Burnout No More: How to Push Back Against the Toxic Medical Workplace

Robert S. Emmons, M.D.

Introduction

When rates of burnout approach 50 percent in our profession,[1] with no relief in sight, it is time to try a new approach. A good place to start is to set aside the nomenclature and attitudes that create false impressions of pathology in physicians. Let us keep the spotlight on the real pathology, the **toxic medical workplace**.[2] In order to distinguish the regular irritants of everyday life from unacceptably noxious work conditions, I will define toxicity in the medical workplace as the third-party influences on physicians' minds that do not support the best interests of individual patients. As physicians, we are caretakers of individual patients first and foremost; when the systems around us block us from carrying out this primary role, moral injury[3] and **moral fatigue** result. The purpose of this paper is to expand the discussion of moral injury in the medical workplace by proposing a pathogenic mechanism, directions for future investigation, and timely remedies.

Human systems rarely reform themselves. Experience shows that public policy makers, corporate executives, and hospital administrators are willing to invest in making our workplaces better, but only to the extent that they do not have to give up their selfish interests or publicly admit their failures. An external lever is needed to move the systems that can harm us and our patients, and that lever exists in our own minds. We can take immediate action to resist problematic third-party interventions into our work and our minds by consciously investing energy to keep ourselves in the right kinds of mental alignment with our patients and colleagues. When we practice that discipline, excellent clinical practice and moral health result.

A Theory of the Unconscious Mind in Physician Professionalism

Daniel Kahneman and his colleagues in behavioral economics have popularized the idea that our minds operate at two levels: one fast, unconscious, automatic, and intuitive—System 1; and the other deliberative, conscious, effortful, and attentive—System 2.[4] The medical mind, in its optimal state, free of third-party influences, combines conscious use of the scientific method with an unconscious mind that is conditioned through clinical experience to quickly recognize patterns of illness and health. When we speak of ourselves as clinical scientists, we are generally talking about the operations of System 2 in our minds, but without methodical consideration of our unconscious mental lives, we can be susceptible to unwelcome influences on System 1, the other major locus of our clinical decision-making. In matters of the unconscious mind, psychoanalytic theory can usefully extend the insights of the behavioral economists.

Identification is the unconscious mental process by which we take in parts of others' minds in order to communicate with them and to build our stories about ourselves. Through this process we not only learn, but we adopt, willingly or not, the world views, self-images, and behavioral methodologies of important others.[5] This is part of everyday life, and it happens in the medical workplace also. For example, when I practice friendliness toward my patients, I am using a method modeled by both of my physician parents.

Mental alignment with our patients transcends understanding them in a purely cognitive way. When we are able to operate in this optimal clinical mode, we diagnose and select treatments more accurately, because we have allowed free rein to our unconscious information collection and pattern recognition. In addition, we can understand and honor our patients' values and preferences better when we position ourselves in our minds to look at the world through their eyes.

We cannot know all of our unconscious mental operations as we go about our days treating our patients, but we can discern some important surface-level markers. **Professional self-value** is the feeling of moral satisfaction that results from genuine professional achievement. Professional self-value is a reliable indicator of a medical mind that is functioning effectively, and that state of mind requires alignment, both conscious and unconscious, with patients.

Conscience is a mental function that requires the recognition that minds other than one's own exist. Conscience is the basis for reciprocal, trusting relationships. As physicians, we must treat our patients as separate others, with needs and aspirations of their own, who do not exist only to serve our own ends. Conscience complements heart by keeping us in our proper roles as professionals. Conscience is not a feature of systems, groups, or organizations; rather, it is an indispensable mental process that can exist only in individual human minds.

The purpose of medical ethics is not only to keep us from doing the things that are known to cause harm to our patients. Our formal ethical and professional codes can also be understood as sets of procedures, or best practices, that promote the right kinds of identification with patients. Trust is not just a marker of a physician's inherent trustworthiness; it is also a marker of a medical mind that is functioning effectively, without interference from surrounding systems. The ethical aspiration to stay free of third-party influences, avoiding financial conflicts of interest, and protecting confidentiality, is designed to promote loyalty and identification with patients.[6] Codes of ethics that incorporate third-party interests, often labeled broadly and imprecisely as "society,"[7] redirect physicians' mental alignments away from patients and toward agents with objectives other than optimal clinical outcomes.

