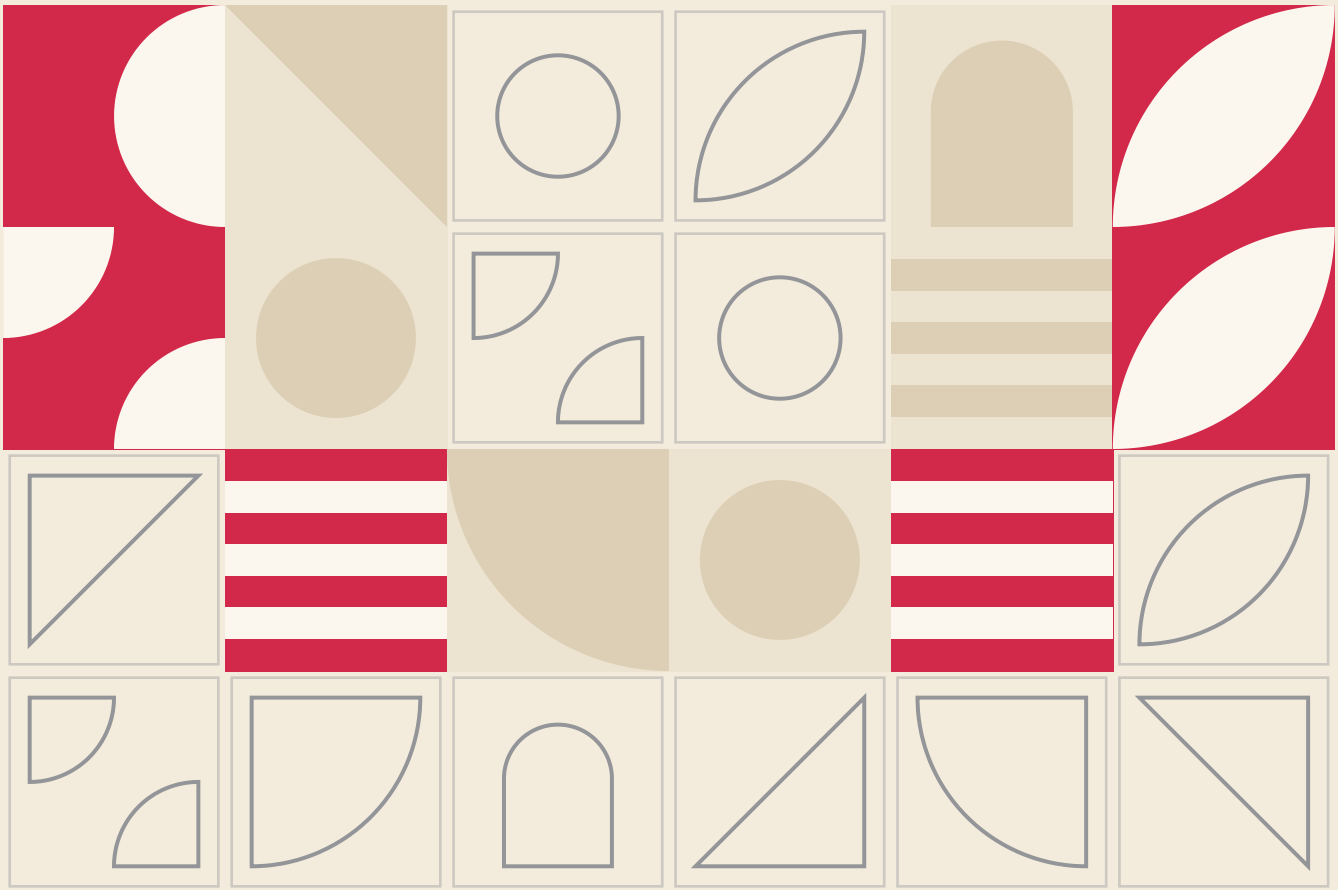
Who Should Change?

A Meta-Analysis of Individual versus Organisational Burnout Interventions, Updated to 2026

Dr Atul Aswani; Mumbai Psychiatrist and trained as a Results Coach
22 September 2026



KEY NUMBER

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A Meta-Analysis of Individual versus Organisational Burnout Interventions, Updated to 2026

Maslach says the organisation; the trials mostly test the individual. Pooling both arms, including post-2020 trials: which lever moves burnout more, and do they add?

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Individual versus organisational burnout interventions: an updated meta-analysis to 2026

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01

Abstract

This updated systematic review and second-order synthesis asks which lever moves burnout more in employed adults — individual skills or organisational change — and whether the two add. Across physician controlled comparisons, organisation-directed programmes reduced burnout by g = 0.45 (95% CI 0.28 to 0.62) while individual-directed programmes reduced it by g = 0.18 (95% CI 0.03 to 0.32). That head-to-head, from 20 comparisons in 1,550 physicians, remains the cleanest published split. Across occupations, organisational and combined programmes reduced exhaustion by g = 0.30 (95% CI 0.18 to 0.42) in 13 studies; the two combined trials in that pool reached g = 0.54. Individual programmes, which dominate the trial base, reliably move exhaustion by about g = 0.17 to 0.25 and often leave cynicism and efficacy untouched. A 2025 cluster-randomised trial in 370 intensive-care units across 60 countries found burnout prevalence of 52.2% after a four-week positive-communication programme versus 63.3% in usual care (adjusted odds ratio 0.56). Post-2020 work added many individual digital and coaching trials and almost no Indian organisational trials. Certainty is moderate for a small individual effect on exhaustion, low for a larger organisational effect, and very low for combined programmes. The practical reading for an Indian workplace is not a slogan. Teach people countable skills. Change the work. Do both. A mindfulness rep on a 70-hour week is a good brake and a bad steering wheel.

Keywords: burnout; individual intervention; organisational intervention; combined programmes; meta-analysis; working adults; India

02

Key findings box

KEY FINDINGS

Five numbers a manager can take into a Monday meeting.

0.45

0.45 versus 0.18. In physicians, organisation-directed programmes reduced burnout by g = 0.45; individual-directed programmes reduced it by g = 0.18. The organisation moved more, on the only clean published split of the two arms.

