Physician Care as a Moral Obligation in Health Care Practice

Michael Philip Atkinson

From the beginning of their education and training, health care professionals are introduced to the principles of patient-centered care. Across health care systems internationally, professional codes of practice emphasize that the primary obligation is to prioritize the interests of patients,[1,2] reflecting the moral ethos of the profession. It shapes not only what clinicians do but also their identity as moral agents.

However, the emphasis on prioritizing patients has had an unintended consequence: the systematic marginalization of health care professionals' own well-being. Although patient-centered care remains morally foundational, its near-exclusive focus risks obscuring a parallel ethical responsibility; namely, the duty to maintain the conditions that enable safe, compassionate, and sustainable practice. This duty demands recognition of a moral obligation at the level of health care systems, not merely a matter of personal preservation or resilience on behalf of the physician.

Given the well-documented prevalence of burnout, moral injury, clinical error, and workforce attrition across health care systems,[3] the question is whether neglecting physician care constitutes an ethical failing. Existing well-being literature has largely framed physician care in instrumental terms as a means of sustaining performance, reducing burnout, or improving workforce retention.[3] Such accounts have often stopped short of explicitly naming the failure to support physician care as an ethical breach. This article advances that discourse by offering a more explicitly ethical analysis, arguing that physician care is not merely supportive of patient care but also morally constitutive of it. Although the Hippocratic injunction to do no harm is traditionally directed toward the patient, a modern ethical interpretation must acknowledge that harm is also done when the clinician's own well-being is sacrificed. If a system's conditions predictably lead to medical error and practitioner burnout, that system is in direct conflict with the foundational ethos of nonmaleficence.

There have been efforts to foreground the value of physician care within health care policy,[4,5] yet the translation of such commitments into everyday clinical practice remains limited, and the gap between policy aspiration and lived experience persists. Framing physician care as a moral imperative implies that systemic failure to support well-being is morally significant, not merely unfortunate. In ethical terms, this failure represents a breach of the duty of nonmaleficence—not only toward patients but also toward practitioners themselves—and raises further ethical concerns related to justice and fidelity insofar as institutions have an obligation to prevent foreseeable harm, distribute burdens fairly, and uphold the moral commitments of professional

practice. This breach of nonmaleficence is not merely theoretic; it has tangible clinical consequences. When a system's conditions predictably lead to practitioner burnout, it creates a latent-error environment in which cognitive fatigue and moral injury become the primary drivers of medical error. Thus, the duty to care for the physician is functionally inseparable from the duty to ensure patient safety.

These dynamics suggest that although physician care is acknowledged within health care discourse, structural and cultural barriers continue to impede its implementation. These barriers are compounded by moral injury (the distress experienced when clinicians are unable to provide care that aligns with their values[5]), reinforcing physician care as a moral necessity rather than a professional adjunct and representing a betrayal of the foundational standards and ethical commitments inculcated during formative years of training.

What, then, does effective physician care look like? To answer this question, the dimensions of self-care and system care need to be equally attended to. First, self-care is commonly associated with emotional intelligence, self-compassion, and emotional regulation,[6] grounded in the understanding that health care professionals are most effective in supporting others when their own well-being is adequately supported. At its core, self-care reflects an awareness that the capacity to care for others is neither limitless nor independent of the conditions in which care is delivered.

Professional norms surrounding self-care are not transmitted primarily through policy documents but through observation and modeling. Senior clinicians, educators, and leaders play a critical role in shaping what is perceived as acceptable and expected within health care cultures.[7] When senior staff visibly neglect their own well-being, this behavior can tacitly reinforce self-sacrifice as a professional virtue rather than a risk factor. Conversely, when self-care is openly modeled by respected leaders, it becomes legitimized as a marker of professionalism rather than weakness; they challenge a cultural hidden curriculum that has long equated professional excellence with the neglect of personal needs, thereby validating physician care as a nonnegotiable professional standard. Such role modeling may be particularly influential for students and early-career professionals, for whom professional identity is still forming, and may contribute to improved retention and willingness to enter and remain within health care professions.[8]

A more ethically grounded understanding of self-care extends beyond basic maintenance to include the cultivation of awareness, boundary setting, and responsiveness to early signs of distress.[6] These capacities enable clinicians to recognize when their well-being is compromised and to respond appropriately, thereby sustaining their ability to practice ethically over time. Although essential, these deeper practices often conflict with a traditional ethos of sacrifice. Consequently, they may be erroneously framed as a retreat from patient obligations, obscuring their actual role as an ethical safeguard for both the practitioner's well-being and the quality of patient care.