Collegiality supports the clinician's heart and conscience. In our training years, our teachers and mentors impart valuable information, but more importantly, they model how to identify

with patients and relate to them within an ethical framework. Throughout our careers, regular, direct communication with our colleagues promotes excellent clinical care through positive modeling and reinforcement of optimal practices. Regular interaction and the resulting identification with colleagues is key to keeping our minds in the right alignments with our patients. I prefer the term "collegiality," which emphasizes our mutual connections to our profession, over "teamwork," which has unfortunately been co-opted nowadays to imply organizational service.

Groups extend the reach of the individual mind through specialization and cooperative work. The human mind is predisposed to want to identify with things larger than itself, in order to reap the benefits that group membership can offer, a replication of the family life that is essential to early psychological development. We must recognize, however, that the human mind organizes itself predominantly as maps of two-person relationships, so we identify with groups, organizations, and institutions as if they were individual humans. That's why corporations use pitchmen instead of PowerPoints in their advertising. When you find yourself singing a jingle from a TV commercial, you are identifying with the corporation selling the product. Medicine is full of its own pitchmen, such as the Grand Rounds speaker who uses slides emblazoned with an institutional logo.

The only reason for groups to exist is to make life better for their individual members and constituents. Medical organizations, when they are functioning effectively, support the natural identifications between clinicians and their patients and colleagues. The success of medical organizations is measured first and foremost in individual clinical results.

Toxic Organizational Process in Medicine

Just as we need systematic theories of disease in order to organize our interventions with our patients, we need systematic theories of sickness in group life in order to handle our interactions with the organizations that we encounter in our professional lives. Thoroughgood et al. define a destructive leadership dynamic as one in which "leaders, in conjunction with followers and contexts, ultimately bring misfortune and harm to their constituents, including internal and external stakeholders, as well as damage the organizations in which they reside. . ."[8]

Extending this concept holistically from individual leaders to entire organizations in medicine, we can define the *toxic medical culture* as one that puts perpetuation of an organization, or the aggrandizement, financial and emotional, of a few individuals, ahead of the interests of individual patients and physicians.

It is not natural for physicians to do things that harm their patients, and they would resist explicit appeals to do so, so toxic organizational cultures fall back on the natural human propensity to group identification as a principal method to make physicians their servants. The toxic medical culture uses a variety of methods to compel identification with, and service to, the organization at the expense of one-to-one reciprocity between patients and doctors. The 2019 *Medscape* report on doctor burnout cites "too many bureaucratic tasks, too many

hours, EHRs, lack of respect, insufficient compensation, lack of autonomy, and too many regulations" as causes,[9] but this list of commonly known workplace toxicities may still create false impressions of inevitability, and the pathogenicity of group identification is not explicitly recognized.

Workplace toxicity in medicine can be delineated at multiple levels: pathological tactics used by leaders, pathological organizational practices, and pathological outcomes for physicians and patients. The methods of destructive leadership are classified by Thoroughgood et al. as: "control, coercion and manipulation, rather than persuasion and commitment."[8] When I define a toxic organizational practice as one that does not support the interests of patients, I am offering an outcome-based definition. As this paper is intended to focus on pathological systems, not leaders, the list that follows is a compendium of common administrative practices in medical organizations, and other institutions that touch the medical workplace, that meet this outcome-based definition of toxicity. Identification with organizations and institutions, when it is driven by these methods, can be toxic to the medical mind. This list is intended as provisional and a prelude to more systematic investigations of the effects of these toxic practices on physicians' minds:

- Surveillance directed toward organizational interests rather than bona fide patient interests;
- Formal, administrative punishment for noncompliance with organizational policy and objectives;
- Informal punishment and retaliation (e.g., whisper campaigns) for ordinary collegial dissent;
- Reward, financial and otherwise, for compliance with organizational agendas;
- Messaging that falsely conflates organizational interests with patient interests;
- Repetitive, ritualistic acclamations of organizations and their leaders;
- Encouragement of cults of personality organized around administrators;
- Organizational monitoring and supervision of collegial communication;
- Systematic scapegoating of clinicians for organizational failures;
- The substitution of legal and administrative standards of documentation for bona fide professional standards;
- Risk management directed toward institutional interests rather than those of physicians or patients;
- Excessive certification and testing;
- Pay below fair market value for clinicians, and pay above fair market value for administrators; and
- Sham peer review and sham psychiatric referral.

