Doctors and strike action: Can this be morally justifiable?

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Abstract

Strikes are rare events in the history of medicine. Mainly their occurrences have been initiated by junior doctors as is the case in South Africa. In the most recent strike action by South African doctors, the root cause appears to be the long-overdue salary increases with specific attention focused on the government's failure to implement the Occupation Specific Dispensation (OSD). It is quite difficult to separate fact from exaggeration during doctors' strikes due to media hype and the variety of players involved. Proximity to life and death and contractual obligations are put forward as the reasons doctors are judged by standards higher than ordinary mortals. For patients, some of the harms occurred may include the following: work-loss (if employed), wasted money for transport, treatment delays, prolongation of suffering, irreversible damage to health, dangerous drug interruptions and death. Concerning doctors, some benefits of a strike action may result in financial gain, improved working conditions which may contribute to less emotional pressure and even a degree of dissuasion from emigrating.

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Introduction

The first recorded strike action in history took place during the reign of Ramses III in the 12th century BC. Craftsmen staged the strike because they had not received their rations, and against the corrupt administration which controlled their activities.[1] Strikes are rare events in the history of medicine. Mainly their occurrences have been initiated by junior doctors[2,3] as is the case in South Africa. In the most recent strike action by South African doctors, the root cause appears to be the long-overdue salary increases with specific attention focused on the government's failure to implement the Occupation Specific Dispensation (OSD).[4] Its aim was to introduce revised salary structures for identified occupations that cater for career-pathing, pay progression, grade progression, seniority and increased competencies and performance with a view to attracting and retaining professionals and other specialists, as well as to review the non-pensionable allowances payable in the public sector. An agreement with government to implement the OSD was signed by doctors in 2007. In 2008, nurses received a 20% salary increase, but the promise to doctors was deferred.[5]

Initially, the focus appeared placed on the OSD, poor wages, and the stoppage of filling vacant posts.[6] Concurrently, complaints of the government's poor financial planning emerged. One report in particular concerned medical equipment, e.g. the lack thereof, the erratic or dysfunction of, and the possible withdrawal of vital equipment due to non-payment. In such circumstances, patients are played as "pawns in the game of inefficiency".[7] But doctors also bear the fate of the pawns, for the requisition of reliable medical equipment in contemporary medical practice is vital. The lack of attention to basic patient needs also came to the fore reminiscent of the late 1980s when letters were published in the South African Medical Journal (SAMJ) concerning the then-Baragwanath Hospital with words such as *'the conditions are appalling'... 'Patients sleep on the floors at night'... 'no linen'... 'an affront to human dignity'... reminding us that 'all that is necessary for the triumph of evil is for good men to do nothing.'* [8]

Nonetheless, the Health Professions Council of South Africa (HPCSA) was quick to issue a stern warning to striking doctors citing their flagrant abuse of the Hippocratic Oath and pointing out the South African legislation that prohibits doctors from striking.[3] While we have omitted some of the aspects of the doctors' strike action, a general picture of their major complaints should be clear. Faced with the "actual or perceived" inaction/unwillingness of the employer to address their grievances, a number of mainly junior doctors joined in the strike action. With strike actions intense ethical debates also arise – notwithstanding their causes.

Discussion

Sachdev[12] outlines a variety of reasons commonly articulated against strike action by doctors:

1. The claim that the results of such an action would result in avoidable harm including the death of patients
2. Strike action breaches the implicit social contract between doctors and patients
3. Strike action negates the doctor's publically declared declarations of service, codes and principles of ethics
4. Strike action would affect the weakest and most vulnerable segments of the population for material gain
5. The image of doctors as selfless healers would be de-mystified and
6. Doctors are already overpaid or at least have the potential to become higher wage-earners than the general population

In the following section we will specifically address his first two reasons while addressing the remainder briefly as comments in the article.

The results of such an action (strike) would result in avoidable harm including the death of patients

It is quite difficult to separate fact from exaggeration during doctors' strikes due to media hype and the variety of players involved. Proximity to life and death, and contractual obligations are put forward as the reasons doctors are judged by standards higher than ordinary mortals. In social myth or reality, a doctor is 'there', present in the absoluteness of death. Although one may question the moral relevance of temporal or geographic distance, the fact of a death whilst doctors are on strike is not afforded any clarification. Rationally speaking, the value of human life is treated by society in relative terms although when doctors' strikes occur, its sanctity is professed in terms of the absolute. By relative terms, we refer to deaths occurring in wars, revolutions, resource battles, domestic hostilities, road-deaths, and substance abuse. Yet, even in viewing life in relative terms, in the context of medical practice how might moral justification for strike action by doctors be argued?

