Life & Times

Ethics and toxic high-workload work environments

Work environments might be considered toxic because of lack of support or because of undermining or intimidating behaviours of work colleagues. In this article we also consider the situation where the workload is too high to feel safe. Such environments may be aggravated by there being no support or opportunity to influence workload allocation, causing greater work-related stress. Workload is the most important factor contributing to stress.[1] Other factors include bullying and harassment, discrimination, lack of resources, conflict, and dealing with pain and suffering.[2]

The effect of slowly increasing work pressure is that, because of their understanding of their 'duty of care', doctors make micro-adjustments to their behaviours and work practices to cope with the increased work. This acceptance of the increased workload has two main effects: it sets a new level of patient expectation; going the 'extra mile' becomes expected, 'just another mile', with a further mile being 'extra'.[3] Also, because some of these micro-adjustments are to cease activities that help maintain doctors' wellbeing (such as spending time with friends, doing exercise, and pursuing interests) they harm doctors; by the time doctors realise that they have a problem, they may have already been seriously harmed by the system (the 'boiling frog' effect) and may be close to (or already at) burnout.

Much of the focus in the NHS currently is on the need for doctors to be trained in 'resilience' — which may imply to doctors that the problem is not with the system but rather with their lack of coping mechanisms. We argue that this is misguided, and the focus of attention should change.

SOME PRINCIPLES APPLIED

Beneficence[4] — while it is important to 'do good', there is sometimes an assumption that doing anything is better than doing nothing. Non-maleficence[4] — the prevalence of presenteeism[5] when doctors are unwell suggests that this principle is largely overlooked, potentially putting patients at risk.[6] This may also put clinicians at risk through stress, poor performance, overwork, burnout, or disciplinary action. This can be expressed as a duty to work safely — The General Medical Council's (GMC's) *Good Medical Practice*[7] emphasises patient safety and the need for patients to be treated to a high standard and in a timely fashion, but says little about protecting the health and wellbeing of the doctor or the potential danger to patients from overworked doctors.[8] Little is said either about the duty to be brave enough to escalate issues so that the responsibility is not completely assumed by the frontline clinician.

Social, professional, and cultural expectations — this relates to the organisational culture of the department or practice and to the social, professional, and cultural norms that are accepted and shared by the health professionals. For example, how acceptable is it for one doctor (if they are swamped) to ask another for help in getting through their workload? Related to this is the level of involvement of 'management' (those who lead and run the department or organisation) in day-to-day operations. Do messages about inadequate levels of staffing and toxic workload reach their ears? Consider the 'core values' of the NHS — these include a statement about compassion: *'We respond with humanity and kindness to each person's pain, distress, anxiety or need.'*[9] Does this apply to our clinical colleagues in the NHS as well as patients? Compassion can flourish when people feel safe, but if everyone is under huge stress then it may wither.

THE RESPONSIBILITY OF INDIVIDUAL DOCTORS, EMPLOYERS, AND CONTRACTORS

Doctors do have a responsibility to do their work to a safe level and quality, and should have regard for the wider effects. There should be a balance between timely care and good-quality care. Individual doctors also have a responsibility not to put themselves at risk of error, disciplinary action, or health problems. *Good Medical Practice* doesn't specifically raise this issue, but it is surely unprofessional to persist with a working pattern that a doctor knows is likely to put them at risk of regulatory action or censure.

Extracts from the GMC's *Good Medical Practice*:[7]

- *'Good doctors make the care of their patients their first concern'* (para 1);
- *'Good doctors … do their best to make sure all patients receive good care and treatment'* (para 2);
- *'You must take part in systems of quality assurance and quality improvement to promote patient safety'* (para 22);
- *'You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised. If a*

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patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away. If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible' (para 25); and

- *'You must offer help if emergencies arise in clinical settings or in the community, taking account of your own safety, your competence and the availability of other options for care'* (para 26).

There are professional, organisational, and societal pressures on individual doctors to work within accepted codes of practice; but it may be that these vary from one organisation to another, and are inadequately described, evidence based, and accepted.

What is less clear is to what extent there is an individual duty of engagement with patient groups, the mainstream media, or social media to correct unhelpful or toxic narratives. How should the establishment and fellow professionals view doctors who are courageous (or foolhardy) enough to do this?

Employers have a responsibility[10] to ensure that the workload on each member of staff is manageable; they have a common law duty to take reasonable care to safeguard staff health and safety, which includes controlling stress levels at work. Setting a daily cap on the number of patient contacts (or decisions) completed by each clinician, or declaring 'black alerts' if an organisation is under unmanageable pressure (common in secondary care but almost unheard of in primary care) might be options to consider. A 'black alert' results in demand being diverted to the next nearest service that is not yet overwhelmed, and we wonder what could provide a safety net of this kind in primary care. Those with management responsibility in general practice (such as GP partners in the UK) are not always themselves protected from such situations, and there should perhaps be much more recognition of the responsibilities of the organisation in GMC considerations. Heroic leadership at the frontline also has the potential to be toxic — if leaders expect staff to take on the same toxic burdens that they are struggling with.

Contractor responsibility for staff workload is relative — the degree of responsibility should be proportional to the degree of control that the doctor has over the work environment. While at first glance a GP partner might be seen as having a high level of control over the workload of each member of their staff, if in fact that expansion of the workforce isn't an option because of funding or the unavailability of suitable candidates then they don't have that control.

We would argue, however, that all of the above — individual doctors, employers, and contractors — do have a responsibility to take action over issues of unsafe workload, rather to ignore them. The approach of just ploughing on and working through the list of patients in front of you may be the simplest way of solving the short-term problem, but if it leads to the doctor becoming unwell (and absent from work), or to long-term recruitment problems to that particular work role or specialty, then that short-term solution causes a long-term problem. The risks of acquiescence — effectively supporting and colluding in an inherently unsafe system — seem to be frequently overlooked.

CONCLUSIONS

We would propose a re-appraisal of our mutual obligations: what do we owe each other? What are the limits of these obligations? In terms of workload, we should be much clearer about when workload moves from obligatory to supererogatory — and then to dangerous. This may depend on the individual and the healthcare setting, but delineating some principles are clearly needed. Individual doctors must make a decision about how they should respond to being in a situation in which their workload is unacceptably high and unsafe. Retention of doctors in the profession might be improved if the options to stay and fight — whether taking non-patient-harming industrial action, whistleblowing, or simply gathering reports from colleagues to build a case for change — were clearer and more acceptable.

The risks and drawbacks of taking any of these actions need to be balanced against the very real risks of doing nothing and allowing an unsafe system to persist. We would propose a much broader debate on these issues to explore and discuss more openly:

1. The wider risks and negative effects of unacceptable workloads;
2. Attitudes to and reasons for putting up with unsafe workloads;
3. How the responsibility and liability for adverse events arising from unsafe workloads should be divided;
4. How safe reporting systems for whistleblowers can be developed and implemented; and
5. How safe organisational cultures around this toxic feature of the healthcare workplace can be embedded within the NHS.

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