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ETHICO-LEGAL INQUIRY INTO STRIKE ACTION BY DOCTORS IN KENYA

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A Research Report submitted to the Faculty of Health Sciences, University of the Witwatersrand in partial fulfilment for the degree of Master of Science in Medicine: Bioethics and Health Law

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DECLARATION OF OWN WORK

Master of Science in Medicine (Bioethics and Health Law)

I, Stephen Ombok Muhudhia, Student Number 887305, a student registered for the degree of Master of Science in Medicine (Bioethics and Health Law), hereby declare that this Research Report is my own unaided work, apart from guidance, encouragement and criticism from my supervisors. The Report is submitted as part fulfilment for the degree of Master of Science in Medicine: Bioethics and Health Law, at the University of the Witwatersrand, Johannesburg, South Africa. It has not been submitted before for any degree or examination at this or any other University.

Date: 20th January 2017

Signature: _____

ACRONYMS

BMA: British Medical Association

HPCSA: Health Professions Council of South Africa

ICESCR: International Covenant for Economic Social and Cultural Rights

ILO: International Labour Organization

KMA: Kenya Medical Association

KMPDU: Kenya Medical Practitioners Pharmacists and Dentists Union

LRA: Labour Relations Act No 14 of 2007

MPDB: Medical Practitioners and Dentists Board of Kenya

MSA: Minimum Service Agreement

OSHA: Occupational Safety and Health Act

RTWA: Return to Work Agreement

SALRA: South Africa Labour Relations Act No 66 of 1995

SAMA: South African Medical Association

WHO: World Health Organization

WMA: World Medical Association

Kshs: Kenya Shillings

USD: US Dollars

CESCR: Committee on Economic Social and Cultural Rights

DoH: Department of Health

ABSTRACT

Doctors serving in public health services in Kenya under the employment of the Government went on strike in December 2011 and September 2012. The strikes were national and doctors withdrew all their services including attending to emergencies in hospitals. The reasons for the strikes were poor salaries, poor working conditions and poor state of public health services. The aim of this research was to analyse legal and ethical aspects of the strikes by doctors in Kenya and to explore ways to minimize harm to patients and society. The research examined the circumstances and contexts of the strike to enable an understanding of the status of health services and the nature of the demands by doctors. Kenyan laws relating to strikes were analysed to ascertain legal compliance or violations during the strikes. Obligations of the medical profession and ethical codes and rules of conduct for doctors were discussed in relation to the strike. Ethical theories of deontology, consequentialism and virtue ethics were applied to establish moral justification or lack thereof.

Analysis of the legal provisions of the Labour Relations Act No.14 of 2007 revealed that it did not provide adequate processes for resolving trade disputes involving workers and employers in essential services. Suggestions were made on some ways to improve the conciliation process to foster appropriate resolution of disputes before strike action becomes necessary. Examination of the reasons for the strikes and status of public health services revealed that there were compelling reasons and circumstances for the strike action by doctors. It was acknowledged that harm and benefits resulted from the strikes. Some grounds for moral justification of the strikes were discussed and found valid. However, comprehensive justification of the strikes was difficult,

considering the professional and ethical obligations of doctors to society and to patients. In particular the withdrawal of emergency services made it difficult to find moral justification for the doctors' strikes. Failure to provide emergency services expunged any moral justification for strike action.

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CHAPTER 1: ETHICO-LEGAL INQUIRY INTO STRIKE ACTION BY DOCTORS IN KENYA

1.1 Introduction

This Research Report is an inquiry into the ethical and legal aspects of strike action by doctors in Kenya. It sets out to examine the question whether strike action by doctors in Kenya could be justified and to ascertain whether the strikes were ethically and legally correct. The Oxford Advanced Learner's Dictionary (Wehmeier and Cowie, 2006, p1465) defines a strike of workers as "a period of time when an organized group of employees of a company stops working because of disagreement over pay or conditions". In comparison, the Labour Relations Act No. 14 of 2007 (LRA) defines a strike as the, "cessation of work by employees acting in combination or a concerted refusal or a refusal under a common understanding of employees to continue to work for the purpose of compelling their employer or an employers' organisation of which their employer is a member to accede to any demand in respect of a trade dispute" (LRA, 2007, s2).

Doctors working within the public health sector in Kenya went on a nationwide strike in December 2011 and September 2012, causing severe disruption of health services (Otieno, 2011). Much suffering was experienced by patients and some deaths occurred as a result of the strike (Daily Nation, December 05, 2011, and Standard Team, December 5, 2011). The strikes triggered moral and legal dilemmas in the doctors themselves, the society and the Government. The doctors petitioned the Government for more than a year requesting improvement in physical facilities, supply of medicines and other materials for care and treatment of patients (Hansard,

2011). The doctors' actions included written petitions handed to the Minister for Health and the Minister for Finance, protest marches, and messages through the print and electronic media. They also lobbied for improvement of conditions of work and public health services through their professional organisation, the Kenya Medical Association (Pontillo, 2012). The doctors demanded better management of public health facilities, better remuneration and improvement of working conditions, as well as payment of salaries to doctors undergoing specialist training (Heraf, 2012). The strike of December 2011 ended after six weeks when the Government and doctors' representatives reached an agreement. The Return to Work Agreement (RTWA) contained significant undertakings by the employer (Government of Kenya) to increase salaries, improve infrastructure, and pay salaries to specialist doctors in training. In addition, the Government pledged to improve management structures and provide adequate supplies of drugs and other materials (RTWA, 2011). However nine months later, the doctors' union, Kenya Medical Practitioners Pharmacists and Dentists Union (KMPDU) drew attention to the fact that the Government had failed to meet its obligations in the agreement (RTWA Analysis, 2012). The doctors once again went on a nationwide strike that lasted three weeks in September 2012.

1.2 Literature Review

Chima (2013) stated that health care workers' strikes had become a global problem and were increasingly common in developed as well as developing countries. Strikes by doctors had been experienced in all continents. Countries such as the USA, United Kingdom, New Zealand, Israel, South Africa, Nigeria, Ghana, Malawi, Tanzania, Canada, Pakistan, Kenya and India had experienced strikes by doctors.

