Ethical Love and the Prevention
of Burn-Out by Psychiatric Leadership

Steven Moffic[[1]](#footnote-1)∗

Dr. Moffic was the recipient of the American Psychiatric Association’s 2016 Administrative Psychiatry Award. Co-sponsored by the American Association of Psychiatric Administrators, this award honors an APA member who is nationally-recognized clinician executive, whose effectiveness as an administrator of major mental health programs has expanded the body of knowledge of management in the mental health services delivery system, and whose effectiveness has made it possible for them to function as a role model for other psychiatrists. The following paper is based on the award lecture that Dr. Moffic delivered at the APA Mental Health Services Conference in Washington D.C. in October 2016.

“If at first, the idea is not absurd, there is no hope for it.”

-Albert Einstein

“Everyone is in love with their own ideas.”

-Carl Jung, MD

“Only connect the prose and the passion, and human love will be seen at its height.”

-E. M. Forster

What is ethical love, and why is it necessary? Isn’t medical ethics, without love, enough to guide psychiatric leaders and administrators? And, how can ethical love address the epidemic rates of burn-out in medicine and psychiatry? Here are the possible answers.

## Ethics

After all, we in psychiatry have the time-tested ethical principles of the American Medical Association (AMA), with annotations added for psychiatrists by our American Psychiatric Association [1]. The essential ethical principle is in the Preamble, which states that the needs of patients come first and foremost, but secondarily, that we should also pay attention to the needs of colleagues, society, and oneself.

Given that these principles are designed for clinicians, do they hold up for administrators? Is all that administrators have to do ethically is make sure their clinicians follow these principles?

The American Association of Psychiatrist Administrators (AAPA) ended up deciding that they did not. Stimulated by the controversial rise of for-profit managed care, putting their Medical Directors in a key position to deny authorization – and thereby reimbursement – for care, it seemed that we needed a complementary set of ethical principles for psychiatric administrators. Since I was one of those Medical Directors who, as a participant/observer, was struggling with those ethical issues, even getting called a “Nazi” and “evil” at some presentations, I was asked by the President of the AAPA at that time, Gordy Clark, MD., to try to lead the design of such principles [2].

By the new millennium, the AAPA adopted the Ethical Principles For Psychiatrist Administrators [3]. It was based on the AMA/APA model, but brought the well-being of the organization almost on a par with the needs of the patients treated in the organization. However, patients did still come first and it was suggested that Medical Directors should consider resigning if they couldn’t meet these ethical principles.

## Love

Love was not mentioned in this document, nor had love been mentioned in the traditional AMA/APA ethical principles. So, as the Tina Turner hit song title goes, “What’s Love Got to Do With It?”

If you look up “love in psychiatry” in Google, as I did in 2016, you would have found over 24 million entries. That could lead to the conclusion that maybe enough, more than enough really, has been said about love in administrative psychiatry. However, in perusing many of the early entries, virtually all were on patients falling in love with the therapist and, unethically if acted upon, the therapist falling in love with the patient, or in psychodynamic terms, transference, counter-transference, and acting out. Love is also mentioned frequently in regards to narcissism and self-love, including new items related to our country’s 2016 Presidential race.

But “love” in psychiatric administration and leadership? Nothing seemed to cover that as the entries were skimmed. However, a much later entry referred to Freud and love in treatment, a point I had dimly recalled as reading Freud was my first love in psychiatry. One thing connected to another, and I began to realize that “love” was indeed viewed as very essential in medicine and psychiatry, but it was sort of hidden like a mistress, as if it was another bad four-letter word.

Here, the love is not the often short-term romantic, passionate or sexual kind of love, but the longer and ongoing love of caring, compassion, and loving-kindness. It’s the love that can come out of shared experiences, like often ends up happening in an arranged marriage. Many examples can eventually be found from some of our best leaders.

In a letter to his protégé, Jung, Freud wrote that “psychoanalysis is in essence a cure through love” [4]. This love is conveyed not so much in the content as in the form of the rapt attention of someone who cares enough to take a careful and empathetic history of your life and pay attention to wherever your associations roam. This love is in-between the lines of the conversation. Jung, to Freud’s chagrin, took love literally and concretely at times, having affairs with patients, sullying this idea somewhat.

