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Commentary

Doctor-Workers: Unite!

Could Disobedience Be the Path Ahead?

Howard Waitzkin, MD, PhD | May 20, 2016

Editor's Note:
The recent conclusion of the junior doctors' strike in the United Kingdom provides illustration of the subject of this commentary: the call for physician unity to protect autonomy. To protect confidentiality, all personal names have been deleted and names of all organizations fictionalized.

A person can become free through acts of disobedience by learning to say no to power.... At this point in history the capacity to doubt, to criticize and to disobey may be all that stands between a future for mankind and the end of civilization.

-Erich Fromm, *On Disobedience*[1]

Disobedience

I confess: I am a disobedient doctor.

After a career in academic medicine and public health, I decided to work part-time in a rural health program. There I began to understand the loss of control over the conditions of medical practice that has affected so many doctors. Administrative demands multiplied and constrained my ability to care for my patients in the ways I thought best.

So I decided to disobey. A seemingly minor training requirement for the International Classification of Diseases, 10th edition (ICD-10), became the administrative demand that pushed me over the line to disobedience. But the struggle might have involved any other segment of clinical medicine, where employer mandates infringe on a doctor's freedom to practice.

Proletarianization

Intrinsically, I have nothing against being a proletarian. I supported much of my education by working as a proletarian—for instance in a tire factory, where I learned first-hand about life as a worker in our capitalist society. Throughout my medical career, I have befriended many "nonprofessional" health workers—wonderful people whose services usually go underappreciated. Such people spend most of their waking lives doing tasks assigned by supervisors, and they enjoy little or no control over the conditions and rhythm of their work.

Medicine, I thought, would provide a way to seize control of my own work process and creativity by organizing at least a large part of the work week as I preferred. A position in academic medicine actually did allow me that liberty, despite the challenges of university bureaucracies—though there, too, autonomy started to erode, a phenomenon usually linked to financial shortfalls and measures of productivity.

However, entering the world of a nonacademic medical employee revealed the awesome scope of proletarianization—a change in doctors' previous social class position. Until the 1980s, doctors for the most part owned or controlled their means of production and conditions of practice. Although their work often was challenging, they could decide their hours of work, the staff members who worked with them, how much time to spend with patients, what to write about their visits in medical records, and how much to charge for their services.

Now the corporations for which doctors work as employees usually control those decisions. Loss of control over the conditions of work has caused much unhappiness in the profession. Early on, an esteemed clinician and mentor described medical proletarianization when it was first emerging as "working on the factory floor."[2] Most doctors have become highly paid employees of hospital and health system corporations,[3] and around one half of doctors report feeling burned out.[4,5] Owing to the mystique of professionalism and their relatively high salaries, doctors often do not realize that their discontent reflects in large part their changing social class position.

Deciding to Disobey

As a doctor-worker, I got into trouble by expressing concerns about the training that our health network (hereafter, referred to as "OHN") was requiring for ICD-10 implementation. Until then, I had received praise and little negative feedback, and had just been reappointed.

OHN had contracted with a corporation (hereafter, "$Corp") to help cope with the transition to ICD-10. This corporation was one of hundreds that have emerged to sell consulting services to healthcare organizations facing the challenges of information technology. Such challenges include electronic health records (EHRs), quality assurance, accountable care, and similar arenas. All involve "metrics" that try to make quality quantifiable, a goal that has generated wide debate.

$Corp's training for ICD-10 took multiple hours of unpaid time, and I decided to disobey the requirement. One reason involved my desire to spend time with a dying friend, which made me even more aware that each moment of life is too precious to waste.

After I previewed the $Corp training, I concluded that its educational quality was poor and that it implicitly encouraged "upcoding," which could generate more payments for OHN. Brief discussions with other practitioners confirmed universal contempt for the training, as well as disgruntled universal compliance. I decided to protest the training.