Strikes by doctors have been discussed extensively in the literature, exploring the variety of reasons for strikes and their outcomes, as well as offering debate on their moral justification. In a report on a strike in Nigeria by Olukoye (2007), the doctors cited several reasons for the strike including low salaries, poor working conditions, poor infrastructure and substandard quality of health services. Olukoye claimed that doctors' strikes are not justifiable except from a utilitarian viewpoint when benefits are significantly greater than any harms arising from the strikes. He asserted that it is better to prevent strikes by doctors and advised that the medical profession "should be prepared to give up strikes as industrial pressure tools, and rather look for equally effective methods consistent with their unique role as caregivers" (Olukoye, 2007, p1). De Villiers (2009) in an editorial in the Journal of South African Family Practice strongly condemned strikes by doctors working in the public sector in South Africa. He declared that denying care to patients was against the ethical principles of the medical profession. He castigated the Government of South Africa for dragging its feet in responding to the strike. De Villiers further stated that strikes caused much suffering to the poorest people in the country and tarnished the image of the medical profession. He was categorical that the strikes by doctors could not be justified.

Grosskopf, Buckman and Garty (1985) discussed the strike by doctors under the employment of the government in Israel. The doctors demanded an increase in salaries and better working conditions. At the time of the strike, medical services in Israel were almost entirely provided by the government. A unique aspect of the strike was that the doctors arranged to provide alternative

medical services through a parallel fee-for-services system. They also continued to provide emergency services in their respective hospitals. During the strike many of the doctors experienced deep moral conflicts about their duty to preserve health because of their Jewish upbringing and their religious beliefs. Grosskopf, Buckman and Garty (1985, p71) stated that "in countries where physicians receive salaries from society, an independent body should set the wages and working conditions in such a manner that the physicians are able to act in the best interest of patients".

Junior doctors in New Zealand went on strike in 2011. During the strike, senior doctors and consultants were deployed in emergency departments of hospitals. It was observed that mortalities were less during the strike period. This was because of the greater experience of senior doctors who took up work in the emergency departments (Robinson et al., 2008). Baer (1997) in a report about a doctors' strike in Canada interviewed several doctors. One of the interviewees, Diamond Allidina, did not support striking action by doctors but was impressed by the determination of the doctors to advocate for better remuneration and conditions of work. He was of the opinion that service withdrawal by doctors was not a moral issue but a trade dispute between doctors and their employer (Baer, 1997). Commenting about doctors' strikes in the U.S.A, Dyer (1985) stated that there was little doubt that most doctors had a genuine ethic of service to their patients. However, he added that the considerable power accorded doctors through their professional autonomy could be misused in the pursuit of self-interest. Dyer highlighted the potential for conflict of interests between doctors and patients, doctors and society and even between doctors and the state. He advised that doctors should adhere to their ideals of service and rise above concerns of status and remuneration.

Park and Murray (2014) reflected on the strike by British National Health Service (NHS) doctors and observed that emergency services continued to be provided during the strike. They agreed with Allan Robertson, the Chairman of the British Medical Association, who argued that doctors should have the same employment rights as other workers. In their opinion, there were no legal restrictions in the employment law prohibiting doctors from going on strike. However, they asserted that withdrawal of treatment was against the principles of the NHS and conflicted with the primary role of doctors. Park and Murray called for greater discussions about the moral acceptability of strike action, especially with medical students and young doctors.

In the last decade junior doctors in the United Kingdom have become more involved in advocating for their interests. Toynbee et al. (2016) observed that the situation had changed within the BMA where the junior doctors' lobby had become more influential leading to the formation of a Junior Doctors Committee within the BMA. The ability to communicate rapidly through social media platforms had enabled them to mobilize for collective action to advocate for their interests. Milne (2016) outlined the sequence of events in 2015 and 2016 culminating on several strikes by junior doctors. She stated that in mid-2012 the Department of Health (DoH) of the British Government announced a plan to introduce a new contract for junior doctors working in the NHS in England. The doctors felt that the new contract would have an adverse effect on their working hours and financial earnings in addition to reducing the quality of medical services on weekends. Negotiations between the government and BMA failed to resolve the issue. The BMA held a referendum among its members on whether the doctors should go on strike. 78% of the doctors voted, and of those who voted 98% supported strike action. Subsequently the doctors went on one-strike in the months of January, February and March 2016. Emergency services

were not withdrawn. The strikes by junior doctors were supported by the public, senior doctors, General Practitioners and consultants. In April the doctors escalated their industrial action and held a two-day strike in the first week of April and on 26th and 27th April. The strikes involved an unprecedented withdrawal of all services including emergency services (Milne, 2016). There was significant disruption of medical services with cancellations of an estimated 113,000 appointments for patients and postponement of 13000 surgeries (NHS, 2016). Further negotiations between the DoH and the BMA did not bear fruit. In August 2016 the BMA called for a five-day strike during each month from September to December 2016. However, the junior doctors opposed the five-day strikes stating that it would result in patient harm. The Academy of Medical Royal Colleges also opposed the planned strike action and the GMC issued a statement that striking doctors would be violating their ethical duties and may be subjected to disciplinary action (Boseley and Weaver, 2016). In early September the BMA suspended the planned industrial action. Negotiations between the BMA and the DoH are to continue (Campbell, 2016).

Ethical conduct and strike action has generated much discussion in the literature. Pellegrino (2006, p73) contended that the "good of the patient cannot be fully protected by rights and duties alone. Some degree of supererogation is built into the nature of the relationship of those who are ill and those who profess to help them". He observed that in most professional ethical codes, virtue and duty-based ethics were intermingled. He gave an example of the American Medical Association's Principles of Medical Ethics which referred to "standards of behavior" and "essentials of honourable behavior", which were aspects of virtue. The Declaration of Geneva of the WMA also recognizes the importance of virtue in its exhortation to doctors to carry out their work "with conscience and dignity" and in keeping with the "honour and noble tradition of the

profession" (WMA, 2006a). Pellegrino (2006, p73) stated that "the virtuous doctor is expected to go beyond legal obligations, rights and duties to do the right thing and the good even at the expense of personal sacrifice and legitimate self-interest". Virtue Ethics, Pellegrino contended, "expands the notions of benevolence, beneficence, conscientiousness, compassion and fidelity well beyond what strict duty might require" (Pellegrino, 2006, p73).