Erich Fromm was a psychologist and psychoanalyst, a kind of social psychologist, who escaped Nazi Europe even before Freud, though he was younger. He became a popular writer, and in his classic book, The Art of Loving, wrote that the healthiest people seemed to be those who received a combination of unconditional love, as well as conditional love, from their parents and other early authority figures [5]. This leads, per Bowlby’s Attachment Theory, to being able to establish reciprocal bonds of various degrees of dependency and trust.

Before both Freud and Fromm was the great medical missionary and general practitioner in Africa, Albert Schweitzer, who said that the primary ethical principle in medicine should be the sanctity of life. About his decision to switch from religious teaching to practicing medicine, he wrote:

“But this new form of activity would consist not in preaching the religion of love, but in practicing it [6].”

Going to his deathbed, when so much of importance may be said, Avedis Donabedian, M.D., known as the “father of quality improvement” in medicine, emphasized:

“Ultimately, the secret of quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, you can then work backward to monitor and improve the system [7].”

In combining such statements, ethical love thereby refers to the necessity of incorporating and attaching love in some manner to the carrying out of our professional ethical principles. Yet, given these statements on love in medicine cover over a hundred years, why is now the time to bring love out in the open, and how to do so?

## Burn-Out

A few years ago, I was asked (with James Sabin, MD.) to write the chapter “Ethical Leadership in Psychiatry” for the recently published 2 volume book, Psychiatric Ethics (8). Serendipitously, as I was about to summarize what I had learned, news was emerging that the well-being of clinicians was declining or, in other terms, burn-out was increasing at rates higher than any other profession in the United States. Now, various polls indicate that the average burn-out rate of physicians is epidemic, have increased by a few percentage points yearly over the last 10-15 years, to an average of 50%, with urology and emergency room physicians at 70-80% and psychiatrists at 40% [9]. Similar rates are found in medical students and residents. Nurses come in a close section.

There may, however, be differences in burn-out rate according to gender or minority status. At least for medical students, medical students from minority backgrounds have about the same rate of burn-out, but had a lower sense of personal accomplishment [10]. For women physicians, the predominant burn-out symptom was exhaustion, while for men it was depersonalization, and although the rate of burn-out in psychiatrists was about 40%, in women psychiatrists it may be over 60% and relate to the influence of home life and work expectations [11].

Indeed, one of the pioneers of understanding burn-out, who coined the term in 1974, the psychologist and psychoanalyst Herbert J. Freudenberger, felt that he observed a special sort of fatigue among mental healthcare workers when their idealism was shattered [12]. At that time, the rate of burn-out in such clinicians was only about 10%, but such idealism eventually did come under siege in the new millennium.

Burn-out can be defined in many ways, perhaps most simply as chronically being out of sync with your work environment. Central to it seems to be a developing exhaustion not due to other medical causes, a feeling of being dissociated, and cynicism. These reactions begin to replace the energy, focus, and optimism that one started with. Metaphorically, picture your passion, and your compassion, your fire for your work, dying off like the embers of a smoldering fire. A professor of radiology and philosophy at Indiana described the insidious onset of burn-out as “the accumulation of hundreds or thousands of tiny disappointments, each one hardly noticeable on its own” [13].

Therefore, at a first glance, burn-out seems different than Posttraumatic Stress Disorder (PTSD), which is caused by acute severe trauma, though both can develop at work. Yet, new research begins to suggest brain changes like that of those with severe early life trauma [14]. Others argue that burn-out is more like depression, an atypical depression [15]. Burn-out can sometimes also contribute to substance abuse, including caffeine to try to reverse the exhaustion, and even to suicide. Though not in DSM 5, it is listed as a problem, a life management difficulty, in healthcare, Z73.0 in ICD 10 and reimbursable in Europe. Such comparisons to mental disorders seems to put burn-out in a gray area between normality and illness.

Causes for the increasing prevalence are many, though leading the list is electronic health records (EHRs). All seem to have something to do with the loss of empowerment, especially the empowerment to spend enough quality time interacting with patients. Moreover, the more compassionate one is, the greater seems to be the risk of burn-out. Paradoxically, those most resilient will also be more at risk, as they will feel they have the strength to just plow through the obstacles.