From a utilitarian perspective, strike action can only be justifiable if there is evidence of great long-term benefit to doctors and their families, a positive improvement in health care delivery[9] and the concurrent increase in benefits to those who are the most in need of health care.[10] This calculus rests on the application of the *Principle of Utility.* In other words, what is moral relies on the production of the greatest amount of happiness/good/pleasure for the greatest number of people. But it is not as simple as it may appear for we are obliged to weigh the likely harms incurred because of strike action with that of the probable good that may result.

For patients, some of the harms occurred may include the following: work-loss (if employed), wasted money for transport, treatment delays, prolongation of suffering, irreversible damage to health, dangerous drug interruptions and death. Concerning the latter, death may or may not be the ultimate harm as no one has returned from death to state the outcome categorically. On the other hand, benefits may include non-care of the patients who tend to seek unnecessary medical treatment in the first place and those who might be better off not seeing a doctor in circumstances where equipment or facilities are beneath an acceptable level.

Concerning doctors, some benefits of a strike action may result in financial gain, improved working conditions which may contribute to less emotional pressure[11] and even a degree of dissuasion from emigrating. Negative responses however may be generated from public opinion. Because of the nature of the practice of medicine doctors are placed in the proximity of intimate human emotions, the fragilities, strengths and weaknesses of patients in life and death. As witnesses to such powerful situations, the image of the doctor as the key figure in what has been termed a "healing relationship"[12] runs the risk of being tarnished in cases of strike action. However and interestingly, public responses do not always look at strike action in a negative light[13] particularly if the strike action identifies the exploitation of doctors.[14] The problem of course, lies in weighing the pros and cons. One cannot know for certain if the benefits will, in fact, outweigh the burdens.

Strike action breaches the implicit social contract between doctors and patients

Doctors are deemed to work under a special ethical commitment because of the nature of the doctor-patient social contract[15] which places them in a distinctive moral position to care for their individual patients. Medicine has a similar contract with society. Doctors accept this special obligation of fidelity by declaring publicly their commitment to place the interests of patients, particularly the vulnerable, above those of all others. This is generally accepted as preclusion against strike action. Yet, it is important to recognise how this maxim is placed under stress in contemporary medical practice.

Medicine is now practiced in many different ways, such as the advent of wage-contracted doctors, rationalised work, administratively imposed limitations of privatisation, corporate cost-containment programmes, and imposed production norms.[16] Most likely as a spin-off of employment in such spheres, doctors have increasingly sought unionisation as a means to protect themselves against proletarianisation and corporatisation, ingredients of what is broadly termed 'Organised Medicine'.[17]

Moreover, in countries where medical care is largely geared towards provision of care to the majority of the population at minimal or no cost e.g. socialised medicine, its provision and the inferred contractual agreements becomes a joint responsibility which includes the doctor, the hospital and the government. In such cases the system is such that if one of the entities by *de facto* fails then the remaining others will bear the consequences. For example if the government fails to meet its obligations then the sanctity of the other limbs of the contract suffer.[18] Concerning this, it is not uncommon to point to the whole claiming that the responsibility for its failure is the sum of all of the shared individual responsibilities, or contributory group-fault: collective and distributive.[19] But this may be misleading because the morality of the role structure which makes up this collective as well as the role-acceptance, role-competence and role-enactment of the individuals who act or choose not to act in this collective are pertinent as well.[20]

Private practice should be the area where doctors are in a better position to maintain their social contract (be their doctor-patient relationship formulated as a covenant, or accord) in keeping with more traditional practices. However, while the tendency at present to act more as 'technocrat' than 'doctor' is through medical education initiatives being somewhat abated, and relationships with patients have become less strongly paternalistic than in previous times, concurrently patients have become more prone to take legal actions against doctors – for right or wrong. The response to this has been that doctors have become more defensive. Thus, the character of the social contract even in private practice is again altered.