African Heads of State met in Abuja, Nigeria in 2001 and crafted the Abuja Declaration. This was in response to the HIV and AIDS calamity that had greatly increased the burden of disease for African countries. The Heads of States committed themselves to action on various important health issues documented as the "Abuja Declaration". They declared that, "we commit ourselves to take all necessary measures that the needed resources are made available from all sources and that they are efficiently and effectively utilized. In addition, we pledge to set a target of allocating at least 15% of our annual budget for improvement of the health sector" (Abuja Declaration, 2011, p5). The state of health services in many African countries was inadequate to meet the challenges of the HIV and AIDS pandemic. Shortages of manpower further limited the capacity of countries to meet the health needs of their populations. Emigration of doctors to other countries compounded the problem of scarcity of skilled health personnel. Lacey (2001) writing in the New York Times, reported that doctors were leaving Kenya in alarming numbers due to poor salaries offered by the public health service. He stated that most of those leaving went to South Africa and Botswana, where they earned much higher salaries. Yonga, Muchiri and Onyino (2012) in a cross sectional study on the opinion of doctors on the emigration of doctors from Kenya, found that 85% had thought of, or were thinking of seeking employment outside of Kenya. The major reasons were poor remuneration and job dissatisfaction due to poor facilities

and shortages of drugs and supplies. Dissatisfaction with social and political conditions was also stated. The doctors suggested that improvement of salaries, increased funding for health services, and involvement of doctors in health policy formulation and implementation would improve retention of health personnel in the country. Kirigia et al (2006) evaluated the cost of the health related brain drain and reported that the World Health Organisation (WHO) Africa Region loses a large percentage of highly skilled health professionals to Australia, North America and the European Union. The report revealed that it costs a country about 1.9 million U.S Dollars for every doctor it loses. According to Kirigia et al, the main push factors for the emigration of doctors were weak health systems, insecurity, low remuneration, poor living conditions, lack of professional development opportunities, and lack of clear career development paths. Political unrest and poor governance were also given as reasons for emigration. The authors argued that the loss of human resources for health from African countries contributed to human suffering and premature deaths. They called for joint action between developing and developed countries to reverse the emigration (Kirigia et al, 2006). This concern was further articulated in the World Medical Association's (WMA) statement entitled 'Ethical guidelines for the international migration of health workers', which called on all countries to make concerted efforts to retain their physicians by providing them with the support needed to meet professional and personal goals (WMA, 2003, p2). The WMA reiterated that physicians have rights as well as responsibilities to patients and society. The Association observed that physicians in many countries experienced frustration because of a variety of factors related to limited resources, government insensibility to the needs of the medical professional, and micro-management of health care delivery by government and corporate organisations. The WMA asserted that physicians were obligated to advocate for and defend health needs of patients. It encouraged

doctors to intervene on behalf of patients against those who deny or restrict access to needed health care. The Association affirmed the right to health, in compliance with the International Covenant on Economic Social and Cultural Rights (ICESCR) of the United Nations (Williams, 2015).

1.3 Research Question

This research set out to answer the question: "can the strikes by doctors in public service in Kenya be justified? It focused on strikes that took place in December 2011 and September 2012.

1.4 Research Aims and Objectives

The aim of the research was to ascertain whether the strikes by doctors in Kenya were ethically and legally correct. The objectives of the study were as follows:

a. To critically evaluate reasons for the strike stated in the memorandum presented to the Minister for Health by doctors before the strikes in December 2011.
b. To analyse the provisions for strike action in The Constitution of Kenya, and the Labour Relations Act No. 4 of 2007.
c. To explore the benefits and harm of the strikes to patients and doctors.
d. To apply ethical theories of consequentialism, deontology and virtue ethics to establish any justification or lack thereof for the strikes by doctors in public service in Kenya.

1.5 Research Methods and Research Structure

The research was purely normative and was based on desktop and library research. Philosophical research methods and standards were used involving critical analyses and interpretations of text with subsequent development of arguments and counter-arguments. An overview of the circumstances in the public health system at the time of the strikes is given in chapter two in order to facilitate an understanding of the context in which the strikes occurred. It was recognized that strikes are not homogenous but take place for different reasons and in varying political, socio-economic and cultural contexts. The position of doctors in Kenya with respect to social status, earnings and work within the public service is discussed. Reasons for the strikes and the outcomes are analysed to provide insight for appreciating the genesis of the strikes and their consequences. Harm and benefits arising from the strike are elucidated.

In chapter three legal aspects of the strikes are discussed. The Constitution of Kenya (The Constitution), the LRA, and the Occupational Safety and Health Act (OSHA), as well as international conventions and declarations related to strikes are analysed to explicate how they apply to strikes. Rights to health and the right to strike are expounded in chapter three for a further understanding of the intricate legal issues that impact on strike action by doctors. The adequacy of the LRA for conciliation of trade disputes in essential services is discussed and suggestions for improvement are made.

Chapter 4 focuses on ethical aspects of the doctors' strike. Professionalism in medicine and the doctor-patient and doctor-society relationships are examined. Ethical codes espoused by the profession are appraised in relation to strike action. Three moral theories: deontology, consequentialism, and virtue ethics are used to analyse the ethical implications of the strike action and to provide an opinion on the justification or lack thereof of the strike action. Reasons for the strikes are discussed with a view to providing a basis for their relevance and justification. The effect of the strikes on doctors and the public are appraised and harm and benefits resulting from the strikes are expounded upon. In concluding the discourse in chapter 5, I make proposals to improve the conciliation process for resolving trade disputes in essential services to make it more inclusive and effective.

1.6 Research Ethics Review

The research did not involve any human or animal subjects and only information in the public domain was used. A waiver of ethics review was applied for and granted. A waiver certificate is attached to this report.

1.7 Outcomes

It is anticipated that this research report will influence the development of appropriate policies by the Government of Kenya for management of its human resources for health. The report will also inform development of guidelines related to strike action by the Medical Practitioners and Dentists Board of Kenya (MPDB). Other governments, health regulating bodies and

organisations that employ or have contracts with doctors will benefit from reading the report. It is expected that the report will provoke discussion for review of labour laws in Kenya to provide for Minimum Service Agreements (MSA) to ensure that the public is not totally deprived of medical services during a doctors' strike.