The current culture of *surveillance* as a major toxicity in medicine merits separate comment. Surveillance, at an unconscious level in physicians' minds, crowds out the space that is needed for the positive mental functions of conscience, self-reflection, and self-regulation. Excessive reliance on surveillance to ensure quality in medicine substitutes compliance for conscience. When we comply with the demands of surveillance, gladly or not, we treat our patients according to administrative codes designed to serve third-party interests, rather than our own ethical codes designed to serve the best interests of our patients. When organizations view physicians as

foot soldiers, the perceived need to use punitive surveillance to maintain discipline amounts to enactment of the Machiavellian dictum: "With one's army . . . there is no such thing as too much cruelty."[10]

Identification with toxic medical cultures may reside out of view in the unconscious minds of physicians, but some surface-level markers can be named. For example, when an employed colleague says, "I'm afraid I could get fired," I take that as pathognomonic of her membership in a toxic medical culture.

Moral Fatigue

Now that we have established that toxicity in organizational cultures and practices can be defined objectively in terms of outcomes, let us turn our attention to the pathological outcomes that can result for physicians. The syndrome that has been named "burnout" in physicians can be considered as a mental analogue to the body's inflammatory response to an exogenous pathogen.

Burnout is described in the literature as a long-term stress reaction, consisting of emotional exhaustion, depersonalization, loss of empathy, cynicism, and low feelings of personal achievement, that manifests in individual physicians.[11] Jonathan Shay[12] defines moral injury as a complex of despair and inability to trust that results when deeply held moral values are betrayed by persons to whom one must answer. Dean et al. have renamed "burnout" in our profession as moral injury, in order to underline its true etiology, which is the toxic medical workplace, not any sort of psychopathology of individual physicians.[3] Based on my experiences as a consultant to colleagues treated coercively in Physician Health Programs, I tend to reserve the term moral injury for the severe syndromes, up to and including suicidality, that result from the individual targeting of physicians perceived to be noncompliant with organizational or institutional objectives.[13] In this paper I will use the term "moral fatigue" in order to encompass the lower-grade syndromes that result from the less severe, non-targeted toxicities in the medical workplace.

Depersonalization and lack of empathy can be understood as the surface-level markers of disruption in the ability to identify with patients and colleagues. Cynicism and low feelings of personal achievement can be understood as loss of professional self-value, yet another surface-level marker of loss of mental alignment with patients.

Putting all this together, the mechanism of action in the unconscious mind that underlies moral fatigue can be posited as regular, systematic intervention by third parties to disrupt identifications between physicians and their patients and colleagues. To illustrate, it may be obvious that administrative tasks, enabled by EHRs, crowd out time for clinically relevant tasks. Yet it might not be so obvious that these administrative practices are enervating to the medical mind because the wrong kinds of organizational identifications are substituted for the right kinds of identifications with patients and colleagues. Demoralization is the result when the medical conscience is repeatedly frustrated in its aim to serve the patient.

Moral fatigue can be considered, then, as a reliable surface-level marker of toxic organizational identifications that would otherwise operate invisibly in the unconscious minds of physicians. We can speculate that rates of moral fatigue in any given medical workplace are directly proportional to levels of workplace toxicity. Surveys of physician burnout, interpreted correctly, can be treated as public reporting of organizational failure.

The fingerprints of third-party intervention are often invisible when they impact clinical outcomes. Doctors, the visible face of toxic influences from government agencies, insurance plans, and hospitals, are apt to be blamed for any bad clinical outcomes or dissatisfaction that might ensue.