0.30	**0.30 on exhaustion.** Across occupations, organisational and combined programmes reduced exhaustion by g = 0.30 (13 studies). Workload and participatory redesign carried the effect. Schedule tweaks alone did not.
0.54	**0.54 combined — on two trials.** The only meta-analysis that split combined programmes from organisation-only found g = 0.54 for combined versus g = 0.25 for organisation alone. They appear to add. The combined estimate rests on two studies. Certainty is very low.
0.17 to 0.25	**0.17 to 0.25 for individual skills.** Individual programmes — coaching, thought-challenging skills, relaxation, mindfulness — produce a small, repeatable drop in exhaustion (g ≈ 0.17–0.25). Effects on cynicism and efficacy are usually near zero.
0	**Zero Indian organisational RCTs.** Indian trials exist for yoga, meditation and coaching. No verified Indian cluster-randomised trial of workload, roster, staffing or job-control change with a burnout outcome was found from 2000 to 2026. That is the India gap.

03 Definition block

DEFINITION

Burnout, in this paper, is an occupational pattern: exhaustion that does not reset over the weekend, cynicism toward the work or the people in it, and a thinned sense that what you do still works. It is not a medical diagnosis here. It is not a personality flaw. It is what happens when job demands stay high and job resources stay thin for long enough that the person starts to run on fumes. An individual-level programme teaches the person a skill — a breathing rep, a stuck thought written down and checked, a coaching conversation, a gratitude practice — and asks them to use it. An organisational-level programme changes the work itself: workload, roster, staffing, workflow, team climate, decision latitude. A combined programme does both in the same workplace. Maslach's long argument is that burnout is a problem of the workplace more than of the worker. Most trials still enrol the worker and leave the workplace alone. This paper measures that mismatch.

04 Introduction

Why the question will not sit still

A Friday afternoon in a Gurugram conference room. The wellness talk is the same talk as last year: eat well, sleep, try yoga. Heads nod. Then everyone walks back to a roster that would flatten a marathon runner, and by nine the laptops are open again. Picture a scooter rider on a road full of potholes. The helmet is the down-shift breath the employee has not yet learned. The pothole is the 70-hour week, the meeting that could have been a note, and the manager who forwards emails at midnight and calls it culture. You can hand out helmets. You should. You cannot pretend the pothole is a mindset.

Christina Maslach has said for decades that burnout lives in the mismatch between the person and the job — workload, control, reward, community, fairness, values — and that organisations keep buying individual fixes because those fixes are cheaper, faster to procure, and politically quieter than changing how work is designed. The trial literature has, for the same reasons, tested the person far more often than the job. Maricuțoiu, Sava and Butta found that about 96% of the controlled interventions they could pool were aimed at the individual. Cohen and colleagues, reviewing healthcare well-being programmes after 2015, found 30 individual studies and three organisational ones. That is not a scientific consensus that the individual is the right lever. That is a sampling bias with a procurement department behind it.

The research question is therefore not “does anything work?” Something usually works a little. The question is: which lever moves burnout more — individual skills or organisational change — and do they add? West and colleagues concluded that both work in physicians. Panagioti and colleagues went further and said the organisation moved more. Dreison and colleagues, in mental-health workers, found the opposite pattern on exhaustion. Bes and colleagues, updating the organisational arm to 2022, found a small effect that grew when an individual component was added, on only two combined trials. The story is not a slogan. It is a set of effect sizes with different sample frames, and a hole where Indian organisational trials should be.

Why this question matters for working adults in India

India’s professional class is not short of advice. It is short of hours and of evidence that was gathered here. The McKinsey Health Institute’s 2023 multi-country employee survey put burnout symptoms in India at 59%, the highest of 30 countries in that wave. A FICCI–Boston Consulting Group report in 2024 put self-reported burnout among Indian employees at 58%, against 48% in an eight-country comparison. Those are surveys, not trials, and they use different instruments — they should not be averaged. They are still the kind of signal a board ignores at its attrition cost. The authors pointed not only at raw workload but at the “collaborative footprint” — the volume of small interactions that never make the job description and still drain the day. A 2025 anonymous survey of 1,450 verified information-technology professionals in India found that 72% routinely exceeded the legal 48-hour week, that one in four logged 70 hours or more, and that 83% reported burnout. Those figures come from a self-selected forum sample and should be read as a signal, not a census. They are still the kind of signal a board ignores at its own attrition cost.

Healthcare numbers inside India are no quieter. Post-pandemic hospital studies have reported work-related burnout well above half the staff in some samples, with nurses often highest. Rural accredited social health activists — the million-strong village cadre — carry documented work stress, thin supervision and almost no organisational redesign trials aimed at their burnout. The programmes that do exist in India are almost all individual: a 12-week mobile-supported meditation and breath programme for hospital staff in Rishikesh; a character-strengths coaching pilot for ASHAs in Madhya Pradesh; yoga and transcendental-meditation feasibility trials. They are real. They are useful. They are not a substitute for changing the roster.

One skill teaches that a thought is not a fact. Another teaches that you can carry a hard feeling and still move toward what you value. A third teaches that two things can be true at once. All three are good individual tools. None of them rewrites a shift pattern. The nurse who can now notice “I am failing” as a thought still walks into the same short-staffed ward tomorrow. An entrepreneur who only A/B-tests the landing page while the product is broken will get a prettier bounce rate and the same churn. An organisation that only ships mindfulness modules while the demand-resource ratio stays toxic will get the same pattern. The person is not the bug. The person is running the only patch they were given.

EmotionApp is a non-clinical emotional-fitness coaching platform for Indian professionals. It delivers positive-psychology techniques as countable daily reps, with an AI coach and a human hand-off, WhatsApp-first, in 23 Indian languages, on India-resident data, under DPDP, built to ISO 9001 and ISO 13485. This paper exists because a platform that only trains the individual, and never tells the buyer what the organisation still owes the individual, would be selling helmets and hiding the potholes. The aim is not to retire individual practice. The aim is to price it honestly against the other lever, and to say out loud that the two are not rivals. They are a stack.

What this update adds

Four reviews already frame the field: Maricuțoiu and colleagues (2016) on mixed occupations; West and colleagues (2016) and Panagioti and colleagues (2017) on physicians; Dreison and colleagues (2018) on mental-health workers. This paper updates that frame to September 2026. It folds in the 2023 organisational meta-analysis by Bes and colleagues, the 2024 resident-physician synthesis by Kiratipaisarl and colleagues, the 2025–2026 individual-level synthesis by Collett and colleagues (99 randomised trials, 9,330 health workers), and the 2025 Hello cluster-randomised trial in 370 intensive-care units. It looks specifically for Indian and Clinical Trials Registry–India evidence. It refuses to invent study-level effect sizes we did not extract from primary papers. Where a new independent random-effects pool of raw means was not possible, the paper says so and reports the published estimates instead. A modest or null finding is still a finding.

