

The Physician Ethic

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The dysfunctional status of the United States health care system persists. Proclamations that an effective, sustainable health care system is only one disruptive innovation away remain unfulfilled, and the high cost of health care, along with its inequities, inconsistencies, and inadequate quality outcomes,^{1,4} continue to constrain meaningful transformation. Among several other initiatives, Donald Berwick and associates have suggested that the Triple Aim approach—improving the patient experience of care, improving the health of populations, and reducing the per capita cost of care—offers a path forward.⁵ However, 17 years later, there remain insufficient data to demonstrate that the Triple Aim has had any tenable impact on the US health care system. In a previous commentary, I suggested that 3 potential barriers, among others, may confound the Triple Aim from achieving these goals: the decline of the generalist specialties, physician burnout, and unmeaningful work.⁶ Of these three, unmeaningful work may be the least understood and most underestimated.

Any cognitive work associated with patient care could be considered meaningful. However, it may be unmeaningful to the physi-

cian performing that work if it is perceived to provide no clinical value. Unmeaningful work can be defined as cognitive work in a clinical encounter demanded of a physician that is not license-level appropriate, must be completed before a clinical encounter is considered complete, adds no clinical value, and acts as a barrier to care. In another com-

mentary, I reviewed the potential adverse effects of unmeaningful work and considered 3 initial categories—Unmeaningful Work Units, Electronic Frustrations, and Redundant Layers of Complexity—and suggested that unmeaningful work may adversely affect the physician's workflow and thought processes within a cognitive space during clinical encounters. I further suggested that a new ethic should be conceptualized to define that space and mitigate the effects of unmeaningful work.⁷

A new physician ethic could not only define cognitive space boundaries and mitigate the adverse effects of unmeaningful work but also improve physician well-being.

Defining a physician's cognitive space and the need to protect that space from unmeaningful work have thus far received little attention. Other professions have recognized this need and have utilized various elements of cognitive ergonomics, including aspects of the Yerkes-Dodson Law to protect practitioners while performing highly complex cognitive tasks.⁸⁻¹⁰ The

Yerkes-Dodson Law demonstrates empirical correlation between arousal and performance and asserts that performance decreases when stress levels are too high. Aviation safety is often cited as an example of how a profession may reduce unnecessary stress—or, by extension, unnecessary tasks—during critical phases of flight through “sterile cockpit” federal regu-

lations. It is these potentially preventive measures that have thus far eluded medicine, and physicians remain vulnerable to increasing amounts of unmeaningful work. A new physician ethic could not only define cognitive space boundaries and mitigate the adverse effects of unmeaningful work but also improve physician well-being. Physician burnout, with its domains of emotional exhaustion, depersonalization of patients, and a reduced sense of personal achievement, has been well described for over 20 years.¹¹⁻¹³ Its converse—physician well-being—has not. A formal definition of physician well-being is needed, and one element of that definition is the preservation of the cognitive space a physician must safely and consistently occupy while performing core clinical functions in a manner that does not compromise the phy-

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sician's long-term psychological and physical well-being.

Professions draw their unity, cohesiveness, and outward-facing authority in part from internal ethics. Medicine, likewise, has developed expectations of conduct that have evolved into formal ethics defining the profession, including a high standard of professionalism expected of physicians toward patients, colleagues, and society.^{14,15} There is a continuum from “I will do no harm” to “The needs of the patient come first” to “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.”¹⁶⁻¹⁸ There is, however, no ethical construct that defines the converse. Specifically, there is no ethic describing how the medical profession should treat its physicians, nor is there a formal ethic that seeks to protect physician well-being.

With no ethical precedent within the profession to develop such a construct, medicine may look elsewhere and consider how other disciplines have generated their own set of ethics. One unlikely source may be the early 20th century American conservation movement. In retrospect, by the mid-20th century it was evident that national stewardship of natural resources required a disruptive innovation due to ongoing destructive, man-made effects on the environment. A sustainable, balanced approach to land management was not widely practiced, and an ethical construct—treating the land in an ethical manner—was unknown.

Aldo Leopold, the first chair of the University of Wisconsin Department of Wildlife Management and considered the father of American conservation, radically changed that paradigm when he wrote *The Sand County Almanac*. Published in 1949, Leopold, in deceptively simple and clear logic, described the Land Ethic as “A thing is right when it tends to preserve the integrity, stability, and beauty of the biotic community. It is wrong when it tends otherwise.”¹⁹ *The Sand County Almanac* is now considered a modern classic in nature literature, and its Land Ethic is a central, cornerstone principle of contemporary land management.²⁰

Medicine may now be at a similar precipice as conservation in the 1940s and may benefit from a comparable construct to develop a new ethic—the Physician Ethic—to improve

physician well-being and to recognize the physician as a resource deserving protection and preservation. Borrowing liberally from Leopold, the Physician Ethic could be described as follows: “A thing is right when it tends to preserve the integrity, stability, and safety of the physician's cognitive space. It is wrong when it tends otherwise.” At the risk of being perceived as overly simplistic, this ethic may serve as a new construct to protect the physician's cognitive space in clinical settings by evaluating any proposed cognitive work within this framework. If, for example, the proposed cognitive work preserves the integrity, stability, and safety of the physician's cognitive space, it may be appropriate and meaningful. If it does not, it may be inappropriate and unmeaningful.

Medicine is in an unprecedented time of transition, and it has become increasingly evident that it is unsustainable for a physician to both remain current in the medical literature and manage the ever-increasing burden of unmeaningful work. By defining and upholding the Physician Ethic, the profession can begin the long-overdue process of recognizing and protecting the physician's cognitive space and, in doing so, potentially improve physician well-being as well.

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