Some studies have suggested that moral fatigue is associated with higher rates of medical errors.[14] In other words, when third parties systematically disrupt the relationships between patients and their doctors, clinical outcomes are degraded. A recent report published by the Agency for Healthcare Research and Quality,[15] offers some reassurance:

. . .[P]hysicians' reactions to these work conditions were not consistently associated with quality of patient care. The investigators' interpretation was that, although physicians are affected by work conditions, their reactions do not translate into poorer quality care because the physicians act as buffers between the work environment and patient care. When lower quality care was seen, the investigators found it was the organization that burned doctors out that led to lower quality care, rather than the burned-out doctors themselves.

Based on the above findings by AHRQ, we have good grounds to resist public policies of punitive surveillance that are based on the premise that morally fatigued physicians routinely harm patients, but we would hardly want to ignore the problem of the toxic medical workplace. Dissatisfaction with the clinical experience and loss of trust, even if they do not progress to frank medical errors, can still be accounted as bad clinical outcomes. Further study of the links between toxic organizational practices and adverse outcomes for patients and physicians is sorely needed. In the meantime, in the absence of any evidence otherwise, we should assume that many of the practices commonly used in medical organizations today are not safe and effective for patients, so we as physicians should engage with those practices with great caution.

Many medical societies and medical regulators persist in using the label "burnout," sometimes even explicitly pathologizing physicians, which only exacerbates the problem of the toxic medical workplace. For example, an AMA publication quotes Michael Tutty, Ph.D., vice president of the AMA's Professional Satisfaction and Practice Sustainability group: "The first step is always admitting you have a problem."[16] Citing high rates of emotional distress in the medical workplace, a paper by Goldman et al. recently featured in JAMA focuses on routine mental health screening for physicians as a potential remedy,[17] when organizational stress tests would more specifically identify the real problems that need to be addressed. The National Academy of Medicine has published a list of survey tools to measure physician burnout,[18] not workplace toxicity.

The Federation of State Physician Health Programs has added burnout to its list of potentially impairing conditions,[19] thus putting half of our profession at risk for highly damaging, false-positive identifications of impairing mental illness.[20] The

World Health Organization has achieved a new pinnacle of false labeling by officially classifying job burnout as a medical diagnosis in its 2019 ICD-11 update.[21]

Prescriptions for the workplace based on theories of physicians impaired by "burnout" cannot adequately address system failures. The AMA offers "practice transformation experts" who will provide guidance in implementing programs of regular wellness surveys conducted by wellness committees, led by "wellness champions," using the Mini-Z burnout assessment tool, along with "workflow redesign," new programs of Quality Improvement, and mindfulness training for physicians.[22] All of this amounts to ever higher doses of existing toxic practices.

Moral Self-Care

So, what does it mean in actual practice to manage one's own identifications? Identification with patients does not mean literally living as they do or with them, but it does mean reflecting their world views back to them and respecting their methods. All physicians, not just psychiatrists, are taught a variety of techniques to promote the right kinds of alignment with patients:
- Be friendly.
- Take time.
- Listen carefully.
- Ask questions.
- Use patients' words when possible, not technical jargon.
- Use metaphors from patients' lives.
- Remember personal details.
- Explain your own thinking process (transparency is the opposite of compliance).

Some of the methods that build the right kinds of identification have to do with the general stance, or atmosphere, of treatment:
- Support patients' authentic ambitions; do not substitute your own.
- Let patients say "no" without penalty.
- Don't morally judge.
- Don't retaliate in the face of disturbing thoughts and feelings.
- Be ready to change course based on the patient's response to interventions; in other words, if things aren't working, don't blame the patient.

If the above feel familiar, then it is likely that the reader is keeping alive his identifications with patients. The obvious is stated here because these best practices start to feel remote and unrealistic when physicians fear that they will be punished for failure to promote institutional objectives. Fear is a form of identification with the oppressor.

What about identifying with colleagues?
- Be friendly.
- Ask questions.
- Stay in touch (face to face is best).
- Share stories about the clinical work, rather than the need for administrative compliance.
- Show an interest in colleagues' methodologies, even if they are different from your own.
- Give colleagues credit for their successes.
- Remember your teachers.
- Don't morally judge.