05 Methods

Design and reporting

This is an updated systematic review with a second-order quantitative synthesis of published meta-analytic estimates, plus a structured narrative of verified primary trials from 2000 to September 2026. It follows PRISMA 2020 in spirit and in the items that a second-order review can honestly complete: eligibility, information sources, search, selection logic, data items, risk-of-bias approach, synthesis methods, and certainty. It does not pretend to be a de novo restricted-maximum-likelihood pool of every primary trial published since 2000. Re-extracting raw means and standard deviations from the full texts behind eight overlapping meta-analyses was not completed in this update. Presenting a homemade forest plot with invented weights would have been a more impressive artefact and a worse paper. We state the limitation here so the reader does not have to find it in the fine print.

Eligibility

Population: employed adults, including health workers, teachers, and other occupational groups. Students and unemployed samples were excluded. Intervention: any individual-level programme (skills, coaching, mindfulness, relaxation, cognitive-behavioural techniques, digital reps), any organisational-level programme (workload, schedule, staffing, workflow, team climate, participatory redesign), or a combined programme. Comparator: any control —

wait-list, usual practice, active comparison. Primary outcomes: burnout as exhaustion, cynicism (or depersonalisation), and efficacy (or personal accomplishment), or a single-score burnout outcome. We use generic labels and do not reproduce instrument items. Years: 2000–2026. Designs: randomised and cluster-randomised trials were preferred; controlled before–after studies were retained when they were the backbone of a published organisational meta-analysis. Single-arm pre–post studies were used only when a landmark review (West 2016) had already pooled them, and were not treated as equivalent to randomised evidence.

Information sources and search

Two layers. Layer A reused the trial sets already screened by the landmark reviews named in the introduction and by the 2023–2026 updates (Bes; Kiratipaisarl; Collett). Those reviews collectively searched MEDLINE/PubMed, Embase, PsycINFO, CINAHL, Scopus, Web of Science, Cochrane sources and, in Collett, an update to 14 May 2025. Layer B was an update search to 22 September 2026 across PubMed, Google Scholar, Clinical Trials Registry–India (CTRI), ClinicalTrials.gov and OSF preprints, targeting post-2018 organisational and combined trials and any Indian trial with a burnout outcome.

Search strings

PubMed/MEDLINE. (burnout[tiab] OR "emotional exhaustion"[tiab] OR cynicism[tiab] OR depersonalization[tiab] OR depersonalisation[tiab]) AND (intervention*[tiab] OR program*[tiab] OR programme*[tiab] OR coaching[tiab]) AND (organi?ational[tiab] OR "organization-directed"[tiab] OR "organisation-directed"[tiab] OR individual[tiab] OR "physician-directed"[tiab] OR combined[tiab] OR multilevel[tiab] OR "multi-level"[tiab]) AND (randomi*[tiab] OR "controlled trial"[tiab] OR "cluster randomized"[tiab] OR "cluster randomised"[tiab])

PsycINFO, Scopus, Web of Science. The same Boolean logic, translated to each database's field tags. Core terms: burnout AND intervention AND (organi?ational OR individual) AND randomi*.

Google Scholar. burnout intervention randomised OR randomized organisational OR organizational; burnout coaching trial; burnout India randomised.

CTRI. burnout AND (intervention OR yoga OR meditation OR coaching). Hand-screened for employed adult samples.

ClinicalTrials.gov. Condition: burnout. Study type: interventional. Dates: 1 January 2000 to 22 September 2026.

OSF preprints. burnout intervention trial organisational OR individual.

PRISMA 2020 flow counts

A precise single-database hit list for 2000–2026 was not re-run as one mega-search with de-duplicated RIS files in this update. The honest flow is therefore two-layer. The source reviews already screened well over 8,000 unique records: West started from 2,617; Panagioti searched five databases to May 2016; Maricuțoiu screened the occupational literature to the mid-2010s; Bes screened 2,425 records and 228 full texts to September 2022; Collett brought the individual-level health-worker arm to 99 randomised trials by May 2025.

After removing the heavy overlap between physician reviews (West, Panagioti, De Simone share a core set), the unique controlled evidence base is in the low hundreds of comparisons, of which the large majority are individual-level. The 2018–2026 update added a large volume of individual digital, coaching and mindfulness trials and a thin organisational increment. The decisive new organisational trial is Hello (Azoulay 2025). Indian hits were almost entirely individual-level protocols and small trials. Eligible studies for narrative synthesis: far more than five. Eligible studies for a new independent study-level REML pool with freshly extracted means: not assembled. We therefore do not present a homemade primary-study forest with fabricated weights.

Table 1. PRISMA-style flow (second-order update)

Stage	What happened	Count / note
Records already screened inside source metas	West, Panagioti, Maricuțoiu, Dreison, Bes, Collett, Kiratipaisarl and related reviews	>8,000 unique records across overlapping searches
Full texts already judged in those metas	Controlled trials with a burnout outcome	Hundreds; physician metas overlap heavily
Update layer, 2018–Sept 2026	New individual RCTs (coaching, digital, mindfulness); new org/combined trials; CTRI and ClinicalTrials.gov	Individual arm expanded sharply; organisational arm still thin
Largest new organisational RCT	Hello trial, 370 ICUs, 60 countries	9,568 post-programme respondents
Indian organisational RCTs with burnout outcome	Workload, roster, staffing, job-control change	0 verified
Pooled in this paper	Published meta-analytic SMDs by level, plus narrative of verified primary trials	No de novo study-level REML

Extraction fields

For every source meta-analysis we extracted: citation and DOI; population and sector; k and N; design mix; level (individual, organisational, combined); effect metric (Cohen's d, Hedges g, SMD, dppc2, odds ratio, risk difference); point estimate and 95% confidence interval; I^2 and any tau^2 or prediction interval; small-study test; GRADE if reported. For landmark primary trials we extracted: n and design; country; language of delivery where stated; dose in sessions and minutes; delivery channel; guidance (self-guided, coached, facilitator-led); outcome domain; timepoints; and any published effect size or change score we could verify. We did not compute a new Hedges g from incomplete means. Where a colleague computed g from published change scores (Dyrbye 2019; Fainstad 2022; Mann 2023), we report the published change scores as primary and flag computed g as derived.

