

Should junior doctors strike?

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Received 11 December 2015

Accepted 14 December 2015

Published Online First

12 January 2016

ABSTRACT

An impasse in negotiations between the Department of Health (DoH) and the British Medical Association in November this year led to an overwhelming vote for industrial action (IA) by junior doctors. At the time of writing, a last minute concession by DoH led to a deferment of IA to allow further negotiations mediated by the Advisory, Conciliation and Arbitration Service. However, IA by junior doctors remains a possibility if these negotiations stall again. Would the proposed action be ethically justifiable? Furthermore, is IA by doctors ever ethically defensible? Building on previous work, we explore important ethical considerations for doctors considering IA. The primary moral objection to doctors striking is often claimed to be risk of harm to patients. Other common arguments against IA by doctors include breaching their vocational responsibilities and possible damage to their relationship with patients and the public in general. These positions are in turn countered by claims of a greater long-term good and the legal and moral rights of employees to strike. Absolute restrictions appear to be hard to justify in the modern context, as does an unrestricted right to IA. We review these arguments, find that some common moral objections to doctors striking may be less relevant to the current situation, that a stronger contemporary objection to IA might be from a position of social justice and suggest criteria for ethically permissible doctor IA.

INTRODUCTION

Industrial action (IA) by healthcare workers is not unknown, occurs in a wide range of healthcare systems and societies, and has complex ethical implications.^{1–3} Junior doctors (all doctors not consultants, GPs or staff and associate specialists) in England have recently voted overwhelmingly in support of IA over a dispute with the Department of Health (DoH) about contract changes. This differentiates it from the strike over pension reform in 2012 and other similar situations worldwide which have tended to involve all grades of doctors. With IA by junior doctors before mid-January 2016 still a possibility, a review of the context and main ethical arguments is timely.

Context

The hours junior doctors work are almost entirely dictated by their employers, who in turn are under pressure to provide adequate healthcare at all times within the confines of their contracts and budgets. By the late 1990s, many junior doctors were still being compelled to work over 80 h per week. In December 2000, the current junior doctor contract was introduced with an aim to decrease these hours and mandate minimum rest periods. Recognising that junior doctors had no real control over the rotas, the new contract was designed to incentivise

employers to stick to a maximum average of 56-h per week with retrospective pay awards if it was proven the junior doctors were being made to work significantly more than this. Subsequently, the Working Time Regulations further reduced the allowed average weekly hours to 48 h in 2009 and the European Court of Justice ruled that all time spent on site was the time worked. Therefore, working all weekend did not constitute appropriate rest periods, requiring employers to change to a shift-based system. The move away from team-based systems ('firms') decreased the number of doctors on site at any one time. This, coupled with the increasing complexity of patient presentations and sophistication of technology, has greatly intensified the workload for each junior doctor and left them responsible for many more patients at any one time.

Workforce planning requirements have also led to junior doctors losing control over their training and the ability to tailor it to their own needs and interests. Whereas the aim was to streamline training pathways, it has arguably resulted in an inflexible, impersonal, overly specialised system with significantly increased paperwork requirements for the trainees and left them with less general medical training.

Student loans and tuition fees replaced free university education and grants in September 1998, meaning society no longer fully funded doctors to train. Current medical students will have average debts of over £70 000 on graduation, without the benefit of free hospital accommodation in their first postgraduation year that their seniors enjoyed.⁴ Combined with this there has been an approximately 15% reduction in real-term wages of junior doctors from 2009 to 2014.⁵ Over the same period, the real-term annual increase in NHS funding averaged 0.9%,⁶ the lowest in the entire history of NHS (average 3.6% real-term increase per year), with associated increased demands on the workforce.

It is on this background that in mid-2015, after 2 years of formal negotiations, the British Medical Association (BMA) Junior Doctor Committee decided not to re-enter talks with the NHS employers due to concerns the contract, which they felt was unfair and unsafe, would be implemented with or without their consent. Worries focused on reversals of previous improvements; change in the definition of 'out of hours' (Saturday until 21:00 would now count as normal working hours), removal of the pay structure which comprises up to 30% of junior doctors' pay to be only partially offset by an increase in pay for hours deemed 'normal' and a removal of the current safeguards regarding total hours they could be compelled to work with no perceived adequate replacement. Subsequently



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To cite: Toynbee M, Al-Diwani AAJ, Clacey J, et al. *J Med Ethics* 2016;**42**:167–170.

these concerns have also been echoed by all the major Royal Colleges,⁷ leading funding bodies and academics,⁸ and the Medical Women's Federation,⁹ among many others.