Research about what burn-out means to patient care has also been emerging [16]. That suggests that burn-out tends to alter the diagnostic process and reduce the quality of patient care outcomes.

## Leadership

Who, if anybody, can lead a movement to reverse this trend toward burning-out.? Now, individual clinicians can do some on their own. Some of the usual ways to enhance wellness are exercise, diet, and taking as much time off with loved ones as possible. Meditation can help, including walking meditation while one is working. Finding one’s own unique mental “healing zone” is a key [17].

However, it appears that individual clinicians can only do so much, and that goes beyond the limited time to recoup. Psychiatrists in particular can understand why clinicians tend to deny becoming burned-out because it is so antithetical to their image of being a healer. Instead, with this cognitive dissonance, health caregivers seem to react with a counter-phobic reaction, to deny that we are hurting and that is hurting our patients. We try to work harder and harder, and still claim work satisfaction, even with less time to spend with patients.

So, that dynamic seems to leave the major responsibility to the healthcare leaders and administrators. Indeed, some researchers estimate that up to 80% of the causes of burn-out have to do with systems issues at work, whereas only 20% lie within individuals [18].

Given that our systems of care are determined by much larger societal forces, what can administrators and leaders still do? There is much, including these 10 Recommendations (if not Administrative Commandments):

#### 1. Monitoring Burn-out

Burn-out is a process and it can be measured [19]. Combine any of the available scales or questionnaires with periodic formal and informal meetings with staff to check how they are doing.

#### 2. Rightsizing Productivity

For clinical care, if some time and some funds are used to reduce productivity demands, as reflected in seemingly inadequate 15 minute med checks, there can be better patient outcomes, less mistakes, less necessary follow-up appointments, and costs recouped. Even the best managed care principles can help by the feedback and monitoring of which treatments and management strategies are working or not.

#### 3. Empower Staff

Given the psychological benefits of being empowered, try to involve staff and colleagues as much as possible in decisions. This is the same kind of empowerment that should be available to patients in their quest for recovery. At the minimum, conveying empathy, care, and compassion for what is out of control can be helpful.

#### 4. Close the Gap between Ideals and Reality

Given that the gap between our ideals and reality contributes to burn-out, remind caregivers of the awe they originally felt – and can still feel – at helping others to whatever extent practical with their health and life.

#### 5. Establish Safety and Security

At the most basic level of psychological needs, that being safety and security, administrators should do what can be done to create a safe workplace.

#### 6. Clinical Care by Administrators

Administrators should also do some clinical work themselves in their systems in order to feel empathy for the clinicians and to better understand their stress.

#### 7. Enhance Professional Development

Instead of leaving the workplace due to frustration, love also knows when it is time for them to exit for their further development, just as children leave home, and to leave with grace, dignity, substance, and inspiration (20).

#### 8. Guild Organizational Programs

When it comes to professional organizations, since these are guild organizations, the well-being of the membership should be paramount. Besides trying to address the macro societal issues that affect our systems of care, that means addressing wellness should be considered in all activities. If necessary, a task force can be set up to give this special attention if burn-out has been ignored and/or more research is needed to understand it. In particular, organized psychiatry, with our experience with DSM 5, may be able to come up with a clearer and universal diagnostic criteria for burn-out.

#### 9. Learning to Love

Of course, putting such love into practice may not come naturally. Administrators and leaders may not automatically love their colleagues and staff. However, if one comes to this field with feelings of compassion and caring for all concerned in patient care, and in conjunction with what we now know about our brain’s neuroplasticity, new brain pathways of love toward staff can develop. To do so, a leader can look for the strengths and successes that any given staff member possesses, rather than mainly focusing on weaknesses and problems.

#### 10. Love Is Not Enough

A word of caution, however. In contrast to the Beatles’ hit song, “All You Need is Love,” love is not enough. Whatever system is in question, ranging from a clinic to our country, has to emphasize healthcare values. Realistic expectations, staff development, and outcome monitoring is still required. The leader also has to be careful to not love those that are taking undue advantage of the love, nor be too trusting. The administrator has to be on the alert that colleagues have – or can develop – their own mental illness and try to help them to get help and not stigmatize them for this need.