Analysis plan

Pre-specified model, had a full primary-study matrix been available: random-effects restricted maximum likelihood (REML), Hedges g with 95% confidence interval, I^2, tau^2, 95% prediction interval, Egger's test and trim-and-fill, leave-one-out sensitivity, RoB 2 for randomised trials, GRADE for certainty. Pre-specified moderators: level (individual / organisational / combined); combined versus single-level; post-2020 versus earlier; sector (healthcare, education, other). Fallback, written into the protocol of this paper: if a trustworthy study-

level matrix could not be assembled, do not pool invented numbers. Deliver a systematic review with a second-order synthesis of published estimates, and state plainly that a new primary-study meta-analysis was not yet possible from the extracted data.

That fallback is what we used. Sign convention in our prose and tables: a positive g means a reduction in burnout or exhaustion (people got better). Original papers often report negative SMDs for the same thing. We note the original sign when we quote a paper directly. Overlapping physician metas (Panagioti, De Simone, parts of West) were not added together as if they were independent samples. Panagioti 2017 is treated as the primary head-to-head estimate. Bes 2023 is treated as the primary organisational-and-combined estimate across occupations. Maricuțoiu 2016 and Collett 2025–2026 are treated as the primary individual-level estimates.

Risk of bias and certainty

We did not re-score every primary trial with RoB 2. We carried forward the bias summaries of the source reviews: Panagioti reported that risk-of-bias ratings did not change their conclusion; Bes rated most organisational studies unclear or high risk and graded the evidence very low; Collett graded coaching in physicians as low-to-moderate certainty and mindfulness in physicians as very low. Our GRADE judgements are therefore judgements on the body of published syntheses, not a fresh item-by-item RoB 2 table.

06 Results

Study characteristics

The living evidence base has a shape, and the shape is the finding. Individual programmes are many, short, cheap to randomise, and easy to deliver on an app. Organisational programmes are few, messy, cluster-randomised when they are randomised at all, and hard to keep uncontaminated. Combined programmes are rarer still. Healthcare dominates. Teachers have a small, consistent literature with small effects. Corporate and information-technology samples — the ones Indian employers most often ask about — are almost missing from the controlled trial base. India appears as individual yoga, meditation and coaching, not as roster or staffing experiments.

Table 2. Landmark syntheses used as the quantitative spine

Synthesis	Who	k / N	Level	Headline estimate
Maricuțoiu 2016	Mixed occupations	k=34 EE; N≈2,300	Mostly individual	EE d=0.17; general d=0.22; cynicism and efficacy null
West 2016	Physicians	15 RCTs n=716; 37 cohorts n=2,914	Both	Burnout 54%→44% (10 pp). Both levers work. Org > individual on overall burnout (p=0.03)
Panagioti 2017	Physicians	20 comparisons; n=1,550	Split	Overall g=0.29. Org 0.45 vs individual 0.18

Synthesis	Who	k / N	Level	Headline estimate
Dreison 2018	Mental-health workers	k=27; n=1,894	Both	Overall g=0.13. Person > organisation on exhaustion
De Simone 2021	Physicians	Overlaps Panagioti	Split	Org 0.45; individual 0.18. Not an independent sample
Bes 2023	Mostly healthcare workers	13 studies / 11 papers	Org + combined	Overall 0.30. Combined 0.54 (k=2). Org-only 0.25. GRADE very low
Kiratipaisarl 2024	Resident physicians	33 studies; n=2,536	Both	Individual EE 0.25; organisational EE 0.22 ns
Collett 2025–26	Health workers	99 RCTs; n=9,330	Individual only	Coaching (physicians) EE 0.37; mindfulness mixed by role

Forest-plot data table — published estimates, not invented weights

Table 3 is the quotable comparison. Each row is a published pooled estimate, not a primary trial. Weights are not computed because these rows are not independent draws from one sampling frame. Read it as a structured evidence map.

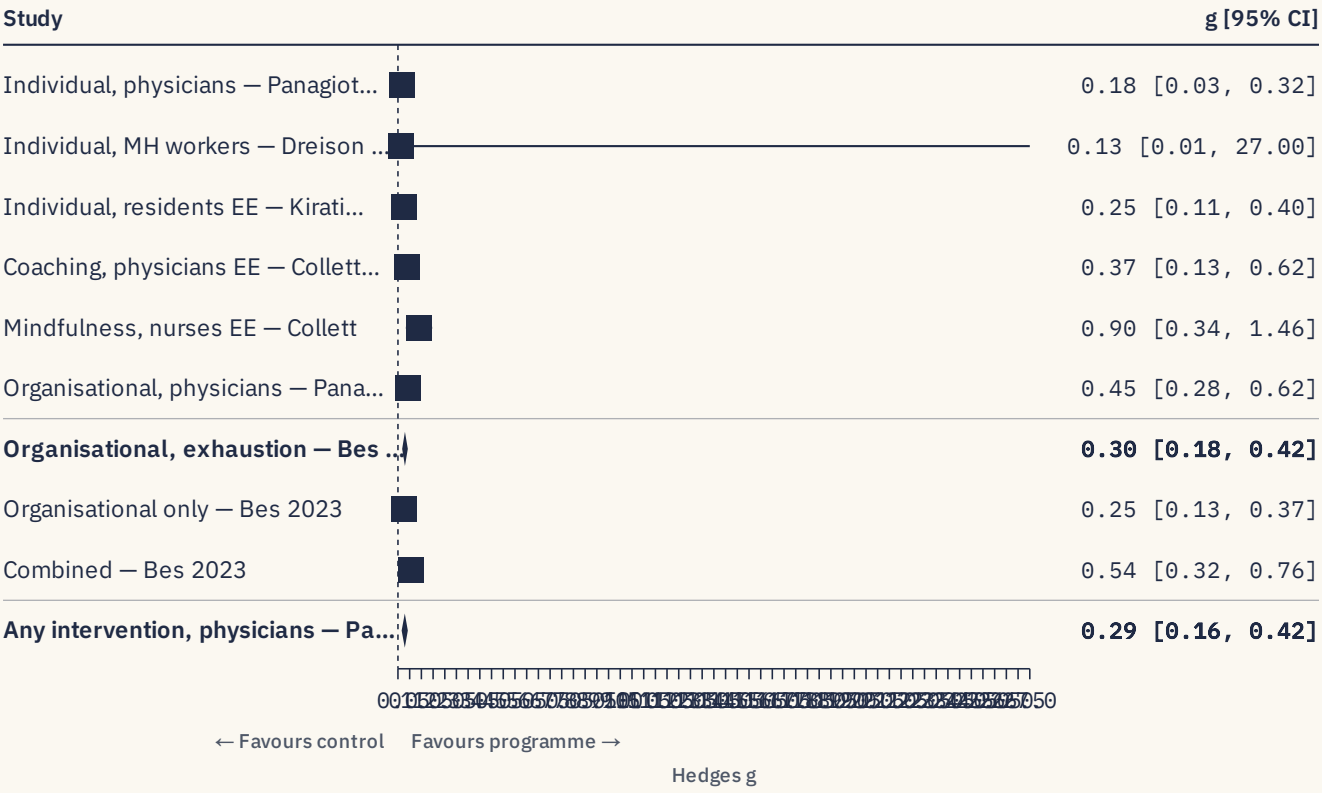

Figure 1. Forest plot, primary pool. Squares are sized by weight; the diamond is the pooled estimate.