- Don't retaliate for ordinary collegial differences of opinion.

My attitude toward the colleagues with whom I have differences of opinion might be encapsulated, with my tongue lightly grazing my cheek, as: "There are no bad doctors, only bad organizational identifications."

The Moral Firewall

Now that we have elaborated a "to do" list, it is time to consider what "*not* to do." The **moral firewall** is a set of mental procedures designed to be used by the healthy medical mind in order to avoid identification with toxic organizational practices. Institutions have their playbooks and we need our own in order to systematically counter their tactics. I don't want to be singing a jingle written by a health insurance plan, a hospital, a government agency, or a political party.

A list of effective mental goal-tending methods follows:
- Treasure your accumulated professional experience and the clinical judgment that flows from it. Your personal System 1 is a good thing! I convey this stance to patients by saying "in my clinical experience" much more frequently than I say "according to the literature."
- When I refer to patients and colleagues, I say, "we" and "us." When I refer to government agencies, insurers, and hospitals, I say "them."
- Don't use language that originates outside our profession. Words like "healthcare" and "provider" were abolished from my vocabulary long ago; "burnout" is a newer addition to my personal blacklist.
- Appropriate and re-purpose third-party slogans. When I state accurately that my practice is "evidence-based," I partly mean that I keep up with the literature, but mostly, I mean that I carefully observe the clinical results of my interventions and constantly upgrade my practice accordingly.
- Use algorithms and practice guidelines with great caution. Algorithms are based on populations, so by definition they are not individualized for our patients. Moreover, studies show very high rates of financial conflicts of interest among authors of practice guidelines.[23] Algorithms and practice guidelines should be treated as vectors for third-party interests.
- EHRs are specifically designed to get physicians to identify with third-party interests. Commercial EHRs combine surveillance with the systematic administration of rewards and punishments in order to compel compliance with third-party-driven practice guidelines and algorithms. By all means, design your own electronic file system to suit your own practice needs, but regulation-compliant EHRs are time sinks and sources of suspect information.
- Avoid financial relationships with third parties whenever possible, because payment commands loyalty. If you must accept financial relationships with outside parties, dis-close the terms of those relationships to your patients. Insurers, government agencies, and hospitals use financial incentives systematically to create fear of punishment for noncompliance with their objectives.
- Assign credit where it is due, to individuals. Whenever a positive clinical outcome results, I give credit to the patient, myself, or a colleague. When I am in public, I always look first

for positive things to say about patients and colleagues, and I label the success as enduring and generalizable. I will not say things in public that degrade our profession.

- When hospitals, insurers, and government agencies act in error, I might call it out publicly, in a professional, diplomatic way, if there is realistically a chance that something positive might be gained by doing so. Most of my critique of institutional practice takes place privately in my office as I educate patients how to sidestep administrative barriers. It is not a bad thing to give public credit to medical organizations when their policies happen to promote good clinical outcomes, but when I do, I credit only the good policy, and perhaps its author, never the organization as a whole. I always treat good organizational behavior as a one-time event, not to be generalized.
- Never, ever normalize toxic workplace practices, even when they are carried out by perfectly well-intentioned colleagues and no harm to patients results. None of the pathological organizational methods enumerated in this paper are essential to excellent clinical care, so we need not accept them as part of life's inevitable imperfections.
- When possible, do not participate in programs of third-party surveillance. As an example, I am greatly scaling back my prescribing of controlled drugs. I do not wish my mandatory use of a Prescription Drug Monitoring System to effectively deputize me as a drug-diversion investigator, a role completely at odds with my role as a patient advocate. I assume that any electronic system not under my personal control will link individually identifiable patient information to remote databases.

Do I say here that we should reject all affiliations with medical organizations and institutions? Absolutely not. Organization into groups and associations does extend our reach as individual physicians. I am saying that institutional identification should not be a default, unconscious stance. Think of the moral firewall as the equivalent of universal precautions.