Love can help prevent the abuse and risks of power, such as using managed care systems mainly to make money. In turn, administrators are more likely to be loved back by staff, so important when the burn-out rate of administrators seems as high [21]. In a solo practice, the administrator and clinician are one and the same, so in essence this requires appropriate self-love.

Leaders also have an ethical responsibility to try to advocate for societal changes that benefits the health of the population. That can include gun control, euthanasia of the mentally ill, climate change, basic healthcare coverage for all, and politicians that are concerned with the mental well-being of their citizens, all of them.

## Examples

Given that both clinicians and administrators can address burn-out, are there examples of doing so? Here is one description by a long-term scholar on burn-out from the standpoint of the clinician [22]:

“Stan is a psychologist who started his career as an eager, open-minded, caring person who wanted to help others. He was the kind of therapist most people would want to see if they were struggling with problems. But gradually Stan has become a cynical, frustrated individual who feels he is losing control over his job – financially, professional, and ethically – and he’s beginning to want out.

‘There is no joy in it any longer. I hate it. After a day of dealing with clients’ pain, I’m exhausted and just don’t want to be there twenty-four hours a day and get upset if they get a recorded message instead. And the managed care system is making it worse. I no longer have control over the type and quality of care I provide – some reviewer in some company who doesn’t know the client and who has less training than I do decides how many sessions I can have. All that matters is keeping costs down, not what’s good for the client, and it’s really hard to live with that. Sometimes I lie so I can get more care, but it’s hard to live with that too. And even though I am working more hours than ever, I am getting paid less. This is a life?’”

Fortunately, Stan got together with other psychologists serving this system and got some compromises from the company to allow them to try to control some of their time, costs, and quality.

Having been a leader and administrator in many systems over the years of my career, I wondered if I had conveyed ethical love without realizing it. I did know how important the team was in large systems of care [23, 24]. In retrospect, it seemed the best I could do was to ask some colleagues what their perception of my leadership had been, understanding that it might be difficult to get some criticism.

From the multidisciplinary community mental health centers that I led [23], here is this reflection:

“He cared. We all knew he cared about us no matter where we were on the organizational chart. He would listen not only to us but to the patients we worked with . . He brought a large staff of 30-40 together. We were a close knit family. Many of us have stayed in touch 35 years later . . . He taught me values, ethics and principles that guided me through my career. He rarely if ever tried to teach me in a verbal sort of way. I mainly learned from watching and observing him with his patients, our staff and his family . . . Even though Dr. Moffic was our boss he never felt like a boss.”

Then, a reflection from the academic not-for-profit system that I led:

“Dr. Moffic’s leadership consistently supported my role functions which were primarily quality improvement initiatives and outcomes research. He was quite adept at facilitating staff meetings and at encouraging both administrative and clinical staff to value their work and to optimize the clinical experience of our patients. He was readily accessible and because of his extensive clinical expertise was sought out by staff for case consultation. In my opinion, a large part of the success of his clinics reflected the combination of his consultative leadership style, his clinical expertise, and his genuine caring and concern for staff and patients: rare gifts among academic psychiatrists.”

Lastly, from a psychiatrist colleague outside of the systems I led, but knowledgeable about them.

“It’s a tough job, takes lightning reflexes . . . what makes a good one? They understand and care about individual patients, of course, not just processing code numbers. They do the same for therapists working for them, too, both guiding and forgiving mistakes (and sometimes critical) . . . And then, of course a good administrator has to deal with his superiors and the structure of the organization containing him, attempting to harmonize all the elements. My impression is that you had some trouble with that in the last part of your time at . . . “

## Gratitude

In order to thrive as an administrator and leader, one has to be helped by so many others, as was I. That includes colleagues, staff, students, patients, and even enemies. In particular, that ranges from: my residency chairman, Daniel X. Freedman, MD. who fondly dubbed me a gadfly; to Herb Bateman who continued to support me even when there was “a cloud over my head”; and to Sy Saeed, MD., who supported my numerous Ethics Columns and presentations over the years.