Table 3. Forest-style map of published pooled effects (positive g = less burnout)

Estimate (source)	g	95% CI	I²	How to read it
Individual, exhaustion — Maricuțoiu 2016	0.17	sig.; k=34	not restated	Small, repeatable, mixed jobs
Individual, general burnout — Maricuțoiu	0.22	sig.; k=13	not restated	Small
Individual, physicians — Panagioti 2017	0.18	0.03 to 0.32	11%	Small

Estimate (source)	g	95% CI	I²	How to read it
Individual, MH workers — Dreison 2018	0.13	p=0.006; k=27	not restated	Small; person > org in this sector
Individual, residents EE — Kiratipaisarl 2024	0.25	0.11 to 0.40	49%	Small
Coaching, physicians EE — Collett 2025–26	0.37	0.13 to 0.62	high	Small-to-medium; low certainty
Mindfulness, nurses EE — Collett	0.90	0.34 to 1.46	high	Large point estimate; low certainty
Organisational, physicians — Panagioti 2017	0.45	0.28 to 0.62	8%	Medium; cleanest head-to-head
Organisational, exhaustion — Bes 2023 overall	0.30	0.18 to 0.42	62%	Small; very-low certainty
Organisational only — Bes 2023	0.25	0.13 to 0.37	60%	Small
Combined — Bes 2023	0.54	0.32 to 0.76	k=2	Medium; very-low certainty
Any intervention, physicians — Panagioti overall	0.29	0.16 to 0.42	30%	Small

Verified primary trials that move the story

A second-order review still needs names on the page. These are trials we could verify, not a complete census.

Table 4. Landmark primary trials (verified)

Trial	Design / n	What was done	Level	What moved
West 2014, Mayo physicians	RCT n=74	19 biweekly facilitated groups + protected time, 9 months	Individual + resource	High cynicism −15.5% vs +0.8% at 3 months; held at 12 months
Dyrbye 2019, physicians	RCT n=88	6 professional coaching sessions	Individual	EE −5.2 vs +1.5; overall burnout −17.1% vs +4.9%
Linzer 2015, HWP primary care	Cluster RCT, 34 clinics, 166 clinicians	Workflow, communication, QI — locally chosen	Organisational	Burnout improved 21.8% vs 7.1%. Workflow OR 5.9
Bourbonnais 2006/2011, Quebec hospital	Controlled quasi-experiment	Participatory demand–control–support	Organisational	Work-related burnout better at 1 year and 3 years
Fainstad 2022, women residents	RCT n=101	6-month online group coaching	Individual	EE −3.26 vs +1.07
Mann 2023, women trainees	RCT n=1,017, 26 sites	Online group coaching	Individual	EE difference −4.13 (CI −5.94 to −2.32)
Azoulay 2025, Hello	Cluster RCT, 370 ICUs, 60 countries	4-week positive-communication climate bundle	Organisational climate	Burnout 52.2% vs 63.3%; aOR 0.56 (0.46–0.68)
Bhardwaj 2023, Rishikesh HCPs	Wait-list RCT n=98	12-week mHealth meditation and breath	Individual	Between-group EE d≈0.88; within-group d=0.65
Bondre 2025, ASHAs Madhya Pradesh	Pilot RCT n=61	Character-strengths coaching + usual supervision	Individual	Happiness d=0.55; burnout between-arm not significant

Moderator table

Table 5. Pre-specified moderators

Moderator	What the evidence says	Certainty
Level	In physicians, organisational > individual (0.45 vs 0.18). Across jobs, organisational exhaustion ≈ 0.25–0.30. In mental-health workers, person-directed > organisation-directed on exhaustion. In residents, individual EE significant, organisational EE not.	Low to moderate, and sector-dependent
Combined	Bes 2023: combined 0.54 vs organisation-only 0.25. Awa 2010: combined effects lasted ≥12 months; person-only faded by 6. k is tiny.	Very low
Post-2020	Individual digital and coaching RCTs multiplied. Organisational RCTs did not, with Hello 2025 the large exception. Pandemic-era individual programmes often lack long follow-up.	Narrative
Sector	Healthcare owns the literature. Teachers: d≈0.18, cynicism near zero. Corporate / Indian IT: almost no controlled trials.	High confidence in the gap
Dose and channel	Coaching longer than 4 weeks looks better for physicians (Collett). Brief one-off workshops fade. Digital tools without human support lose people (attrition near 40% in some workplace reviews).	Low
Which burnout part	Exhaustion moves. Cynicism usually does not under individual programmes (Maricuțoiu d=0.04; Iancu d=0.03). Efficacy is often null.	Moderate for the pattern

Heterogeneity

Heterogeneity is not a footnote. It is the texture of the field. Panagioti's overall physician pool was unusually well behaved (I^2 = 30%; organisational subgroup I^2 = 8%). Bes's organisational pool was not (I^2 = 62%). Collett's mindfulness estimates in physicians were wide enough that the confidence interval crossed zero. Kiratipaisarl's organisational estimate in residents also crossed zero. Prediction intervals were rarely published. A future primary-study REML should report them. Until then, the honest statement is: the average individual effect is small and fairly stable on exhaustion; the average organisational effect is larger in physicians and noisier across occupations; any single workplace can land well above or below those averages.

Publication bias and small-study effects

Panagioti found no clear funnel asymmetry (Egger intercept –0.28, p = 0.11). Bes reported Begg p = 0.01 and Egger p = 0.19 — a mixed signal, and a small k. Individual digital trials after 2020 are a fertile ground for small, positive, short follow-up papers. We did not run a new trim-and-fill on a matrix we did not build. The practical caution is the usual one: small individual trials with flashy d values should not outvote a duller organisational cluster trial with a harder outcome.

