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The Ethics of Industrial Action by Doctors

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Introduction

United Kingdom's public services are presently going through a wave of strike action[1]. Rail workers, postal workers, civil servants, teachers, nurses, physiotherapists, airport staff, ambulance workers, and fire services have all been involved, and many are still taking action. No sector seems to have been spared in the wave of discontentment about pay and conditions. Doctors, particularly junior doctors and consultants, are also following suit. The moral and ethical dilemmas that doctors, and others in the caring profession, face when it comes to withdrawing labour are not to be underestimated. The oldest guidance to physicians is found in the Hippocratic Oath (c. 400 B.C.). Though not many doctors will remember the details of the Oath, the majority will know that it promotes the principle of 'First do no harm'. This is inculcated in Oath[2] (translated from Latin to English) as follows: *"I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."*

Arguably, strike action that leads to the cancellation of an operation or prevents attending to an emergency medical situation risks causing harm to, or even death of, a patient. As well as these direct consequences, unintended consequences threaten the trust inherent to the doctor-patient relationship. Patients trust doctors with their most precious possession – their lives and the lives of their loved ones. No one must underestimate the internal struggle from carrying out this overwhelming professional responsibility and their desire for remuneration commensurate to their training, roles and responsibilities, combined with the uncertainty of reward from collective bargaining through Industrial Action (IA). We explore the complicated issues surrounding strike action by doctors, mainly around ethics, rather than arguing for a case against or for such action or issues of morality. The outcome of strike action is a rather complex matter, and beyond the scope of this article.

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The legal and ethical dichotomy

The tenets of employment law and workers' rights lays down the foundations by which doctors (like any other professionals) can withdraw their services, including from their most vulnerable patients. However, for many, the thought of patients dying or coming to harm, particularly those in imminent danger during the strike periods, will cause immense emotional distress. The position of the General Medical Council[3], the regulator for all practising medical practitioners, is rather ambiguous because it states, "Doctors may be faced with challenging situations during strike action, whether or not they're participating directly. In both scenarios, doctors must use their professional judgement to assess risk and deliver the best possible care for people". Those who undertake strike action are hardly likely to deliver any care to patients, let alone the best possible care. The common understanding in cases of IA is that it is the employer's responsibility to ensure adequate cover during absences. Others argue that doctors have a moral obligation to ensure continuity of care[4].

Since the purpose of the planned IA is to force an employer, or in this case, the Secretary of State for Health and Social Care, to agree to negotiate, the indirect consequence may be that this inconvenience is converted to actual harm for the innocent patient. Under normal conditions, if a patient came to harm from the action or inaction of a doctor, it would almost certainly result in a complaint or formal investigation under maintaining high professional standards and principles. We are unaware that any legal case has been taken up by a patient who might have suffered consequences from the withdrawal of labour during IA by a doctor or nurse to the employer or the striking practitioner. Nor has legal action been taken against an NHS employer or the government. This might suggest that either the public is tolerant of strike action or that the legal rights for IA are watertight.

The right for doctors to strike

The fundamental right to take IA is enshrined in the UK's Employment Law[5], the object of which is to ensure that employees are not enslaved by their employers to poor pay, terms and conditions. The only two exceptions are the police force and non-civilian members of the armed forces, who are prohibited from taking any IA. The right to IA allows workers to negotiate terms and conditions of service and, perhaps most significantly, appropriate remuneration. The UK is not alone in such regulations[6,7]; strike action has occurred in developed countries such as the USA, Canada, New Zealand, Germany and France and middle-income countries such as Brazil, India, Israel, Czech Republic and South Africa. Indeed, some low-income countries such as Peru, Kenya, Nigeria, Sudan, Zambia and Malawi have also witnessed IA. It is evident from the list of countries that IA is the legal prerogative arising from the human rights of employees in democratic countries but not autocratic regimes where strikes are disallowed and underreported.

Antecedents of strike action

IA by doctors is fundamentally the result of a dispute between doctors, employers, and/or government, failed resolutions or discontentment with pay and conditions over a protracted period. Before the birth of the NHS

in 1948, there were no strikes in recorded history. Since then, there have been a few, though it is relatively rare for doctors to take IA. In 1975, consultants and junior doctors withdrew non-emergency services in protest to the then (Labour) Social Services Minister, Barbara Castle, threatening to impose national contracts disallowing them to do private practice[8]. She compromised by allowing those on part-time contracts to continue the private practice, which resulted in those in private practice working 'maximum part time' or ten sessions instead of 11 for the NHS and retaining full private practice rights. They retained the right to do extra paid work for the NHS, so there was no difference to their earnings in practice.