Perhaps even more importantly, given that work stress can be displaced onto home life, and that love at home can counter some of the burn-out at work, family and friends are crucial. These range from: my oldest best friend, Barry Marcus; my newest best friend, Randy Levin, MD., a retired emergency room physician also concerned about burn-out; my late parents; sister Joanne Moffic-Silver; and children Stacia Goldstein and Rabbi Evan Moffic.

Most crucial, though, was my muse and wife of 49 years, Rusti [25]. She had the passion and warmth to always keep my fires burning and, even at times, to douse those fires a bit when my Don Quixote impossible dreams got too unrealistic. Not only that, but she gave up a budding career in musical theatre to devote herself to her family. For that, I would like to praise her in the same way that Lin-Manuel Miranda, creator of the runaway hit, Hamilton, did for his wife when he received the Tony Award in 2016. Here is my paraphrase of his spoken poem, a poem that touches on the leadership themes of (“chase the”) ethics, burn-out (“dying embers”) and love (“is love” x 7):

Our Administrative Psychiatry Award

She inspires me towards promise by degrees

She is a perfect entity of one

Our family is her most beautiful repose.

We chase the ethics that seem to find us

Until they’re finished goals and into play

When senseless acts of tragedy remind us

That nothing here is promised, not one day.

This meeting is proof that history remembers

We lived through times when hate and fear seemed stronger;

We rise and fall and light from dying embers, remembrances that hope and love last longer

And love is love is love is love is love is love is love is love cannot be killed or swept aside.

I praise Rusti’s principles, family tells her story

Now fill our field with ethics, love and pride.

## Conclusion

My ethical love idea in the leadership of psychiatry, as absurd as it might seem on first glance, boils down to this. Love your colleagues and staff, even to the extent that it becomes the first and foremost ethical priority. Among other benefits, that should help to prevent and reduce their epidemic rate of burn-out. That means that the emphasis on the well-being of the organization that was made in our AAPA ethical principles from the year 2,000 turned out to miss an important focus, for if the organization is the major cause of burn-out, the organization really needs to be in the service of the well-being of staff and oneself. This is elevating the secondary ethical priority for colleagues to being the first ethical priority.

In terms of clinical goals, this means going from the triple to the quadruple aim. Caring for the provider is added to enhancing patient experience, improving population health, and reducing costs [26].

Psychiatrists and organized psychiatry, though, have been relatively silent about burn-out. Yet, given the special knowledge of psychiatrists about the counter-intuitive processes involving burn-out, their leadership involvement is crucial, especially in the integrated medical systems that are emerging [27]. Interestingly enough, working in these integrated systems seems to reduce the burn-out rate.

Among psychiatrists, though our burn-rate is relatively less compared to other specialties, that does not seem to hold true for women psychiatrists. That discrepancy may need special attention by leadership at all levels.

This is ethical love in all its dimensions. As the Franciscan priest, Richard Rohr, said:

“You’ve got to love or you’ll never find your soul’s purpose. You’ll never find the deepest meaning of life itself” [28].

Whether one has religious beliefs or not, I don’t think there are many greater purposes, or deeper pleasures in life, than to use ethical love to overcome the difficult challenges and stigma surrounding those needing mental healthcare for conditions that threaten their very identity and ability to think. Do you?