CHAPTER 2: ORGANISATION OF HEALTH SERVICES IN KENYA AND REASONS FOR AND OUTCOMES OF THE STRIKES

2.1 Introduction

The majority of people in Kenya use health services that are provided for by the public health system. A wide range of services are catered for, ranging from primary health care in dispensaries to management of complicated illnesses at National tertiary hospitals (Muga et al, 2005). A brief explanation follows below on the delivery of health services in Kenya.

The reasons for the strikes are examined and fall mainly into two categories. The first is related to doctors' remuneration and working conditions. The second concerns the poor state of public health services (KMPDU, 2011). The majority of doctors have financial responsibilities beyond their nuclear families. The doctors in public service earn much less than those working in the private sector (Kanyoro, 2011). Social and financial burdens of doctors working in the public health sector are discussed.

The strikes resulted in good outcomes but also caused harm. The benefits of the strikes included increased salaries for doctors and a commitment by the government to improve various aspects of public health services (Kluvers, 2012). Some deaths occurred and patients were subjected to much suffering during the strikes (Menya, 2011). The doctors' union used the media appropriately to highlight the poor state of public health services and the dangers it caused to

patients. This resulted in a favourable attitude to the striking doctors by the public (Ayienda, 2011). The general consensus of the public was that the government was unresponsive to the plight of people using public health services, and that extraordinary measures were necessary to pressurize the government to improve the services (Hannali, 2011). A conclusion is made on the compelling nature of the reasons for the strikes, the benefits and harm, and possible justification for the strikes.

2.2 Health Services in Kenya

Health services in Kenya are provided by the Government of Kenya, private health providers, faith based organisations and secular charity organisations. 60% of health services are provided by the Government, 5% by private-for-profit organisations and companies, and 35% by faith based organisations and secular charity organisations (Muga et al., 2005). The public health services are provided through integrated systems involving dispensaries, health centres, sub-county hospitals, county referral hospitals and national referral hospitals. Private hospitals range from small establishments to large teaching hospitals offering advanced level treatment. Nurses, clinical officers, doctors and dentists may be licensed to operate private clinics. In addition, there are other unconventional health care providers who are licensed to provide health services such as traditional doctors, herbalists, chiropractors, Ayurvedic and traditional Chinese medicine practitioners (Muga et al, 2005). Faith based organisations charge fees for health services, but it is much lower than fees charged by private hospitals and clinics. Some charity organisations provide free services to specific categories of patients such as children, cervical cancer patients, and people with HIV and AIDS. Doctors, dentists, nurses and clinical officers may operate

private clinics on a full-time basis or part-time basis. Employees of the Government, including health care workers are allowed to undertake private business outside their official working hours. Many health care professionals employed in the public health service run their own private clinics or are employed part-time in private health facilities. The Government has two National Referral Teaching Hospitals namely, Kenyatta National Hospital and Moi Referral and Teaching Hospital which have doctors undertaking training in various specialties (Muga, et al.2005). Doctors in specialist training are involved in providing health care services as part of their training. They do the bulk of the work in these teaching institutions. Previously, all doctors undergoing specialist training were employed by the Ministry of Health of the Government of Kenya and were paid salaries. The Government reversed this policy and from 2008 until the time of the strike, no salaries were paid to doctors in specialist training in government teaching hospitals (Ng'ani, 2012).

The public health system serves low income and lower middle-income sections of the population. Good quality private health care is expensive. Only a small percentage of people in Kenya can afford to pay for quality health services in the private sector. In 2006 about 2% of people in Kenya had medical insurance (Barnes, 2006). The number increased to 8% in 2013 (Ravishankar, Thakker and Lehman, 2013). Services at public health institutions were generally poor due to a multiplicity of factors including poor physical facilities, perennial shortages of medicines and supplies, inadequate and poorly functioning equipment as well as understaffing. Low staff morale and poor management further contributed to sub-standard delivery of services (Luoma, 2010). For about ten years prior to the strike, poor services in public health facilities had been frequently discussed in the media and professional forums. Despite much debate and calls for action almost

nothing was done to remedy the situation (Hannali, 2011). Generally people utilised public health facilities only when they could not afford private health services (Capital Advisors, 2012). For the majority of Kenyans there was no choice as they could not afford to pay for private health care (Barnes, 2006). It was ironical that those who were responsible for making important decisions that affected the provision of health services in the public sector did not use public health services. Senior government officials and senior administrative staff in health institutions could afford private health services. Opinion leaders and leaders in private business sectors as well as elected representatives of the people at all levels of government did not utilise public health facilities (Hannali, 2011, Ng'ani, 2012). This had important implications in the implementation of policy regarding public health services and sensitivity to complaints about poor services in government health facilities. The response to complaints about poor public health services were often slow and inadequate (Kanyoro, 2011, Hansard, 2011). The low socio-economic sectors of the population were most adversely affected when workers in public health institutions went on strike (Abbasi, 2014).

2.3 The Doctor's Social and Financial Burden

After graduation and internship, doctors find that their peers who took up shorter courses at the university are middle level managers with incomes higher than that of junior doctors (Kanyoro, 2011). The doctors also became aware of the shortcomings and difficulties for doctors working in the public health sector. Medical work is hard, requiring long hours in emotionally stressful circumstances (Hannali, 2011). There are large numbers of patients to be attended to but facilities are poor and shortages of drugs and of essential supplies are common. Compounding the situation

is the fact that administrators are often incompetent and administrative systems inefficient (Chankova, Munyiri and Kombe, 2009). The doctors find that they are unable to provide the services for which they spent many years training. Most distressing to the doctors is the fact that nobody seems to think that young doctors are important. They realise that people do not have much regard for doctors who work in public hospitals. With much disquiet, the doctors realise that their status in society is diminished because of being associated with sub-standard services in public health institutions (Kanyoro, 2011). In addition to diminished social status, their earnings are lower than that of their peers in other professions. On the contrary, doctors working in private hospitals are held in high regard, are highly respected and are better paid (Bliss, 2012). Doctors in Kenya enter into the profession of medicine under circumstances which promote professional, social and economic dissatisfaction (Lacey, 2001).