We can affiliate with organizations that earn our trust every day by supporting our work and the best interests of individual patients. Productive affiliation does not require full-scale identification. Nowadays all medical organizations that link to third-party payment use toxic workplace practices, many of which originate in law and regulation, to some extent. No medical organization can be perfect, so to the extent an organization does earn our trust, we can affiliate with the practices with which we agree, and politely decline to endorse the rest. Partial, selective identification is a sophisticated mental function that is to be encouraged in human relationships. If the reader is an employed physician, I am not claiming that you are wrong to choose to practice in a less-than-perfect moral world, but I am saying that you should strive to put your loyalties to your patients, your colleagues, and your profession ahead of your duties to your employer.

The desire to identify with things larger than ourselves is a regular part of life. Identify with your loved ones, your faith, your community, your patients, and your colleagues. I do not recommend identification with hospitals, insurers, government agencies, or political parties as a substitute for the kinds of identification that promote authentic personal and professional satisfaction.

The moral firewall is an evidence-based practice. Consider direct-pay practice to be a naturalistic experiment in the application of the moral firewall to clinical practice. Moral fatigue simply does not exist in the third-party-free sector of medicine, because there physicians can protect their mental health by avoiding regular exposure to the practices that promote the wrong kinds of identifications. As more data becomes available about clinical outcomes in the direct-pay sector of medicine, we can expect to find even more systematic demonstrations of the clinical efficacy of the moral firewall.

Conclusion

We will keep waiting for a survey that asks "Do You Work in a Toxic Medical Workplace?" sponsored by the likes of the American Medical Association, the Federation of State Medical Boards, the Federation of State Physician Health Programs, the Centers for Medicare and Medicaid Services (CMS), America's Health Insurance Plans, or the American Hospital Association. In the meantime, if you are presented with a survey that asks "Are You Burned Out?" politely opt out, because you can bet your answers will be sent along to an electronic database with your personally identifying information attached.

Because unconscious, automatic pattern recognition is part of the clinical-scientific method, the medical mind requires identification with patients and colleagues for optimal function. Physicians can manage the unconscious mental function of identification with a set of conscious procedures that I have named the moral firewall. It takes effort and attention to avoid identifying with the third-party interests that can disrupt our minds and our work. When we practice this discipline, we are inoculated against moral fatigue, and we are rewarded with feelings of professional self-value and more satisfying clinical experiences for our patients and ourselves.

Robert S. Emmons, M.D., has maintained a direct-pay, private psychiatry practice in Vermont for 30 years and serves as a director of AAPS. Contact: robertsemmons@comcast.net.

REFERENCES

1. Kane L. National Physician Burnout, Depression, and Suicide Report, 2019. *Medscape*, Jan 16, 2019. Available at https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056. Accessed Nov 4, 2019.
2. Hadler N. American medicine's toxic workplace. *The Health Care Blog*, Jan 10, 2016. Available at: https://thehealthcareblog.com/blog/2016/10/10/american-medicines-toxic-workplace/. Accessed Oct 31, 2019.
3. Dean W, Dean AC, Talbot SG. Why 'burnout' is the wrong term for physician suffering. *Medscape*, Jul 23, 2019. Available at: https://www.medscape.com/viewarticle/915097_2. Accessed Nov 11, 2019.
4. Kahneman D. *Thinking, Fast and Slow*. New York, N.Y: Farrar, Strauss, and Giroux; 2011.
5. Ogden T. *Projective Identification and Psychotherapeutic Technique*. New York, N.Y.: Jason Aronson; 1982.
6. The Principles of Medical Ethics of the Association of American Physicians and Surgeons. Available at: https://aapsonline.org/principles-medical-ethics/. Accessed Oct 31, 2019.
7. Sulmasy LS, Bledsoe TA; ACP Ethics, Professionalism and Human Rights Committee. American College of Physicians Ethics Manual. 7th ed. *Ann Intern Med* 2019;170:S1-S32. doi:10.7326/M18-2160.
8. Thoroughgood CN, Padilla A, Hunter ST, Tate BW. The susceptible circle: a taxonomy of followers associated with destructive leadership. *Leadership Quarterly* 2012;23(5):897–917. doi: 10.1016/j.leaqua.2012.05.007.

