The article by Dubov and colleagues (2016) evokes the inadvertent possibility of adverse ethical outcomes arising from the worldwide trend toward mandated work practices. These outcomes include the undermining of key elements of the medical relationship, such as the commitment both to caring for one’s patients and to the profession itself. The adoption of inflexible rules about working hours, according to which doctors refuse to alter their work practices regardless of circumstances, may also undermine the trust of the public in medicine and erode the ability of doctors to discharge their responsibilities to their patients, their colleagues, and society.

In calling into question safe working hours or medical shift work as an unquestioned good, we do not posit that doctors should be subjected to exploitative work practices that compromise their or their patients’ well-being; rather, we wish to highlight some fundamental threats to the culture of medicine that may be imposed under the guise of safety (Fremantle et al. 2015).

An underlying ethical purpose of health care professionals is the provision of care to their patients. To be able to achieve this it is necessary for the professionals to care for themselves. This means that the processes according to which care is shaped and delivered are implicated in the outcomes they themselves generate. This leads to a paradox. On the one hand, as is clearly demonstrated in the literature, excessive working hours lead to underperformance, increased risks, and actual harms, and judicious management of human resources both enhances health outcomes and minimizes economic costs. On the other hand, the application of rigid, dogmatically applied rules about when doctors can and cannot work puts at risk some of the most fundamental values on which the entire profession of medicine rests.

Both trainees and their supervisors have argued for flexibility in working hours in order to increase their sense of personal control, to enhance educational opportunities, to improve clinical decision-making capacity, and to allow them to achieve better overall patient outcomes (Dubov et al. 2016). Dubov and colleagues cite the median working hours of post-intern residents in parts of Europe as 48 and in the United States as less than 80 for interns and potentially more for more senior residents. In contrast, Australian doctors work a median 55 hours weekly (Glasgow, Bonning, and Mitchell 2014). If working hours over and above an arbitrary minimum of 48 are by definition unsafe, many hospital doctors are working in an unsafe manner. If so, this means that the health systems themselves are generating excessive risks.

Glasgow and colleagues (2014) have claimed that in the training of residents in Australia steps have been taken to reduce fatigue and ensure optimal continuity of patient care by “profession-led advocacy promoting risk minimization as well as patient and staff safety.” Patient care is assured by processes to ensure the timely recognition and management of fatigue and the maintenance of
adequate staffing and patient handover practices, although it is acknowledged that “more sophisticated rostering arrangements are required to preserve quality in clinical education” (Glasgow et al. 2014).

These are obviously beneficial outcomes. However, if applied in a rigid and inflexible manner, the introduction of mandated working hours can also transform the culture of medicine from one of powerful personal agency and moral purpose to a mentality of shift work and lack of ownership by health professionals of their work circumstances and outcomes. We consider that the dogma of “safe working hours” fails to understand the inherent ethical content associated with the physician’s unconditional commitment to serving his or her patients, as well as the key educational role played by the experience of personal challenge and sacrifice.

Indeed, it is the culture of neoliberalism, for which “rational” control of labor and labor practices are paramount, that poses the greater and more insidious threat to patient welfare. The deep infiltration of neoliberal imperatives into the institutions of health and higher education has already profoundly compromised traditional ethical values and goals (Komesaroff et al. 2015). Organizational changes presented as initiatives to improve patient safety are often untested assumptions, whereas they also may function as devices to limit staff costs. In the process, they also attenuate the ability of health professionals to operate autonomously in accordance with their considered expert judgments, as required by their relationships with their patients. The imposition of blanket bans on overtime are presented as strategies to oppose exploitative work practices. However, their more pernicious intent—and effect—is to increase the regimes of control over medical labor and to extirpate from it the traditional values of supererogatory action and self-abnegation.

The penetration of technical rationality into the discursive space of medical decision making, and the systematic depletion of ethical values, manifests itself in many ways. The insertion of the computer-driven checklist into the daily ward round directs conversations with patients and limits the possibilities of open, free-flowing dialogue, or as Verghese has observed, this is the “chart-as-surrogate-for-the-patient approach” (Verghese 2008). An increase in shift work diminishes the educational value of training rotations not only by reducing working hours but also by dismantling mentoring relationships through which junior practitioners traditionally acquire skills and knowledge. Role modeling and mentoring are acknowledged to be crucial in the determination of a health professional’s identity and subsequent actions as an independent practitioner. Collegial interactions influence one’s disciplinary choice and future mode of practice. If a culture of discontinuous care is permitted, or worse is prescribed by medical shift work, this mode of behavior may become normative.

Neoliberal regimes for the control of medical labor—which include rigorous and inflexible regulation of work schedules—undermine the ability of medical professionals to control key decisions associated with patient care, which for millennia has stood at the ethical center of the institution of medicine. Authentic ethical commitments cannot be subject to conditions of being “on-” or “off-shift.” If doctors are to discharge—and to protect—their historical responsibilities they must preserve their capacity to control the organization and rhythm of the clinic and from time to time be prepared to encounter personal, sometimes difficult, challenges in the process of doing so.

To practice ethically one must assert the ability to act effectively, and this comes with a price. Ethical agency is not concerned with the actions of isolated individuals protecting personal interests; rather, it refers to the capacity to engage in reciprocal relationships characterized by trust and mutual responsibility. To retain its authenticity, such agency must remain faithful to the needs of the participants in the relationships, not to disciplinary regimes that seek to regulate it or to the economic imperatives that seek to contain it. Mutual, responsible decision making fosters an environment of care that is sensitive to local material and ethical conditions, improves practitioner
well-being (Dubov et al. 2016), enhances pedagogical outcomes, and helps propagate ethical value in other social domains.

The technocratic and reductionist erosion of medical care does not occur merely through the application of rigid, scientistic modes of thought and judgment. It also arises as a result of the formal, bureaucratic regimentation of the contexts within which thinking and judgments take place. “Efficiency” and “safety” are admirable objectives to which we should legitimately and vigorously aspire. However, in our endeavors to attain them we must take care to avoid sacrificing the very values they were originally invented to realize.

REFERENCES