2.4 Reasons for Strikes, and Consequences

Doctors petitioned their employer, the Government of Kenya for over one year before making the decision to go on strike (Pontillo, 2012). The KMPDU raised several reasons for doctors to strike in petitions to the Ministry of Health and the Ministry of Finance (KMPDU, 2011(a), KMPDU, 2011(b))

The main reasons for the strikes were as follows:

a) Poor state of health services

The doctors contended that the people of Kenya were being denied their constitutional right of access to health services. Government health facilities at all levels from dispensaries to the

national referral and teaching hospitals lacked essential equipment, and were perennially short of basic drugs and supplies. There were shortages of staff in public health facilities including general and specialist doctors, nurses, and other health professionals (Hansard, 2011, Ng'ani, 2011).

b) Poor working conditions

The doctors' union observed that doctors in public health institutions worked longer hours than other public sector workers. Doctors worked an average of 80 hours per week compared to 40 hours required of public sector employees. There was no compensation for the additional hours. The environment and conditions of work exposed doctors to a high risk of contracting infections from patients. They stated that the Government was grossly in violation of the requirements of the Occupational Safety and Health Act (OSHA) (Reuters, 2011, Houreld, 2011).

c) Establishment of a "Health Service Commission"

The KMPDU asserted that there was a need to establish a "Health Service Commission" to manage the developments and services in the health sector, including personnel issues. Other important sectors in Kenya have such commissions. There is a Teachers Service Commission, Judicial Service Commission and Land Commission, to mention a few (Heraf, 2012).

d) Salaries and allowances for doctors doing specialist training

The doctors demanded payment of salaries and allowances for doctors undergoing specialist training. They contended that doctors in specialist training were full-time workers like other employed doctors and often had heavier workloads. For decades, doctors in specialist training

received full salaries from the Government but this was withdrawn in 2008 (Ng'ani, 2012, KMPDU, 2011(b)).

e) Fair remuneration

The KMPDU stated that doctors employed by the Government were grossly underpaid compared to other professionals. They demanded a 300% increase in salaries and 30% increase in risk allowances (Hansard, 2011, Reuters, 2011, Hannali, 2011).

f) Funding for healthcare

The doctors observed that underfunding of health services by the Government was a major contributor to the deterioration in the state of health services. They noted that national budgetary allocations for health had been decreasing over the previous three years: 9% in 2008, 7% in 2009 and 6.5% in 2010 (KMPDU, 2011(b), Mwenda, 2012). The allocation was far below the recommendations of the Abuja Declaration that 15% of the national budget should be on health (Abuja Declaration, 2001).

2.5 Achievements of the 2011 and 2012 Strikes

The doctors' strike of December 2011 was regarded as highly successful by the KMPDU. After various conciliation meetings, the Government and the union reached an agreement and the strike ended with the signing of an RTWA. The parties agreed to the following (RTWA, 2011):

1. A Task Force to be established to look into a range of issues that touch on policy and on other matters.

2. The Government to set up a negotiation team to address industrial relations issues.
3. The Government to pay doctors extraneous allowances of Kenya Shilling (Ksh.) 15,000 to 20,000 two weeks from the date of the agreement and a further Ksh. 15,000 to 20,000 six months later.
4. The Government to avail Ksh. 200 million for the training of health personnel.
5. Emergency allowances to be paid to doctors: Ksh. 30,000 per month starting two weeks after the agreement.
6. The government to employ an additional 200 doctors to reduce the shortage of doctors in public hospitals.
7. The government to avail Ksh. 113 million to cater for additional salaries for promoted doctors.

Within two days of signing the RTWA, a Task Force on strengthening health service delivery was established. It completed its work and provided a report to the Government within two weeks. Below is a summary of some of the issues covered in the Task Force report, (Musyimi, 2012). Health infrastructure facilities were noted to be old and dilapidated, while pharmaceutical and non-pharmaceutical supplies to public health institutions were inadequate. Medical equipment was old resulting in frequent breakdowns. Staffing levels were far below those recommended by the WHO, while funds for training were only 20% of the required amount. The report confirmed that doctors undergoing specialist training worked hard yet received no salaries. The Task Force report noted short comings in the management of health facilities and acknowledged the need for the establishment of a Health Service Commission. It noted with concern the underfunding of the health sector in the national budget allocations. The Task Force report made recommendations to address the issues and provided details on specific actions to be

carried out as well as estimates of finances required to carry out the activities. The report was officially handed over to the Permanent Secretaries of the Ministry of Medical Services and Ministry of Public Health and Sanitation in order to spearhead the actions by various government organs. Implementation of the RTWA and the recommendations of the Task Force proceeded slowly and evaluation after eight months by the KMPDU showed that only the extraneous allowances had been implemented as agreed. Emergency allowances were partly paid, and doctors undergoing training were still not receiving salaries. Only 57 additional doctors had been employed. The government had also not cooperated in discussing a Collective Bargaining Agreement with the union. While it was agreed that no staff would be victimized for participating in the strike, the chairman of KMPDU's employment with the Government was terminated (RTWA Analysis, 2012).

In September 2012, the KMPDU called for a national strike for all doctors in the Public Health Service. The Union cited non-compliance with the RTWA signed in December 2011 and non-implementation of the recommendations of the Task Force on strengthening health service delivery (KMPDU, 2012). Doctors went on strike and demanded that the Government embark on measures recommended by the Task Force to improve buildings and infrastructure; address persisting shortages of medicine and supplies and provide adequate equipment to health facilities (Kibira, 2012). The union demanded payment for doctors in specialist training and employment of additional doctors as agreed in the RTWA. In addition the union demanded that the Government establish a Health Service Commission (KMPDU, 2012, Heraf, 2012).

