently.[1] Appropriately, burnout is conceptualised as a breakdown in the relationship between people and their work. That burnout has worsened acutely in the context of radical changes in the nature of clinical work—electronic health records that reduce face-to-face time and documentation mandates that have exponentially increased the burden of meaningless tasks—speaks against a purely individual syndrome.

Pragmatically speaking, considering burnout solely as a mental illness of individual workers rather than work-related distress would be disastrous in the US context and perhaps elsewhere. Many US institutions and medical boards require that physicians report any history of mental illness when applying for a medical licence and hospital privileges, an unfortunate reality. Physicians will be more willing to accept that they are burned out and seek help if they feel that they will not be stigmatised for what they see as a systemic or institutional problem. In March, 2016, Vivek Murthy, the US Surgeon General, declared that burnout among health-care workers was one of the two most pressing health problems in the nation to be addressed during the subsequent year. It is our hope that we will continue to clarify the conceptual and measurement issues while moving forward quickly to alleviate a pressing national—and global—problem.

We declare no competing interests

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Department of Error

Rona RJ, Burdett H, Khondoker M, et al. Post-deployment screening for mental disorders and tailored advice about help-seeking in the UK military: a cluster randomised controlled trial. Lancet *2017;* **389:** *1410–23*—In this Article, "The US Congressionally Directed Medical Research Programs" has been corrected to "The US Army Medical Research and Material Command–Military Operational Medicine Research Program (USAMRMC–MOMRP)" in the Funding, Declaration of interests, and Acknowledgments sections. The Acknowledgments section has also been updated to include details of funding from the National Institute for Health Research to SW and MK, and to acknowledge that views expressed are those of the authors only. These corrections have been made to the online version as of March 27, 2017, and the printed Article is correct.

Le Roux CW , Astrup A, Fujioka K, et al. 3 years of liraglutide versus placebo for type 2 diabetes risk reduction and weight management in individuals with prediabetes: a randomised, double-blind trial. Lancet *2017;* **389:** *1399–409*—In table 1 of this Article, some rounding errors in the percentages have been amended. Additionally, the y-axis scale for figure 2C was incorrect. The y-axis scale has been amended to –0·6 to 2. These corrections have been made to the online version as of March 14, 2017, and the printed Article is correct.

Bayliss LE, Culliford D, Monk AP, et al. The effect of patient age at intervention on risk of implant revision after total replacement of the hip or knee: a population-based cohort study. Lancet *2017;* **389:** *1424–30*—In the Summary of this Article, the funding section was missing. This Article should have been published with an Open Access copyright licence. This correction was made to the online version as of April 6, 2017, and the printed Article is correct.

Schreurs BW, Hannink G. Total joint arthroplasty in younger patients: heading for trouble? Lancet *2017;* **389:** *1374–755*—This Comment should have been published with an Open Access copyright licence. This correction has been made to the online version as of April 6, 2017 and the printed Comment is correct.