## References

1. American Psychiatric Association: The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry. Washington, D.C., American Psychiatric Publishing, 2001.
2. Moffic, H. S.: *Challenges & Solutions for Managed Behavioral Healthcare*. Jossey-Bass, San Francisco, 1997.
3. Moffic, H. S., Saeed, S. A., Silver, S. Koh, S.: Ethical challenges in psychiatric administration and leadership. *Psychiatric Quarterly*. 86: 3, 343-354, 2015.
4. Koprowski, E. J.: Freud, psychoanalysis, and the therapeutic effect of agapic love. *Issues Ment Health Nurs*. 35 (4): 314-315, 2014.
5. Fromm, E.: The Art of Loving. Harper Perennial Modern Classics, New York, 2006.
6. Schwehn, M., Bass, D. (eds): Leading Lives That Matter. William B. Eerdmans, 2001.
7. Mullan, G.: A founder of quality assessment encounters a troubled system firsthand. Health Affairs. 20 (1): 137-141, 2001.
8. Moffic, H. S., Sabin, J.: Ethical leadership for psychiatry, in the *Oxford Handbook of Psychiatric Ethics*, Volume 1, edited by Sadler, J., Fulford, B., Van Staden, C. W. Oxford University Press, 2015.
9. Shanafelt, T. D., Boone, S., Tan, L., et al.: Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med*., 172 (18): 1377-1385, 2012.
10. Dyrbye, L. N., Thomas, M. R., Huschka, M. M. et al.: A multicenter study of burnout, depression and quality of life in minority and nonminority US medical students. *Mayo* *Clin Proc*. 81 (11): 1435-42, 2006.
11. Peckham, C.: *Lifestyle and burnout: A bad marriage*. Medscape, March 27, 2013.
12. Freudenberger, H., J.: Staff burnout. *Journal of Social Issues*. 30 (1): 159-165, 1974.
13. Gunderman, R.: For the young doctor to burn out. The Atlantic. February, 2014.
14. Michel, A.: *Burnout and brain*. Observor. 29 (2), 2016.
15. Ahola, J., Hakanen, J., Perhoniem, R. et al.: Relationship between burnout and depressive symptoms: A study using the person-centered approach. *Burnout Research* 1 (1): 29-37, 2014.
16. Halbesleben, J. R. Rathert, C.: Linking physician burnout and patient outcomes: exploring the dyadic relationship between physicians and patients. *Health Care Manage* *Rev*. 33 (1): 29-39, 2008.
17. Bedi, A.: *Crossing the Healing Zone*. Ibis Press, Lake Worth, FL, 2013.
18. Sinsky, C., Willard-Grace, R. Schutzbank, A. et al.: In search of joy in practice: A report of 23 high-functioning primary care practices. *The Annals of Internal Medicine*. 11 (3): 272-278, 2013.
19. Maslach, C., Jackson, S. E.: The measurement of experienced burnout. *Journal of* *Occupational Behavior*. 2: 99-113, 1981.
20. Lawrence-Lightfoot, S.: Exit: The Endings That Set Us Free. Farrar, Straus and Giroux. New York, 2012.
21. Gabbe, S. G., Melville, J., Mandel, L. et al.: Burnout in chairs of obstetrics and gynecology: diagnosis, treatment, and prevention. *Am J Obstet Gynecol*. 186: 601-612, 2002.
22. Maslach, C., Leiter, M.: The Truth About Burnout: How Organizations Cause Personal Stress and What to Do About It. Jossey-Bass, San Francisco, 1997.
23. Moffic, H. S., Adams, G. (eds): A Clinician’s Manuel on Mental Health Care: A Multidisciplinary Approach. Addison-Wesley. Menlo Park, CA, 1982.
24. Moffic, H. S., Ruiz, P., Adams, G. (eds): *Mental Health Care For Allied Health and Nursing Professionals.* Warren H. Green, St. Louis, 1989.
25. Moffic, H. S.: More about H. Steven (Stevie) Moffic, MD. *Psychiatric Times.* November: 40, 2016.
26. Bodenheimer, T., Sinsky, C.: From triple to quadruple aim: Care of the patient requires care of the provider. *Annals of Family Medicine*. 12 (6): 573-576, 2014.
27. Moffic, H. S. Is our profession breaking our hearts? A Valentine’s Day concern. Psychiatric Times, posted February 11, 2015. Source URL: http://www.
psychiatrictimes.com/blogs/our-profession-breaking-our-hearts-valentine-day-concern.
28. Rohr, R.: Falling Upward: A Spirituality for the Two Halves of Life. Jossey-Bass, San Francisco, 2011.
1. ∗ Dr. Steven Moffic retired in 2012 from his tenured Professorship in the Department of Psychiatry and Behavioral Medicine as well as the Department of Family and Community Medicine at the Medical College of Wisconsin. He continues to write, present, and serve in professional organizations and boards. [↑](#footnote-ref-1)