Recognising that the circumstances of contemporary medical practice have changed and agreeing that the medical ideal of a social contract is under stress may lend understanding as to why doctors engage in strike action. However, focusing only on the idea of the social contract presents a rather simplistic view of medical practice where moral boundaries are not so easily defined.[21] Doctors do have special obligations to individual patients who they take under their care and this is reciprocated by the patient in trust. In keeping it becomes a fiduciary duty of the doctor to provide her skills and work always in the best interest of her patient. This also implies a continuation of her care, or a transfer of care to an equally competent doctor should she be unable to continue. The doctor is, in a sense, always "*on call*" to the patient because of the mutually accepted commitment implicit in the doctor-patient relationship. Even in the event of a strike action, this duty cannot be discarded. For example, should that particular patient be in the doctor's room in consultation when strike action is called, the doctor cannot morally abandon the patient and rush to picket.

The type of contract doctors have with greater society is different in the sense that a doctor is bound to act responsibly and caringly when he is present in hospital in a clinical encounter. However, he has no duty to be present for all patients under all circumstances. When doctors are employed by the state, which is of course composed of and managed by individuals, the provision of health care becomes a joint responsibility. This shared commitment to the provision of good medical care does not, even in times of great disarray, remove a doctor's primary responsibility to provide the patient with the best care possible. However, the structure of the health care enterprise as shared does lend itself to support the position that doctors should not be viewed as the only bearers of blame for making the decision for strike action. When facilities, equipment, and personnel are substandard, when mistakes are made which are identifiable because of administrative blunders or political gain, which are out of the control of doctors, 'continuing to hold doctors to the sanctity of their professional commitments becomes morally questionable'.[22]

Thus far we have pointed to the nature of the doctor-patient relationship which entails a special *moral contract* with a doctor and an individual patient. A question arises which asks if doctors have the same moral obligation towards individuals who through no mutual accord may become their patients in the future. In state-run hospitals mere chance and symptoms often determine patient assignment. If this special contract is applied to all society then it would be immoral to engage in strike/go-slow action. It would also be morally questionable for a doctor *not* to be present whenever that particular patient returned to hospital – day or night – or sought her assistance. If a doctor were to leave the practice of medicine, transfer to a different medical system, be on vacation or absent from duty she would not have any special obligations to patients who presented to a state-run hospital during her absence.[18] The institutional context of medical practice by its very nature limits the ideal notion of a doctor-patient relationship. This is not to say that in state-run institutions doctor-patient contracts do not ever exist. Yet a doctor's contract with society to act dutifully and responsibly in patient care is limited by the circumstances of a shared structure of responsibility.

Frequent and misunderstood statements that doctors are bound by the Hippocratic Oath and as such they are in breach of their ethical duties always arise in strike actions. What is not sufficiently understood is that the Hippocratic Oath was sworn by students and is patient-benefitting in doctor-patient relationships on an individual level. Against this it can be argued that doctors have a greater responsibility to the public's health (particularly the vulnerable) than they have towards the treatment of an individual under their care. Doctors should not perpetuate the provision of substandard care even if betterment can only be achieved through strike action. One might even argue that it is immoral for doctors not to strike under substandard and patient-endangering circumstances.

Ethical guidelines, which are largely descriptions of a doctor's duties, identify *particular prima facie* obligations which are alleged to guide moral behaviour. In medicine, two important principles are the duty of *fidelity* (obligation to keep promises) and *beneficence* (obligation to try to do good, to actively help others). These and some of the other principles of medical ethics would appear to stand against any strike action. Of course, arguments can be made that keeping promises and trying to do good/actively help others applies to current, not future, patients and benefits may be viewed both in the short and long term.[22] Yet such arguments aside, there are other duties which may be viewed as supporting strike action, for example, justice. Justice is often defined in terms such as fairness and equity. Yet justice is not limited only to others, but also to oneself and family. So it is possible for an argument to be made that strike action is ethical if the injustice caused by it to the patients is outweighed by the justice done to the doctors and their families. Again, the problem is finding the right balance.