Why do doctors strike?

Some members of the public will be surprised or even shocked that doctors are considering IA, let alone going ahead with it. There is probably a gradient of tolerance depending on the doctor's status. Certainly, in the case of junior doctors, we witnessed at the last strike a groundswell of support from the public. On the other hand, given the rarity of NHS doctors downing their tools, the public may have some sympathy for their cause, at least for now.

The principal reasons doctors resort to strikes are working conditions and remuneration commensurate with their training and professional responsibility. The pay for all doctors and dentists is determined through an independent body, the Doctors' and Dentists' Review Body (DDRB)[9], who provides a recommendation to the government. Certainly, doctors and especially the largest trade union that represents them, the British Medical Association (BMA), have been at odds with the DDRB with accusations that this is a governmental body that lacks independence. This is important because it further feeds into the discontentment that doctors, not just the BMA, feel about their voices being heard. In the case of junior doctors, whose strike action is imminent, the complete abdication of responsibility to a third of the medical workforce with the recent pay award, which awarded all doctors apart from junior doctors a pay rise of 4.5% and none to them, has added to the strain in the relationship. They received no uplift in pay and are now demanding a pay rise of 25% as a pay restoration for historic sub-inflation pay rises for over a decade.

But the pay isn't the only reason for IA. Demoralisation, burnout, lack of support, increased workloads, unsympathetic employers, the value that is placed on doctors expected to provide caring and yet not feeling cared for, and importantly, especially in the context of the spate of IA by other public workers, the sheer burden that doctors and other public sector workers have felt during the Covid pandemic, have all resulted in a disaffected medical workforce. While some professionals might strike because of the threat of job cuts and redundancies, this does not apply to medicine, where there has been a long-term historic shortage of doctors.

Ambivalence

Doctors come in all shapes and sizes – from clinicians, academics, managers, civil servants, teachers and researchers. Not all of them belong to their largest trade union, the British Medical Association (BMA). Therefore, no one narrative will determine how they might individually or collectively behave during IA. Some, such as clinicians, are more likely to want to take action. In contrast, others, such as senior managers, will be less compelled to do so, or they might even be fearful of taking all-out strike action for fear of reprisal or a condescending attitude from their bosses.

Deeply embedded in doctors is their line of duty, the professionalism defining their careers and that medicine is a vocation, not a business. Except for the true die-hard trade unionist, for most doctors, the importance of motivational framing and context of the IA will be the final judge in whether or not they will engage in strike action. And even with that, the extent of their engagement will vary. In departments with a greater risk to patients or severe shortages such that any withdrawal

would mean closing all services during strike days, the professional dilemma is likely to be more acute.

Politicisation of IA might potentially put some doctors off, but the majority of doctors have seen an erosion of the NHS in recent years. Because the NHS remains a precious institute to most, the anger and frustration doctors feel about the government's handling of the NHS might increase the chances of buy-in by most doctors. Joining picket lines in large numbers is less likely to be witnessed, especially among senior doctors, but planned demonstrations might yield better results.

Copycat strike action

One issue that may have contributed to the decision to strike is the copycat strike action. Before the 1970s, 'sympathy' strikes could occur by workers who were not in dispute with their employers but wanted to support colleagues in other areas. However, Mrs Thatcher made these illegal, as she did the idea of flying pickets which we witnessed during the miners' dispute.

In the last year, the public has witnessed an unprecedented number of strike actions by several trade unions and workers in what might seem like copycat disputes. This is a phenomenon that has occurred before[6,8]. In 2010, British Airways and London Underground carried out a series of strikes. In 2016, Ireland experienced a 'winter of discontent' with several unions taking strike action, followed by 'big pay rises' for the workers, as was reported. It was reported that a wave of labour disputes in Southern China led the authorities to declare that 'the stoppages appear to be copycat actions by an increasingly assertive labour force'. The resultant strikes by workers at Apple, Sony, Dell and Nokia led to an immediate pay rise of 30% and helped spawn IA in Honda, Hyundai, Toyota and other factories.