The Slippery Slope to Fascism

My subsequent interactions with OHN administrators surprised me, despite my knowledge about medical proletarianization. The chief medical information officer (CMIO) at OHN wrote that "Practitioners with incomplete ICD-10 coursework at midnight on 10/7/15 will be suspended until the coursework is completed." In response, I sent an email message asking him to explain the rationale for the training requirement. Copying the chief executive officer (CEO), the CMIO pasted his responses into the text of my original message:

1. Please provide evidence that additional training in ICD-10...improves any measurable patient outcomes, costs, or collections.
    - *Not a debatable point. This is a requirement by OHN, so, sorry to say, whether you agree with it or not, it must be done.*
2. Please provide the costs to OHN for the training.
    - *Not relevant, as this is a requirement.*
3. Please provide quantitative estimates of the financial benefits of the training for OHN.
    - *Not relevant, as this is a requirement.*
4. Please give a concrete description of the process by which you concluded that "completion of this training allows us to achieve both appropriate care and remain fiscally responsible—part of OHN stewardship."
    - *Not relevant, as this is a requirement.*

This response pressed one of my alarm buttons, which I might call the "fascism button." In my response, I explained the slippery slope to fascism,[6] when people do what they are ordered in their jobs without understanding why. Such unjustified requirements, I argued, deserve our conscientious questioning and sometimes noncompliance.

Standardization

The CMIO was unimpressed with my argument about incipient fascism in the workplace, so I next appealed to practicality. I proposed coming to the office, unpaid, and practicing ICD-10 within our EHR. His reply? "OHN's transformation is a movement to ensure process consistency and standardization.... Therefore, your request for an 'exception' is outside the organization's expectation."

Again, the CMIO's reply pressed an alarm button. I must behave like an automaton in a medical assembly line, "the factory floor" foreseen by my mentor.

I then requested a face-to-face meeting and details about my forthcoming suspension—including, most importantly, a plan of coverage for my patients. I repeated my concerns about authoritarianism in the medical workplace and the extensive evidence that standardization actually may reduce quality, creativity, and productivity.

Punishment

My moral predicament deteriorated quickly. On the next morning, the CEO sent an email message asking for my resignation effective within 1 week, despite packed schedules that included many unstable patients. Then, 5 days before the deadline for suspension, I received a letter stating that my office hours with patients had been canceled until further notice. Because I needed to respond to lab results and urgent messages, I tried to connect with the EHR but found that I had been cut off.

I now faced the apparent abandonment of hundreds of my patients, many of them unstable, who had not received any alternative plan of care. Medical abandonment is unethical according to the American Medical Association Code of Ethics[7] and is illegal in many states. I contacted the chief of the medical staff, who got me reconnected to the EHR so that I could manage acute problems for my unstable patients.

Because I was not willing to abandon my patients, I also persuaded an administrator to get me reconnected to the ICD-10 training, which I completed under protest late the next night. On the following morning, a Sunday, I received an email message from the CEO thanking me for completing the training and stating that my breach of contract had been "cured."

Redemption

As a doctor-worker, I faced a challenging ethical situation that included loss of professional autonomy, authoritarian practices in the workplace, and apparent abandonment of patients. My first suspension in more than 40 years of practice also raised concerns, such as: Would a report about the suspension from OHN to the National Practitioner Data Bank affect my medical licenses or ability to practice in other settings? Was it my responsibility to blow the whistle on OHN's practices to licensing, accreditation, and insurance agencies?

My small act of conscientious disobedience eventually led to some unexpected responses. My contract and state law required that OHN convene an external review to examine possible interference with my professional judgment, and the coordinator of the state agency that licenses health facilities expressed willingness to investigate this issue and the abandonment of patients.

Facing the probability of external review, the CEO finally met with me in person, and I proposed a formal mediation process. Instead, the CEO composed a document that included an apology, a statement that information about breach of contract would be removed from my personnel file, a commitment to consider individual physicians' preferences in meeting future training requirements, and a promise to meet individually with a physician when a suspension is considered so that patient care would not be disrupted.

Where is the path toward a noncorporatized vision of what we know medicine can be at its best? I don't think that path involves our continuing acquiescence. I confess that I have decided to approach these problems through personal acts of disobedience. For a person like me, closer to the end of my medical career than the beginning, such acts don't risk much. For others, overcoming the risk will require a more organized approach to disobedience.[8] Dare I encourage disobedience in unison? To paraphrase someone else: Doctor-workers of the world, unite!

Supplementary Material

"eDocuments of Disobedience," available on request, includes memoranda intended as illustrations for doctor-workers to use when contemplating or executing acts of disobedience.

"Resources for Organizing Among Doctor-Workers" is available upon request and contain links to additional readings and pertinent organizations.

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What Do You Think?

Is disobedience the answer? We want to know what our members think. Join the discussion.

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