Professional activism

Advocacy in medical practice concerns promoting health care values rather than government or institutional policies which undermine the medical profession. As the practice of medicine in contemporary life becomes more complex (e.g. in systems which involve government, hospital and doctors) just how to ensure the three entities meet their moral obligations to society is the singularly most important issue to address. One side cannot endlessly support the others. Smouldering behind the strike action are failures on all three sides: failure on the part of the employer to act in accordance with its stated recognition of the importance of health care, failure on the part of institutions to support their personnel, hospitals and clinics to reach their optimal potential, and failure on the part of doctors to consider seriously their duties and obligations to selves, patients and profession.

Advocacy, dissent and even disobedience are tools which should precede any strike action. When a situation comes forth which is ethically catastrophic then exit from professional duties can be justifiable. In such situations patients are likely to be harmed so the justification, as in 'whistle blowing', must be made on moral grounds. The only moral ground is that health care will overall be substantially improved for the greater population. *Can strike action by doctors ever be morally justifiable?* Yes, it can. But always at a cost.

Conclusion

We hope that this article has provided some insight on the doctor-patient and the employer-employee relationships when doctors embark on strike action. A strike action is a failure on the part of the employer to act in accordance with its stated recognition of the importance of health care, failure on the part of institutions to support their personnel, hospitals and clinics to reach their optimal potential, and failure on the part of doctors to consider seriously their duties and obligations to selves, patients and profession.

References

1. el-Hamalawy H. Egypt under Ramses III, c1155BC: First recorded workers' strike 2007. Accessed June 2009 at: http://arabist.net/arabawy/2007/02/27/egypt-under-ramses-iii-c1155bc-first-recorded-workers-strike/
2. Breacher R. Striking Responsibilities. J of Med Eth 1985; 11: 66–69.
3. Naik A. Resident doctors on strike. Issues on Med Eths 1996; 4(2): 46–47.
4. de Villiers JT. Striking doctors. SA Fam Pract 2009; 51(9): 201.
5. Thom A, Bodibe K. Docs halt strike, for now. Health-e News 2009. Accessed April 2009 at: http://www.health-e.org.za/news/article.php?uid-20032282&PHPSESSID.html
6. Bodibe K. Doctors' protest action spreads. Health-e News. 2009. Accessed April 2009 at: http://www.health-e.org.za/news/transcript.php?uid=20032279&PHPSESSIC
7. Bateman C. No pay, no cure-can our hospitals be salvaged? S Afr Med J, 2009; 99 (5): 289–292.
8. (Quote attributed to) Burke, E. No definite original quote. Accessed May 2009 at http://www.En.Wikiquote.org/wiki/Edmund Burke
9. Beacher R. Striking responsibilities. J of Med Eth 1985; 11: 66–69.
10. Veach RM. Interns and residents on strike: Commentary. The Hastings Center Report 1975; 5(6): 7–9.
11. Grosskop I, Buckman G, Garty M. Ethical dilemmas of the doctors' strike in Israel. J of Med Eth 1985; 11: 70–71.
12. Pellegrino ED, Thomasma DC. The ChristianVirtues in Medical Practice. NY. Oxford University Press 1996: xi.
13. Baer N. Despite some PR fallout, proponents say MD walkouts increase awareness and may improve health care. Can Med Assoc J 1997; 157: 1268–1271.
14. Jesani A. Ethics, rights and strikes of health workers (editorial). Ind J of Med Eth 2009; 6 (3): 1.
15. Veach RM. A Theory of Medical Ethics. NY: Basic Books 2003.
16. Thompson SL, Salmon JW. Strikes by physicians: A historical perspective toward and ethical evaluation. Int J of Health Serv 2006; 36(2):331.
17. Klein S. AMA to establish national collective bargaining unit. AMA News 1999; 42: 34–35.
18. Sachdev PS Ethical Issues of a doctor's strike (correspondence). J of Med Eth 1986; 12: 53–54.
19. Feinberg J. Collective responsibility. J of Phil 1968; 65 (21): 674–683.
20. Dowie RS. Collective Responsibility. Royal Inst of Phil 1969; 44(167): 66–69.
21. Wynia M, Latham SR, Kao AC, Berg JW, Emanuel LL. Medical professionalism in society. NEJM 1999; 341 (21): 1612–1616.
22. Sachdev PS. Doctors' Strike--an ethical justification. N Z Med J. 1986; 99(803):412–414.