On 19 November the results of a postal ballot by BMA to all eligible members were announced—76% voted, almost 28 000 junior doctors, and of those an almost unprecedented 98% voted for IA if it was required. Subsequently, there were talks hosted by the Advisory, Conciliation and Arbitration Service, which succeeded in deferring strike action at the last minute.

The GMC released a statement on 4 November reminding doctors that “Their actions must not harm patients or put them at risk.”¹⁰ Given these duties, is IA by doctors ever morally justifiable? If so under what circumstances might it be considered? Might IA even be seen as a moral imperative in some situations?

SHOULD DOCTORS EVER STRIKE?

Absolute moral objections

For some, doctors striking amounts to exploitation of the suffering of patients for personal gain by the professionals in whom society puts most trust and is therefore indefensible in any circumstances.¹¹ However, the moral legitimacy of strike action is generally accepted, especially if the actions of the employees only negatively impact the employers. In practice, for public servants in particular, IA will invariably impact on third parties. Some in the UK, such as the Police and the Army are legally barred from taking IA. Others, including doctors and other healthcare workers are not barred from IA but are often considered to be special moral cases due to the nature and obligations of their work.^{12 13} As these obligations are committed to freely, and are of such importance to society, once undertaken some feel strike action, or withdrawal of labour at excessively short notice, constitutes a definitive moral wrong. This special contract endows privileges and responsibilities and doctors therefore have a ‘moral obligation’ to set an example to the rest of society¹² and accept a greater degree of self-sacrifice while being rewarded by a sense of pride and moral satisfaction.¹³

Another common argument for an absolute moral prohibition on doctor IA is that it necessarily results in harm to patients.¹¹ This harm is a loss of trust from breaching the special contract, and direct physical harm as a consequence of willingly omitting care.^{12 14} This assumption of harm is rarely challenged by defenders of doctors taking IA, rather they tend to accept its likelihood and justify it on utilitarian grounds, as necessary for the greater good. Some opponents of doctor IA further suggest that all instances of doctor IA are futile, as patients and doctors always suffer, and are therefore unacceptable.¹¹ For example, the strike over pensions in 2012 inconvenienced patients and doctors lost out financially when the proposed changes were made anyway.¹⁵

To sustain an absolute moral objection to IA by doctors based on a breach of an unconditional special trust requires an acceptance that once a person becomes a doctor they are obliged to work under any conditions, at any time, with any number of patients. Such a conception of doctors' duty may have been defensible when medical care consisted of little more than a caring attitude from a paternalistic authority figure who was free to choose their own patients. But in the modern context this simplistic notion of a doctor's duty appears naïve.^{16 17}

Claims that doctor IA is necessarily futile are also hard to sustain and seem to rely on the idea that any compromise in negotiation necessarily results in ‘embittered’ doctors.¹¹ DoH's temporary lifting of the threat of imposition is just one example of positive outcomes for doctors. More importantly, as we shall see later, it is unclear if, on balance, patients are always harmed.

If neither harm nor futility is inevitable from doctors' IA, an absolute prohibition becomes less defensible. If there is not an absolute moral ban, the question becomes under what circumstances may it be permissible? The concepts of trust and harm become restrictions to possible IA rather than absolute objections.

Relative moral objections

The idea that doctors have a special moral contract with society is in part related to the doctor-patient relationship. In recent times there has been a continued shift away from paternalistic doctor-patient interactions to a more patient-centred model.¹⁸ In a paternalistic relationship, patients waive their autonomy and to an extent cede moral responsibility to the doctor, trusting they will only act in their best interests and will do them no harm. The patient-centred model requires a sharing of responsibility with the patient, not necessarily equally, by promoting their autonomy.

A further modification to the special contract occurs in socialised medical systems where this responsibility is further shared with the State, as ultimate custodian of the resources for healthcare. By assuming responsibility for the populations' health and using doctors as agents to discharge this responsibility, the State compels doctors to take some responsibility for the interests of the whole population. Combined with their fundamental moral responsibility to the patient in front of them, this requires that doctors act in the interests of their individual patients and as advocates for all the patients in their care to the State. Altogether, this results in shared responsibility for patients' well-being between doctors, the State and to a certain extent, the patients themselves.¹⁸

From the State's perspective, any resources allocated for doctor remuneration cannot be apportioned for other uses that might arguably benefit patients more directly. As long as it is accepted that doctors are relatively well rewarded, IA focused on ‘personal and financial gain’ of doctors over treating patients is of course hard to justify.^{14 19} However, particularly in the context of a socialised system where the State sets the salaries and dictates the workload, there is a danger of an implicit assumption that treating patients will always trump doctors' financial interests. Although unlikely to result in no reward at all, salaries may fall below a minimum threshold. Unacceptable reward may not be unviable reward, but there is a risk of making a career in medicine unattractive, especially when considering the extra debts imposed by longer studies and the pay contrasted with other comparable professions.⁵