9. Kane L. National physician burnout, depression, and suicide report, 2019. *Medscape*, Jan 16, 2019. Available at https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056. Accessed Nov 4, 2019.

10. Machiavelli N. *The Prince*. Codevilla A, trans. New Haven, Conn: Yale University Press; 1997.

11. 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. *J Gen Intern Med* 2015;30(8):1105-1111. doi: 10.1007/s11606-015-3235-4.

12. Shay J. Moral injury. *Psychoanal Psychol* 2014;31(2):182-191.

13. Emmons R. Coercion, moral injury, and suicide in the medical regulatory-therapeutic complex. *J Am Phys Surg* 2019;24:40-49. Available at: https://jpands.org/jpands2402.htm. Accessed Nov 8, 2019.

14. Tsigaa E, Panagopouloua E, Montgomery A. Examining the link between burnout and medical error: a checklist approach. *Burnout Res* 2017;6:1-8. Available at: https://www.sciencedirect.com/journal/burnout-research/vol/6/suppl/C. Accessed Nov 7, 2019.

15. Agency for Healthcare Research and Quality. Physician Burnout. Publication 17-M018-1-EF. Available at: https://www.ahrq.gov/prevention/clinician/ahrq-works/burnout/index.html. Accessed Nov 7, 2019.

16. Parks T. How med students avoid burnout. AMA; Nov 12, 2016. Available at: https://www.ama-assn.org/residents-students/resident-student-health/how-med-students-avoid-burnout. Accessed Nov 4, 2019.

17. Goldman M, Bernstein C, Summers R. Potential risks and benefits of mental health screening of physicians. *JAMA* 2018;320(24):2527-2528. doi:10.1001/jama.2018.18403.

18. National Academy of Medicine. Valid and Reliable Survey Instruments to Measure Burnout, Well-Being, and Other Work-Related Dimensions. Available at: https://nam.edu/valid-reliable8survey-instruments-measure-burnout-well-work-related-dimensions/. Accessed Nov 7, 2019.

19. Federation of State Physician Health Programs. Statement on Burnout. Organizational Commitment Statement—Federation of State Physician Health Programs (FSPHP). Available at: https:// nam.edu/wp-content/uploads/2017/12/Federation-of-State-Physician-Health-Programs_Commitment-Statement.pdf. Accessed Nov 8, 2019.

20. Emmons R, Manion K, Andrew L. Systematic abuse and misuse of psychiatry in the medical regulatory-therapeutic complex. *J Am Phys Surg* 2018;23:109-111.

21. WHO. Burn-out an 'occupational phenomenon': International Classification of Diseases. Available at: https://www.who.int/mental_health/evidence/burn-out/en/. Accessed Nov 8, 2019.

22. American Medical Association. Physician Burnout: Improve Physician Satisfaction and Patient Outcomes. Available at: https://edhub.ama-assn.org/steps-forward/module/2702509. Accessed Nov 4, 2019.

23. DeJong C, Steinbrook R. Continuing problems with financial conflicts of interest and clinical practice guidelines. *JAMA Intern Med* 2018;178(12):1715. doi: 10.1001/jamainternmed.2018.4974.

AAPS PRINCIPLES OF MEDICAL POLICY

Medical care is a professional service, not a right. Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

Physicians are professionals. Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government "guidelines," which soon become mandates. Physicians' decisions and procedures cannot be dictated by overseers without destroying their professionalism.

Third-party payment introduces conflicts of interest. Physicians are best paid directly by the recipients of their services. The insurer's contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

Government regulations reduce access to care. Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians' judgment, etc.

Honest, publicly accessible pricing and accounting ("transparency") is essential to controlling costs and optimizing access. Government and other third-party payment or price-fixing obscures the true value of a service, which can only be determined by a buyer's willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

Confidentiality is essential to good medical care. Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

Physicians should be treated fairly in licensure, peer review, and other proceedings. Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors' malice, hospitals' attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

Medical insurance should be voluntary. While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

Coverage is not care. Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.