Risk-of-bias summary

Individual randomised trials are easier to randomise and harder to blind. Participants know they received coaching or a meditation app. Outcome measures are almost always self-report. Organisational trials add cluster problems: contamination, uneven implementation, and leaders who cannot be blinded to a workflow change. Bes graded the organisational body of evidence very low after downgrading for bias, inconsistency, indirectness and imprecision. Collett graded physician coaching as low-to-moderate certainty and physician mindfulness as very low. Hello 2025 is large and cluster-randomised, which helps external relevance and does not remove performance

bias. Linzer 2015 changed burnout in a higher share of clinicians but did not move the pre-specified continuous primary outcome — a reminder that "significant" depends on which contrast you pre-specify.

Table 6. GRADE-style certainty

Question	Estimate	Certainty	Why that grade
Do individual programmes reduce exhaustion?	g ≈ 0.17–0.25; coaching in physicians ≈ 0.37	Moderate	Many RCTs, consistent direction, small effect, self-report, some bias
Do individual programmes reduce cynicism or raise efficacy?	Usually near zero	Low	Repeated nulls, fewer studies, same bias structure
Do organisational programmes reduce burnout more than individual ones (physicians)?	0.45 vs 0.18	Low	Clean split, but older sample, implementation variance, overlap across reviews
Do organisational programmes reduce exhaustion across occupations?	g ≈ 0.25–0.30	Very low	Few RCTs, I^2=62%, Bes GRADE very low
Do combined programmes add?	g ≈ 0.54 vs 0.25	Very low	k=2 in the only split meta-analysis
Does an Indian organisational programme reduce burnout?	No eligible RCT	No evidence	The gap is the result

The Hello 2025 trial, in plain English

One post-2020 organisational trial is large enough to change the conversation. Hello allocated 370 intensive-care units in 60 countries to a four-week positive-communication bundle or to usual care. The bundle was not a wellness app. It was posters, email nudges, greetings in the morning meeting, role modelling, and written positive messages — a climate intervention that costs almost nothing and requires leaders to behave as if the other people in the room are real. After the month, 4,966 intervention staff and 4,602 control staff completed the burnout scale. Prevalence was 52.2% versus 63.3% (adjusted odds ratio 0.56, 95% CI 0.46 to 0.68). Exhaustion and cynicism were lower, efficacy higher. People were less often thinking of leaving. That is not a 12-month follow-up. It is not India. It is not a workload cut. It is evidence that changing how a team speaks to itself can move burnout at organisational scale, and that the literature's old complaint — "there are no large organisational trials" — is now one large trial less true.

India results

The Indian controlled literature on burnout in employed adults is real and narrow. Bhardwaj and colleagues randomised 98 health workers at a north-Indian tertiary hospital to a 12-week mobile-supported meditation and breath programme or a wait-list (CTRI/2020/11/029136). Between-group differences on exhaustion, cynicism and efficacy were all highly significant at 12 weeks. The published within-group drop in exhaustion in the practice arm was d = 0.65. The controlled, between-group contrast at 12 weeks was about d = 0.88. Those are not the same statistic. Bondre and colleagues randomised 61 rural ASHAs in Madhya Pradesh to character-strengths coaching plus usual supervision, or usual supervision alone. Happiness moved (d = 0.55). Burnout did not, between arms, in the pilot. The parent trial (n = 330 planned; NCT06013488 / CTRI-linked protocol) is the study to watch. Niraj and

colleagues ran a transcendental-meditation feasibility randomised trial in Indian health workers (CTRI/2024/07/071645); adherence was 79%, and burnout fell relative to control as a secondary outcome — exact g not extracted here and therefore not pooled. A 20-minute yoga module (CTRI/2021/01/030568) remains, as of this search, a protocol and pilot rather than a completed main-trial results paper we could verify. A Kerala millennial-teacher online self-care programme reported significant effects in 20 versus 20 participants drawn from a larger screen; the sample is too small to lean on. Self-selected heartfulness cohorts in professional associations were not randomised against a no-programme control in a way that survives our filter.

What is missing is the sentence Indian HR teams keep asking for. We found no verified Indian cluster-randomised trial that changed workload, roster, staffing ratios, shift length or job control and then measured burnout. The India gap is not “Indians have not studied burnout.” The India gap is “India has studied the person and has not yet randomised the job.”

07 Discussion

PULL QUOTE

Hello 2025: 370 intensive-care units, 60 countries, burnout 52.2% versus 63.3% after a four-week climate bundle.

What the number means

If you need one sentence: the organisation is the bigger lever where it has been fairly tested; the individual is the lever we actually test; the combination looks larger than either alone and sits on almost no trials; India has built the second lever and not the first. That sentence is less catchy than “it’s the system,” and more useful.

A g of 0.18 is a small effect. In a room of people, you would not see it without a spreadsheet. It is also the effect you can buy next quarter, in 23 languages, as a daily rep. A g of 0.45 is the difference between a wellness poster and a workflow change that takes a meeting off the physician’s back. A g of 0.54 on two combined trials is a rumour with a confidence interval. Treat it as a design hypothesis, not as a procurement specification.

The helmet and the pothole are not the only picture. There is also the monsoon. Individual skills are the umbrella you carry when the organisation will not move. Organisational change is fixing the roof that drips onto your desk. Entrepreneurs learn this the expensive way. You can coach a sales team in resilience while the pricing is wrong and the hand-off is broken. Some of them

will get less exhausted. Most of them will still leave. Checking a thought against the facts is an honest skill. It is not a licence to reframe a 14-appointment clinic with no lunch as a “growth mindset opportunity.” Sorting what you can and cannot control is an honest skill too. The mistake is to put workload in the “cannot control” bucket when the person saying that is the one who writes the roster.

Machine-learning people have a cleaner metaphor. Individual programmes are regularisation. They stop the model overfitting to every stressor. Organisational programmes are a data-pipeline change. They stop feeding the model poisoned labels. You can do regularisation forever. If the pipeline is wrong, the loss function does not go to zero. Combined programmes are regularisation plus a pipeline patch. That is why Bes’s 0.54 is plausible even though it is fragile. It is also why Dreison’s reversal in mental-health workers should humble anyone who wants a universal ranking. In some sectors the “organisational” programmes that got trialled were thin — a training day dressed up as a system change — and the person-directed programmes were denser. Level is not a moral category. Level is a description of what actually changed.