2.6 Benefits of the Strikes

Following the second strike in 2012, the Government and KMPDU signed another RTWA which asserted that recommendations of the Task Force of December 2011 would be fully implemented (RTWA, 2012). The Government subsequently implemented most of the recommendations. Doctors in specialists training were paid salaries. Money was allocated for buying new equipment for hospitals and promotions of doctors in the public health services commenced. More doctors were employed to reach the agreed number of 200. The Government provided more funds for purchase of pharmaceuticals and non-pharmaceutical supplies and embarked on streamlining the relevant management systems to improve efficiency. A salary increase for doctors was fully implemented as agreed in December 2011.The gains from the strikes were significant for doctors and to the society. Individual patients who utilise public health facilities also benefited (Kluvers, 2012).

2.7 Harm Arising from the Strikes

It was difficult to know the extent of harm caused as a result of strike action by doctors in December 2011 and September 2012. The Government often suppressed information to give the impression that the strikes were not serious. However, the media reports suggested there was much suffering and that some deaths occurred due to absence of doctors from hospitals during the strikes (Standard team, 2011). The Government underplayed the disruption of health services, and the degree of suffering and deaths resulting from the strike. It is not possible to estimate the extent of suffering, morbidity and mortality that resulted from disruption of health services during the strikes (Menya, 2011, Kibira, 2012).

2.8 Public's Reaction to the Strikes

Following the two nationwide strikes, the reaction from the public towards the striking doctors was not significantly unfavourable. The doctors used the media appropriately and informed the public of the poor condition of public health services. They explained that doctors were taking desperate measures by going on strike to pressurize the Government to take action to improve the quality and quantity of public health services. The fact that the media had been reporting about the poor state of health services, and demanding for action to improve services, assisted in the public's attitude being favourable towards the strike by doctors (Ayienda, 2011). The realization that the Government had not acted on demands made through the media over several years convinced many that desperate steps were necessary to compel the Government into action. Waithaka (Daily Nation, 24 Feb. 2012), in an interview by a Daily Nation reporter stated that the KMPDU would continue fighting for better health care for the people of Kenya. She said that the union was aware that the absence of doctors from hospitals caused much suffering to patients. Waithaka also asserted that doctors were saddened that the Government forced them into strike action resulting in much suffering by patients. She reiterated that as long as the public continued to witness death and suffering in their communities because of the Government's neglect of the health sector, the public would continue to support doctors' strikes.

2.9 Discussion

There were definite gains made as a result of the strikes. However, there was much suffering experienced by patients and several deaths occurred. Many sick people had to use their scarce

resources to pay for treatment in private hospitals (Ayienda, 2011). There were several reasons given by doctors in Kenya for the strike in December 2011 and September 2012 (KMPDU, 2011(a), KMPDU, 2012). Two of the main reasons for the strike are discussed: poor remuneration and conditions of work, and poor state of public health services. Doctors demanded that the Government, who was their employer, needed to act to improve their remuneration and working conditions and to improve the state of public health services in the country. The union stated that doctors were underpaid and worked longer hours than other government employees. They pointed out that the working environment and conditions exposed them to infections, psychological distress and physical exhaustion. Such circumstances reduced their capacity to carry out their professional duty of providing healthcare to patients.

The union also stated that the Government failed in its constitutional mandate to enable the people of Kenya to progressively achieve their right to the highest attainable standard of health, as provided for in The Constitution. The state of public health services was deplorable due to poor infrastructure, poor staffing, insufficient drugs and supplies, and poor management (Atwoli, 2011, Ng'ani, 2011). The KMPDU mentioned that funding for health services in the country was only 6.5% of the national budget which was far below the 15% recommendation passed in the Abuja Declaration (Abuja Declaration, 2001). The union observed that the funding had been decreasing over the previous three years while the population of the country and the demand for services was increasing (KMPDU, 2011(b)). The union demanded a three-fold increase of remuneration for doctors and other measures to improve health services. These included the employment of more doctors, improvement of infrastructure, purchase of equipment, and ensuring adequate supplies of

drugs and consumables (KMPDU, 2012). They demanded for the establishment of a Health Service Commission to be responsible for recruitment and deployment of doctors (Heraf, 2012).

2.9.1 Salaries and working conditions

Striking doctors in Kenya demanded an increase in salaries, allowances and improvement in working conditions. The union added that junior doctors earned salaries of between Ksh. 40,000 (USD 400) and Ksh. 80,000 (USD 800) per month, depending on years of service. The union further claimed this was far below that being paid to workers of similar professional standards in other sectors. Non-medical workers comparatively earned higher salaries and did not work as many hours as the doctors. The union claimed that doctors worked an average of 80 hours in a week, against 40 hours per week required for other public sector workers (KMPDU, 2012). They demanded that working hours which averaged 80 hours per week be revised. The majority of doctors in Kenya were from low income families and had a heavy financial burden not only to themselves but for their immediate and extended families. The doctors were expected to assist a large "family" immediately upon commencing employment. Even without this additional burden, the salary paid to doctors working in the public health sector was not sufficient to afford middle income lifestyles expected of doctors in Kenya (Kanyoro, 2011).

The KMPDU contended that improvement of remuneration and working conditions would result in better morale and enhanced enthusiasm for work. Retention of doctors in the public health service would greatly improve and more doctors would be attracted to join the public health sector. Fewer doctors would leave the country in search of greener pastures. The union stated that the majority of Kenyan doctors preferred to work in Kenya due to family responsibilities (Yonga

et al, 2012). Many who left the country did so out of necessity occasioned by poor salaries, poor working conditions and lack of opportunities for professional advancement (Lacey, 2001).

Improvement in working conditions was also demanded by the doctors' union. Public health facilities in Kenya served large numbers of patients beyond their capacities. The risk for contracting diseases from patients and from contaminated working environments was significantly high. The union argued that public health facilities did not meet the safety standards required by the OSHA. The Act requires employers to protect the safety, health and welfare of persons and to ensure that premises, equipment, systems and procedures of work are safe and without risks to employees. It is notable that when doctors in the public service in South Africa went on strike in 2009, the reasons for the strike were similar: poor salaries, poor working conditions and poor state of public health services (Zeijlstra, 2012).