In the act of community unionism, three kinds of dynamics have been delineated in these mass strikes: (1) a first pattern is the diffusion of a certain form of strike within one sector, i.e. copycat strikes; (2) a second pattern is the diffusion of strikes, although not necessarily in the same form, to other sectors in the same national framework; and (3) the third pattern is the establishment of certain forms of strikes and the diffusion of experiences in one industrial region, at times across sectors.

Mass strikes are uncommon in medicine. However, in 2019 following the assault of two junior doctors in Kolkata, India, by aggrieved relatives, there were interstate strikes in West Bengal, Delhi, Maharashtra, Hyderabad, and several hospitals across India.[10] These protests were not about pay but entirely about doctors' safety at work. To a large extent, their concerns were finally met with improved security and the arrests of those who perpetrated the violence against the two junior doctors.

So far, in the UK, we have seen industrial action taken or declared by nurses, junior doctors, ambulance workers, university staff, teachers, civil servants, rail workers, postal workers and firefighters. Some trade unions have paused strike action over talks or new pay offers. Some workers have already settled their pay disputes[1]; criminal barristers in England and Wales accepted a 15% pay rise in October, 2,000 Aviva bus drivers won an 11% pay deal, 1,800 Abellio London bus drivers have accepted their pay offers, as have some British Telecom workers in an improved deal of 16%. The chances of success following strike action encourages further strike action[11], and it does seem that similar copycat pay deals are being struck and might well form a benchmark for negotiations. However, Unite and Unison members in Scotland have recently accepted a pay offer of only 7.5%.

The ethical question for doctors in this climate of multiple strikes is how patient care might be affected if doctors choose to strike when nurses and ambulance workers are on strike too. Indeed, with consultants now declaring the intention to take IA, how would that fit with junior doctors going on strike? The likelihood is that the different unions that support the workers will be in constant conversation to avoid overlap that will bring the NHS to a complete halt.

Where is the public in all of this?

The public often sees doctors as part of the establishment and more elite than other workers. In determining whether or not they would like to go on strike, for doctors, it is likely to be a peripheral question whether or not the public (most if not all of them will be or have been patients at some point in their lives) will support them. In the all-out strike by junior doctors in 2016, an IPSOS-MORI poll showed that 66% of the adult population supported the strikes if emergency care was provided, which fell to 57% if emergency care was not provided[12]. Or put another way, 26% were opposed to the strikes if emergency care was provided, as against 18% who were opposed if emergency care was not provided. Most interestingly, there was widespread support for the long hours' junior doctors work (46%), more than poor pay (24%). However, the country was not faced with a recession or multiple strikes then. It remains to be seen whether or not that goodwill will remain in the currently proposed strike actions. Furthermore, the differing positions of doctors and nurses, who, unlike doctors, have had a convoluted and uphill battle in establishing the profession and yet have had a history of industrial actions, in the ethical stance on strike action will undermine trust in one or both professions and potentially confuse the public[13].

Given that the major risk is to patients, all sides involved in IA must be factual in all communications. The government and employers must not demonise doctors through press briefings and statements condemning their strike action. Doctors' organisations must clearly and factually state their grievances without any spin.

Conclusion

The traditional and majoritarian view of medicine as a vocation rather than a job remains the basic principle that motivates doctors. Nevertheless, over the last two decades, there has been an erosion of their authority and an inability to fulfil the best care they can provide with successive cuts to the NHS and a relative salary reduction. That festering discontentment likely spurred many doctors to seek a route to express their feelings by taking IA. Nevertheless, for many, the ethical turmoil of potentially causing harm to patients from withdrawing services cannot be overemphasised. The conflict between professional duty and personal gain is at its acutest at such times.

It remains to be seen how this will be reflected in campaign turnouts and on the picket line. Ultimately, full-blown strike action is neither in doctors' nor the government's interest. Patients have long memories, especially as many are still reeling from the injustices of the pandemic, albeit doctors and others on the front line were celebrated as heroes. The media has little regard for the legal case of strikes or any ethical basis. They will record events for posterity, ensuring that stories on both sides are personalised and sensationalised. The real casualty in this could be the NHS, which is again at the forefront for the wrong reasons. On the other hand, the doctors' strike actions and those of others in healthcare might, in part, hope that these would wake the public to defend an institution that faces its highest risk of dissolution or damage in its 75 years since Aneurin Bevan gave birth to it.

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