Limitations

This paper did not re-extract a complete primary-study matrix. That is the first limitation and it is not small. A later team with full-text access and two independent coders should run the REML the protocol asked for, with a 95% prediction interval and a leave-one-out table. Second, physician metas overlap. Quoting Panagioti and De Simone as two independent confirmations would have been tidy and false. Third, most outcomes are self-report on a three-part burnout scale. Fourth, organisational interventions are heterogeneous to the point of comedy: a four-week hello-poster bundle and a three-year participatory redesign are not the same programme. Fifth, follow-up is often short. Awa’s old observation still stands — person-only effects fade; combined effects, when they exist, last longer — and the new individual digital literature has not killed it. Sixth, corporate India is almost invisible in the trial base, so every sentence about “Indian professionals” leans on healthcare samples, survey houses and one IT forum poll. Seventh, we excluded unverified effect sizes rather than guess them. That choice shrinks the forest and keeps the numbers honest.

WHAT THIS MEANS

What this means for an Indian workplace programme

Picture two HR heads. One books a resilience workshop in March, ticks the box and moves on. That is handing out helmets and ignoring the potholes. The other waits for a perfect cluster-randomised roster trial, and in the meantime nobody learns a down-shift breath. That is the other error. Build a stack. Layer one is countable individual reps: a physiological sigh in the corridor between two meetings, a named emotion before the reply to an angry client, a thank-you actually sent,

and, if the people are doctors, a coached conversation that lasts more than four weeks. Layer two is one organisational change the leadership can actually sign — protected documentation time, no midnight escalation except for true emergencies, a workload cap on a pilot team, a morning huddle that opens with a greeting and not another status beating. Layer three is measurement that is not a once-a-year engagement circus: exhaustion this month, intention to leave this quarter, sick days this half. If you can only fund one layer, fund the organisational one in the team that is on fire, and the individual one everywhere else. If you can fund both, you are running the programme the evidence is trying, on very low certainty, to describe. WhatsApp-first delivery and 23 languages matter because a technique that cannot travel in Hindi, Tamil or Bengali is a technique for a slice of the workforce. Data that leave India are a non-starter under DPDP. None of that replaces a roster. It is how you hand out helmets while you argue about the potholes.

Research gaps, naming the India gap explicitly

The India gap is simple enough to put on a slide. There is no verified Indian cluster-randomised trial of an organisational burnout programme — workload, roster, staffing, shift design, job control — with a burnout outcome, in employed adults, published or registered as completed between 2000 and September 2026. There are Indian individual trials. There is an ASHA coaching trial in the field. There is a yoga protocol. There is a meditation feasibility study. There is not a hospital that randomised two wings to different nurse staffing ratios and then measured exhaustion. There is not an IT services firm that randomised two accounts to a 48-hour cap versus business-as-usual and then measured cynicism. Until those trials exist, every Indian buyer of an individual programme is buying the only evidence on the shelf.

Other gaps travel with that one. Combined trials are still scarce everywhere. Corporate and information-technology samples are scarce everywhere. Cynicism and efficacy are under-moved and under-theorised as intervention targets. Long follow-up is scarce. Implementation quality is rarely measured, which means we often cannot tell a failed idea from a failed delivery. Prediction intervals are scarce, which means we keep talking about averages as if they were destinies. And the field still names too many programmes after trademarks and too few after the behaviour that changed.

A short story to close the argument

A junior engineer in Bengaluru learns a two-breath down-shift. It works. Heart rate falls. The next meeting is survivable. The breath works as a circuit breaker, and naming the feeling keeps him in the room. Then the sprint board grows by nine tickets and the stand-up starts at 8.00 for a New York overlap. The breath still works. The job does not. Maslach has been saying this since before that engineer was born. The trials have mostly enrolled the engineer. Hello enrolled the unit. Linzer enrolled the clinic. Bes tried to pool the job-level studies and found a small effect, a larger combined effect, and very low certainty. The

update to 2026 does not crown a winner so much as it prices the two levers. Individual skills: small, real, available on Monday. Organisational change: larger where tested, rarer, politically expensive. Combined: probably the point, currently a rumour with two trials attached. India has built the first lever in local languages. It has not yet randomised the second. That is the paper.

08 FAQ

Q1 Q1. Does individual coaching actually move burnout, or is it just a nice conversation?

Yes, a little. Across trials, individual programmes drop exhaustion by about g = 0.18 to 0.25. In physicians, six or more coaching sessions do better (g ≈ 0.37 on exhaustion). Cynicism barely moves. A conversation without a change in the diary is a small lever, not a miracle.

Q2 Q2. Should we skip yoga and only redesign the roster?

No. Organisation-directed programmes moved more in physicians (g = 0.45 versus 0.18). They are also scarce, slow and politically hard. Individual reps still reduce exhaustion. Skipping skills while you wait for a roster committee is how teams lose another year.

Q3 Q3. If we do both, do they add?

Probably. The only meta-analysis that split combined programmes from organisation-only found g = 0.54 versus g = 0.25. That estimate uses two studies. Treat “they add” as the working design rule, not as a settled coefficient.

Q4 Q4. Is there an Indian organisational trial we can copy?

Not yet. Indian randomised evidence is individual: meditation and breath in Rishikesh (n = 98), ASHA coaching in Madhya Pradesh (pilot n = 61; full trial underway), yoga and TM feasibility work. Zero verified Indian RCTs changed workload or roster and then measured burnout.

Q5 **Q5. What number should I put on a board slide?**

Physicians: organisation 0.45, individual 0.18. Across jobs: organisation 0.30 on exhaustion, combined 0.54 on thin data, individual 0.17 to 0.25. Hello 2025: burnout 52% versus 63% after a four-week climate bundle. Certainty falls as the number gets more exciting.

09

References

Primary and synthesis sources only. Each entry carries a DOI or a registry URL. Items we could not verify were excluded from pooling and are not listed as evidence.