Can demand for better salaries and better conditions of work be justifiable reasons for strikes by doctors in Kenya? When viewed against the background of the professional obligations of a doctor according to the WMA International Code of Medical Ethics (WMA, 1949, p2), and the MPDB Code of Professional Conduct and Discipline (MPDB, 2012, p34), the strikes could not be justified on the basis of the demand for better remuneration and conditions of work. However, examination of the prevailing circumstances at the time may provide more insight into the strike action. Maslow's law shows that needs are hierarchical and basic needs must be met before higher needs can be actuated (Maslow, 1943). The human instinct or drive for survival may override other obligations demanded of the person (Huit, 2007). It may therefore, be postulated that when salaries of doctors are so low that their survival or that of their family is threatened,

they are likely to ignore professional obligations and values enshrined in codes of medical ethics (Brecher, 1985). Similarly, when working conditions are so poor that their lives are threatened through mental and physical exhaustion, and enhanced risks to their health, doctors are less likely to honour their professional obligations and medical ethics (Ogunbanjo and Bogaert, 2009).

There are differing opinions on the justification of strike action by doctors. Daniels (1978) stated that demands by doctors for improvement of health services could benefit society and were more credible reasons for strike action. However, he was unconvinced that physicians' demands for better socioeconomic status had any concern for patient care. In Israel, doctors working in the public health service went on strike in 1985 due to poor salaries and poor working conditions. At that time, doctors' salaries in Israel were lower than those of nurses and x-ray technicians (Grosskopf, 1985). In a report on the doctors' strike, Grosskopf noted that doctors found it difficult to strike because of their commitment to medical ethics and religious beliefs. They only proceeded to strike when the situation was very desperate. He claimed that professional obligations and codes of medical ethics could foster exploitation of doctors. The risk of exploitation was higher where doctors were in employment and subjected to relatively poor remuneration, hazardous working environments, and sub-standard conditions of work. Grosskopf further observed that when doctors were underpaid and forced to work excessively, the quality of medical care and the ability to work in the best interest of patients was adversely affected. He noted that, "depriving physicians of proper wages constitutes a breach of contract and justifies a walkout" (Grosskopf, 1985, p71). He reiterated that the doctors' strike in Israel was justified. Brecher (1985) also stressed that inadequate remuneration of doctors was exploitative and could justify strike action. Sachdev (1985) observed that, in the public health system, situations could

arise when working conditions of doctors were so bad that strikes became understandable. Philip Ochieng (2013a), in a commentary in the Daily Nation Newspaper stated that:

> "Admittedly, he must eat well before he can treat well. But the Hippocratic Oath constrains him to treat well and with alacrity even those who obviously cannot contribute even a penny to his table of viands and wine. That, precisely, is where the collective government steps in to arbitrate and solve the contradiction. The Government can do so because, through taxation, all members of society have invested a pool of money in it which it can use to reward servicemen and women according to the necessity and quality of their contributions. That is why doctors must be paid better than office clerks" (Ochieng, Dec 21, 2013, p25).

Baer (1997) stressed that fair compensation for doctors resulted in better quality of services to patients. In most developed countries doctors' incomes are relatively high and often above the average earnings of the general population. The higher level of remuneration is a reflection of their worth in society. Michael Halberstam argued that doctors have been generously rewarded by society because the medical profession has contributed selflessly to the health of the nations. He pointed out that professional idealism provided the best leverage for improving the doctors' economic status. He declared that strike action by doctors was not appropriate (Halberstam, 1973).

Glick (1985) observed that physicians' strikes on record were almost entirely for the benefit of doctors and not patients. He stated that demands for improvement of the public health services were made merely to improve the public image of striking doctors and to appease their conscience. Whereas Murray (2014), referring to a strike by doctors in the U.K. due to reduction in their

pensions, noted that it was focused on personal financial gains for the doctors at the expense of patient welfare. Such strike action, he contended, could not be justified. Appropriate remuneration for healthcare workers is recognized as an important factor in the provision of good standards of health care. The ICESCR asserts that countries should include in their health policies strategies to have "trained medical and professional personnel receiving domestically competitive salaries in addition to ensuring adequate supplies of essential drugs and functioning public health services" (ICESCR, 1976, p6): The demand for better remuneration and better working conditions by doctors in Kenya may be regarded to be within reason, and justifiable given the prevailing circumstances.

2.9.2 Improvement of public health services

The second main reason for strikes was a demand for improvement of the state of public health services. The Constitution of Kenya recognizes healthcare as a basic right and states that every person has the right to the highest attainable standard of health. The poor state of public health services hampered the realisation of this right for the majority of people in Kenya. Doctors working in public health facilities were unable to carry out their professional and ethical obligations to patients and the society, due to inadequacies and inefficiencies in the public health sector. Abbasi (2014) discussed a strike by doctors in Pakistan which was undertaken because of poor salaries, poor working conditions, and the poor state of public health services. He stated that when doctors in public service were underpaid, had no well-defined career progression path and worked excessively long hours, their ability to act in the best interest of patients was greatly compromised. He asserted that "the Government being in charge of resources and management

decisions should assume greater responsibility in good faith for the greater good of all stakeholders including doctors and patients" (Abbasi, 2014, p4).

Doctors in the public service in Kenya were aware of deficiencies in public health services. They felt compelled to take extraordinary action to pressurise the Government to improve health services; otherwise they would be guilty of complicity in propagating injustice to the society. Faced with an unresponsive Government, the doctors were forced to make difficult professional and moral choices, with the hope that the outcome would benefit their patients, the society, and the profession (KMPDU, 2012). Chima (2013), in regard to a similar demand by doctors in South Africa, conceded that doctors may feel ethically and morally obligated to act on behalf of society and their patients to compel the Government to improve public health services. The WMA reiterated the social responsibility of doctors as advocates for the society regarding health issues. (Williams, 2015). Boyton (2008) asserted that doctors should have the courage to act on their beliefs when they are convinced that conditions and circumstances at work put patients at risk. She stated that when grievances of doctors are real and the demands reasonable, strike action could be morally acceptable. The demand for improvement of public health services provided a credible justification of strike action by doctors.

2.10 Conclusion

The strikes in Kenya occurred in circumstances where the remuneration for doctors in public service was relatively low and working conditions were wanting. The provision of services in the

public health sector was substandard. Doctors were frustrated by their low socioeconomic status, increased risk of contracting illness at their work places, and the inability to carry out their professional obligations to patients and the society. In addition, they were concerned that the public was being denied the right to the highest attainable standard of health promised in The Constitution. Doctors in the public health sector were acutely aware of the possibility of harm to the public resulting from public health services that were poorly equipped, inadequately staffed and deficient in management capacity. They were witnesses to the suffering and even preventable deaths that occurred because of substandard services (Atwoli, 2011, Ng'ani, 2011).