Embedding physician care meaningfully within the health care professions requires, however, more than individual motivation; it demands cultural and structural transformation across multiple levels, including policy, education, leadership, and organizational norms. Although self-

care involves emotional regulation, system care requires the intentional design of environments that mitigate cognitive load, ensure safe staffing ratios, and provide protected time for rest and recuperation. Without these structural scaffolds, resilience becomes an unfair demand placed on the individual to withstand an inherently challenging environment. At an institutional level, physician care should be explicitly recognized within professional codes of ethics, departmental objectives, and leadership expectations, signaling that attending to physicians' well-being is a marker of professionalism and conscientious practice rather than a personal indulgence. Departments could incorporate well-being indicators into routine governance processes, treat sustainable workload and relational support as ethical priorities, and expect leaders to model boundaries, rest, and reflective practice. Such measures would help shift physician care from an optional personal strategy to a shared professional responsibility, embedded within the everyday functioning of health care organizations.

Although training approaches aimed at cultivating physician care, such as mindfulness-based programs, are increasingly available,[9] organizations must take care not to present such provision in a tokenistic way. When offered in isolation, such initiatives risk reinforcing the mistaken assumption that well-being is a product of atomized interventions that remain exclusively the responsibility of the individual. True physician care requires sustained institutional commitment and a rigor comparable to that of other clinical competencies, embedded within curricula and supported by working conditions that make ethical practice possible.

By legitimizing and actively supporting physician care, the health care professions can begin to bridge the gap between the ideals of compassionate caregiving and the lived realities of those who provide it. Recognizing this interdependence invites a broader ethical reorientation within health care, one that understands care as reciprocal rather than unidirectional. Systems that normalize exhaustion and self-neglect risk cultivating environments in which ethical erosion becomes routine rather than exceptional. Reframing physician care as integral to professional ethics therefore offers an opportunity not only to protect individual clinicians but also to hold health care institutions morally accountable for the conditions under which care is delivered. Without such reform, initiatives that promote physician care risk remaining aspirational rather than transformative.

References

1.
General Medical Council. *Good Medical Practice*. UK General Medical Council; 2024.
2.
World Medical Association. WMA International Code of Medical Ethics. Published October 8, 2022. Accessed January 9, 2026. https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/
3.
Tawfik DS, Profit J, Morgenthaler TI, et al. Physician burnout, well-being, and work unit safety grades in relationship to reported medical errors. *Mayo Clin Proc*. 2018;93(11):1571-1580. doi:10.1016/j.mayocp.2018.05.014PubMedGoogle ScholarCrossrefFind It
4.

West M, Coia D. *Caring for Doctors, Caring for Patients: How to Transform UK Healthcare Environments to Support Doctors and Medical Students to Care for Patients*. General Medical Council; 2019.
5.
National Academies of Sciences, Engineering, and Medicine. *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*. National Academies Press; 2019.
6.
Neff K. Self-compassion, self-esteem, and well-being. *Soc Personal Psychol Compass*. 2011;5(1):1-12. doi:10.1111/j.1751-9004.2010.00330.xGoogle ScholarCrossrefFind It
7.
Lamb EI, Alberti H. Twelve tips for positive role modelling in medical education. *Med Teach*. 2024;46(7):898-902. doi:10.1080/0142159X.2023.2289842PubMedGoogle ScholarCrossrefFind It
8.
Scruth EA, Allen A. Self-care: the ethical imperative for nurses and other healthcare professionals. *Clin Nurse Spec*. 2022;36(4):181-182. doi:10.1097/NUR.0000000000000683PubMedGoogle ScholarCrossrefFind It
9.
Knudsen RK, Ammentorp J, Storkholm MH, Skovbjerg S, Tousig CG, Timmermann C. The influence of mindfulness-based stress reduction on the work life of healthcare professionals—a qualitative study. *Complement Ther Clin Pract*. 2023;53:101805. doi:10.1016/j.ctcp.2023.101805PubMedGoogle ScholarCrossrefFind It