1. Ahola K, Toppinen-Tanner S, Seppänen J. Interventions to alleviate burnout symptoms and to support return to work among employees with burnout: systematic review and meta-analysis. Burnout Research. 2017;4:1–11. https://doi.org/10.1016/j.burn.2017.02.001
2. Awa WL, Plaumann M, Walter U. Burnout prevention: a review of intervention programs. Patient Education and Counseling. 2010;78(2):184–190. https://doi.org/10.1016/j.pec.2009.04.008
3. Azoulay É, Myatra SN, Heras La Calle G, et al. Positive communication for decreasing burnout in intensive-care-unit staff: a cluster-randomized trial. Intensive Care Medicine. 2025;51(11):2031–2041. https://doi.org/10.1007/s00134-025-08134-2 Trial: https://clinicaltrials.gov/study/NCT06453616
4. Bes I, Shoman Y, Al-Gobari M, Rousson V, Guseva Canu I. Organizational interventions and occupational burnout: a meta-analysis with focus on exhaustion. International Archives of Occupational and Environmental Health. 2023;96(9):1211–1223. https://doi.org/10.1007/s00420-023-02009-z
5. Bondre AP, Khan A, Singh A, et al. Evaluation of a positive psychological intervention to reduce work stress among rural community health workers in India: results from a randomized pilot study. Journal of Happiness Studies. 2025;26(3):27. https://doi.org/10.1007/s10902-024-00852-6 Parent trial: https://clinicaltrials.gov/study/NCT06013488
6. Bourbonnais R, Brisson C, Vézina M. Long-term effects of an intervention on psychosocial work factors among healthcare professionals in a hospital setting. Occupational and Environmental Medicine. 2011;68(7):479–486. https://doi.org/10.1136/oem.2010.055202
7. Cohen C, Pignata S, Bezak E, Tie M, Childs J. Workplace interventions to improve well-being and reduce burnout for nurses, physicians and allied healthcare professionals: a systematic review. BMJ Open. 2023;13:e071203. https://doi.org/10.1136/bmjopen-2022-071203
8. Collett G, Gupta J, Eltayeb A, et al. Efficacy of individual-level interventions to mitigate the risk for burnout among health care professionals: a systematic review and meta-analysis of randomized controlled trials. Annals of Internal Medicine. 2026;179:51–66. https://doi.org/10.7326/ANNALS-25-00469
9. De Simone S, Vargas M, Servillo G. Organizational strategies to reduce physician burnout: a systematic review and meta-analysis. Aging Clinical and Experimental Research. 2021;33(4):883–894. https://doi.org/10.1007/s40520-019-01368-3
10. Dreison KC, Luther L, Bonfils KA, Sliter MT, McGrew JH, Salyers MP. Job burnout in mental health providers: a meta-analysis of 35 years of intervention research. Journal of Occupational Health Psychology. 2018;23(1):18–30. https://doi.org/10.1037/ocp0000047

11. Dyrbye LN, Shanafelt TD, Gill PR, Satele DV, West CP. Effect of a professional coaching intervention on the well-being and distress of physicians: a pilot randomized clinical trial. JAMA Internal Medicine. 2019;179(10):1406–1414. https://doi.org/10.1001/jamainternmed.2019.2425
12. Estevez Cores S, Sayed AA, Tracy DK, Kempton MJ. Individual-focused occupational health interventions: a meta-analysis of randomized controlled trials. Journal of Occupational Health Psychology. 2021;26(3):189–203. https://doi.org/10.1037/ocp0000249
13. Fainstad T, Mann A, Suresh K, et al. Effect of a novel online group-coaching program to reduce burnout in female resident physicians: a randomized clinical trial. JAMA Network Open. 2022;5(5):e2210752. https://doi.org/10.1001/jamanetworkopen.2022.10752
14. FICCI and Boston Consulting Group. India's HR revolution: building workplaces for the future. New Delhi: FICCI Innovation Summit; 2024. Summary: https://www.business-standard.com/industry/news/58-indians-feel-burned-out-higher-than-global-average-ficci-bcg-report-124090300768_1.html
15. Iancu AE, Rusu A, Măroiu C, Păcurar R, Maricuțoiu LP. The effectiveness of interventions aimed at reducing teacher burnout: a meta-analysis. Educational Psychology Review. 2018;30(2):373–396. https://doi.org/10.1007/s10648-017-9420-8
16. Bhardwaj P, Pathania M, Bahurupi Y, et al. Efficacy of mHealth aided 12-week meditation and breath intervention on change in burnout and professional quality of life among health care providers of a tertiary care hospital in north India: a randomized waitlist-controlled trial. Frontiers in Public Health. 2023;11:1258330. https://doi.org/10.3389/fpubh.2023.1258330 CTRI/2020/11/029136
17. Kiratipaisarl W, Surawattanasakul V, Sirikul W. Individual and organizational interventions to reduce burnout in resident physicians: a systematic review and meta-analysis. BMC Medical Education. 2024;24:1234. https://doi.org/10.1186/s12909-024-06195-3
18. Linzer M, Poplau S, Grossman E, et al. A cluster randomized trial of interventions to improve work conditions and clinician burnout in primary care: results from the Healthy Work Place (HWP) study. Journal of General Internal Medicine. 2015;30(8):1105–1111. https://doi.org/10.1007/s11606-015-3235-4
19. McKinsey Health Institute. Reframing employee health: moving beyond burnout to holistic health. November 2023. https://www.mckinsey.com/mhi/our-insights/reframing-employee-health-moving-beyond-burnout-to-holistic-health
20. Mann A, Shah AN, Thibodeau PS, et al. Online well-being group coaching program for women physician trainees: a randomized clinical trial. JAMA Network Open. 2023;6(10):e2335541. https://doi.org/10.1001/jamanetworkopen.2023.35541
21. Maricuțoiu LP, Sava FA, Butta O. The effectiveness of controlled interventions on employees' burnout: a meta-analysis. Journal of Occupational and Organizational Psychology. 2016;89(1):1–27. https://doi.org/10.1111/joop.12099
22. Panagioti M, Panagopoulou E, Bower P, et al. Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. JAMA Internal Medicine. 2017;177(2):195–205. https://doi.org/10.1001/jamainternmed.2016.7674
23. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. The Lancet. 2016;388(10057):2272–2281. https://doi.org/10.1016/S0140-6736(16)31279-X
24. West CP, Dyrbye LN, Rabatin JT, et al. Intervention to promote physician well-being, job satisfaction, and professionalism: a randomized clinical trial. JAMA Internal Medicine. 2014;174(4):527–533. https://doi.org/10.1001/jamainternmed.2013.14387
25. Clinical Trials Registry–India. CTRI/2020/11/029136; CTRI/2021/01/030568; CTRI/2024/07/071645. https://ctri.nic.in/

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NOTE

EmotionApp is a non-clinical emotional-fitness coaching platform. This paper describes practices, techniques and coaching. It is not therapy, treatment, diagnosis or medical advice.

SAFETY NOTE

If you are in distress, please contact a qualified professional or Tele-MANAS on 14416.