If doctors' hours are increased and pay reduced to the extent that the size and quality of the workforce is likely to negatively affect safe care, patients' best interests are not served. In this instance the State may be held responsible. Reflecting on just such a situation in Israel in the 1980s that resulted in up to 90% of doctors striking at any one time over a 3 month period, Grosskopf felt IA could be justified.²⁰ In line with Bion's argument¹⁹ regarding the 2012 IA, the perception by one half of the doctor-state duopoly that the other half is not fulfilling its responsibilities does not justify potential harm to the public. This echoes Grosskopf's view that this position is not an excuse for doctors to hold the government to ransom to the detriment of patients. However, doctors' acceptance of responsibility for the health of the whole population in socialised health systems should not be used as a means of exploitation either. It follows that a mutually acceptable minimum is practically and morally necessary to uphold the patients' best interests.

Even without the shared responsibility with the State and the patient, some are not sure that doctors have a completely

separate moral status. They feel that if omission, in the form of organised strike action, constitutes morally illegitimate harm then we are all guilty to some extent as few, if any of us, truly maximise the resources at our disposal for the good of others.^{18 21} The GMC is clear that doctors have a responsibility for patients under their care and must ensure this responsibility is handed over to an adequately qualified professional when their shift ends. In this modern healthcare structure, it is hard to sustain a claim that doctors are solely, or even partially, morally responsible for all patients, all of the time. As such, there must be periods certain doctors can strike without undermining personal doctor-patient relationships or risking harm.

What's the harm?

There is often an assumption that doctor IA necessarily causes significant harm to patients.¹² This direct violation of the doctors' duty of non-maleficence is interpreted as an absolute contraindication to IA. However, if doctor IA does not *necessarily* result in patient harm, or that harm is outweighed by the longer-term outcomes, perhaps it is permissible. Furthermore, as discussed in the previous section, in a socialised context, the State and patients share some of the responsibility. Previous reviews of IA by doctors have, unsurprisingly, found that doctors generally claim they are acting primarily in their patients' (longer-term) best interests, while their opponents feel they are acting mainly out of self-interest.² The economic concerns of doctors and patient safety concerns may not be mutually exclusive.³ Reviews of strike action by doctors in various countries ranging in duration from 9 non-consecutive days to 17 consecutive weeks and including periods of only 10% of all doctors providing care in one case, none were shown to have resulted in increased mortality, and more than one appeared to show improved mortality during the strike periods.^{1 22} The sample sizes, disparate nature and lack of other outcome measures preclude definitive conclusions but it does weaken the assumption that doctors striking necessarily harms patients when viewed from a mortality perspective. IA does however lead to delays and inconvenience.^{1 15} This can be seen as harm and it is also possible that delay can lead to greater harm (ie, non-urgent problems becoming more serious) in the future.¹² It seems arguable such harm is less severe, or at least less apparent, than is commonly presupposed by both sides of the argument. Therefore the balance between harm of IA and preventing future harm is less clear. Striking may still be inconsistent with immediately satisfying patient expectations and if patients' best interests are always the paramount concern then even inconvenience should be avoided. However, in a resource-limited system, such an all-encompassing understanding of best interests is hard to justify.

Explanations as to why overall mortality does not seem to increase during IA include a likely decrease in mortality due to the greatly reduced numbers of routine procedures. This seems to outweigh any increase in patients dying from emergencies. As such, doctor IA may be causing different patients to suffer in the short term and the same patients in the longer term by merely postponing their procedures. Different individuals may be harmed as a direct result of the IA—a medical trolley problem.²³ So a justification must be made for the possibility that the act, or omission, leads to different unidentifiable patients suffering.

Relative moral indications

If there are situations where doctor IA may be morally permissible, perhaps there are situations where it becomes morally

imperative, or at least indicated. For example, under the wider understanding of the modern duty-of-care to include the patient population, IA can be seen as, in certain circumstances, imperative. Doctors' duty to highlight patient-safety concerns, and maintain the welfare of colleagues²⁴ might make it morally necessary to take IA. A proposed contract that was felt to endanger the healthcare system by inadvertently reducing the number and quality of doctors might be such a case. In situations where the care in the short term is not likely to suffer due to adequate medical cover, as is the case in the current situation, this argument is even stronger.

SHOULD JUNIOR DOCTORS STRIKE?

Traditionally, most discussions about IA by doctors have referred to all grades and seniorities. The current dispute is between DoH and junior doctors. Therefore, in the event of IA all other doctors, including GPs, consultants who have ultimate responsibility for, and greatest experience of, patient care in hospitals, and healthcare professionals, would still be at work and reallocated appropriately. Patients requiring emergency care would therefore receive senior medical attention more efficiently than normal, which is arguably beneficial. However, many routine appointments and administrative tasks would be compromised causing exponentially increasing inconvenience and risk the longer the IA continued. There was a similar dispute between the government and junior doctors in New Zealand in 2006; no mortality figures are available but an improvement in A&E efficiency was reported and ascribed to more senior doctors covering the workload.²⁵

A strike by junior doctors necessarily impacts on patients and on consultants, GP's, doctors not actively taking IA and other healthcare workers. In the current situation in England there is ongoing, almost unanimous, support from consultants and GPs, which was not the case in New Zealand. Therefore, short-term, limited strike action by junior doctors is highly unlikely to be harmful.

Other than being less theoretically harmful to patient care, there are other reasons why strikes by junior doctors have been seen as less morally problematic; because junior doctors are open to exploitation by their seniors and employers, and because they don't have ultimate authority over the patients—the senior doctors do.² Any group open to exploitation should be empowered to oppose such action. If the junior doctors are accepted to be acting primarily from altruistic motives having exhausted all other avenues of redress against an employer, ultimately the State, who dictates their hours and their wages, then their action can be seen as justifiable, especially if patient care is adequately covered by their seniors.

Alluding to the possibility of exploitation, Park and Murray commented on their perception of a 'growing power and influence' of BMA on its more junior members.¹⁴ While this may or may not have been true at the time, if true would arguably have been unprecedented in the history of BMA. Today however, with instant communication on social media by technology-literate junior doctors, any influence is on BMA and not the other way around. Claims that junior doctors are being 'misled' fail to recognise that BMA has appeared to be catching up to the almost universal disquiet at grass-roots levels, as reflected in the effectively unanimous ballot result.

Is IA by junior doctors ethical?

Understandable action is not the same as morally acceptable action, especially where patient care is involved. To help guide doctors in such circumstances ethical criteria have previously

Current controversy

been suggested,² but all from different times and contexts. From the perspective of the current situation we conclude that for doctor IA to be morally permissible:

1. All patients must still have access to emergency care.
2. Maintenance of patient well-being must be a goal.
3. Strikers must feel that all possible other forms of communication have failed.

Additionally, for doctor IA to be morally imperative, as well as points 1–3, there must be:

1. An imminent threat to patient well-being.

The currently proposed junior doctor IA arguably fulfils the first three but probably not the fourth. Patients would have access to more efficient short-term care, well-being would be preserved by not returning to unsafe rotas and all other forms of communication, including third parties (Advisory, Conciliation and Arbitration Service), could be said to have been exhausted.

FINAL THOUGHTS

Strike action by doctors often leaves all involved with a sense of moral unease. Those that defend the legitimacy of IA by junior doctors in the current situation arguably accept a risk of harm to the doctor-patient relationship and must justify this. Doctors have a duty to provide the adequate patient care and as employees have a duty to promote and protect their own interests. In a socialised healthcare system, doctor self-interest is not inevitably incompatible with patient interests. Those that oppose IA due to the risk of harm, given the current support from consultants, evidence from other doctor IA and the limited nature of the proposed action, may find it hard to sustain a claim that harm, above inconvenience, will necessarily be suffered by patients. Also, those that argue IA risks the special status of doctors may need to do more to explain what this means in the modern context. A stronger moral objection to junior doctor IA may lie in respecting the duty of the State to allocate resources as it sees fit for the best of society.

Junior doctors choose their career freely, work fewer hours than their predecessors and enjoy excellent relative job security. However, they face increasing debt from tuition fees and student loans, significant real-term reduction in wages, no real control over their hours and increasingly intense and unsupported roles where the outcomes, patients' well-being and lives for which they are responsible, are increasingly out of their control. Claiming that IA by such a group is necessarily morally wrong, if it is accepted they have explored all other avenues and that there is explicit support from the consultants, is very hard to defend.

Contributors MRB conceived the idea, MT drafted the article, and MT, AAJA-D, JC and MRB contributed to the editing of the article.

Competing interests MT, AAJA-D and JC are junior doctors. MT, AAJA-D, JC and MRB are employees of Oxford Health NHS Foundation Trust. All authors are members of the British Medical Association.

Provenance and peer review Commissioned; internally peer reviewed.

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J Med Ethics 2016 42: 167-170 originally published online January 12, 2016

doi: 10.1136/medethics-2015-103310

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