The Social Contract of the medical professional with society demands that the profession advocates for better health of the society. It is within the professional obligations of the medical professional, and by extension the responsibility of each individual doctor, to demand that the Government takes appropriate action to improve health services in the public sector. The impact of strikes is more severe in developing countries which heavily rely on public health care services that are often the target of striking doctors. Further injustice occurs in these countries, as the poorest members of society suffer the most during strikes by doctors (Ogunbanjo and Bogaert, 2009). It is to the credit of doctors in public service in Kenya, that for more than 14 months before the strike of December 2011, they had used various means to urge the Government to take action to improve health services (Pontillo, 2012). The poor remuneration, poor working conditions and poor state of public health services were compelling reasons for justification of the strikes.

CHAPTER 3: LEGAL CONSIDERATIONS REGARDING THE STRIKE ACTION BY DOCTORS

3.1 Introduction

In August 2010 a new Constitution was promulgated in Kenya replacing the one adopted when the country gained independence from the United Kingdom in 1963 (Kenya Law, 2010). This was the culmination of almost 20 years of political and human rights activism to revise The Constitution (Wanga, 2011). The new Constitution of Kenya, 2010 (The Constitution), is more democratic and based on respect for human rights. It has a liberal and comprehensive Bill of Rights and provides for adoption of international conventions and agreements (Wanga, 2011). Kenyans used the momentum generated by activism for The Constitution to assert various rights it protected (Kituri, 2011). The Constitution protected the rights of individuals to assembly, picket, strike, and to join or form trade unions (The Constitution, 2010). After the promulgation of The Constitution in 2010, there were many strikes in private and public organisations. Some of the most notable strikes were by public universities' staff, teachers and nurses (Rajab, 2012, Kaimenyi, 2010). The public supported these strikes and celebrated them as fruits of the new Constitution. The mantra of the strikers was "Haki yetu! Haki yetu!" translated as "Our right! Our right!" (Kituri, 2011, p1). The strike by doctors in the public service in December 2011 came on the crest of this wave of excitement about rights. There was a general feeling that workers had been oppressed for too long and were justified in exercising their rights to strike and to demand for better terms of work (Kituri, 2011).

In this chapter the legal aspects of strikes by doctors is explored. The Constitution of Kenya and the LRA are analysed to ascertain how they address the issue of strikes by workers. More attention is given to strikes in essential services with particular focus on health services. The rights of workers to strike and the legal constraints against strikes are expounded. The LRA is examined to understand the process of conciliation between employers and employees during a strike. Comparison is made between the LRA of Kenya and the South African Labour Relations Act No. 66 of 1995 (SALRA) to identify significant differences and similarities. The OSHA is discussed in relationship to conditions of work for doctors employed in the public service. An opinion is made on the inadequacy of the conciliation process of the LRA. Proposals are made on changes that would improve the conciliation process. Strategies to minimize harm to patients during strike action by doctors are suggested.

International conventions and agreements with respect to workers' strikes are reviewed to provide an understanding of their roles in regulation of labour relations and protection of the rights of workers and employers. Kenyan laws are analysed to ascertain conformity with the International Labour Organization (ILO) agreements and ICESCR on protection of the rights of workers. The doctors' strike of 2011 and 2012 is examined to determine any infringement of The Constitution and the LRA. The role of unions in advocating for rights of workers and the necessity for doctors to have unions is discussed. The allegation that unionisation for medical professions may affect the doctor-patient relationship is examined. The opportunity for doctors' unions to embrace advocacy for patients and society in addition to their service to doctors is explored.

3.2 The Constitution

The Constitution of Kenya 2010, Chapter Four contains the Bill of Rights. It states in section 19(1) that the Bill of Rights is an integral part of Kenya's democratic state and is the framework for social, economic and cultural policies. It further points out in s20(4)(a) that "in interpreting the Bill of Rights, a court, tribunal or other authority shall promote the values that underlie an open and democratic society based on human dignity, equality, equity and freedom". Sections 19(3) (a) and (c) affirm that these rights belong to each individual and are not granted by the State and are subject only to the limitations contemplated in The Constitution. The Bill of Rights addresses several issues; some of which are outlined below:

- Every person has inherent dignity and the right to have that dignity respected and protected, s28.
- Every person has the right, peaceably and unarmed, to assemble, to demonstrate, to picket, and to present petitions to public authorities, s37.
- Every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare, s43(1)(a).
- A person shall not be denied emergency medical treatment, s43(2).
- Every person has the right to fair labour practices, s41(1).
- Every worker has the right to fair remuneration, to reasonable working conditions, to form, join or participate in the activities and programs of a trade union and to go on strike, s41(2).
- A right or fundamental freedom in the Bill of Rights shall not be limited except by law, and then only to the extent that the limitation is reasonable and justifiable in an open and

democratic society based on human dignity, equality and freedom, taking into account all relevant factors s24(1).

- It is a fundamental duty of the State and every State organ to observe, respect, protect, promote and fulfil the rights and fundamental freedoms in the Bill of Rights (Article 21).

The Constitution, Chapter one section 2(5), recognises international laws and conventions which Kenya is a signatory to, such as the International Labour Organization's Convention No. 87 of 1948, and No. 98 of 1949. These Conventions address the issues of freedom of association, the right to organise, and collective bargaining (ILO, 1948). In compliance with these Conventions, The Constitution of Kenya, provides for and protects the rights of workers to form or join trade unions and to participate in strikes and to fair remuneration. These rights are affirmed in the LRA.

3.3 The Labour Relations Act No. 14 of 2007

The Labour Relations Act (LRA) upholds the rights of workers to form or join trade unions and to go on strike (LRA s4, s76). However, the LRA does not apply to persons serving in the Kenya Defence Force, the Kenya Police Service, the Kenya Prisons Service, the National Youth Service and any other reserve force or service thereof (LRA, s3).

The preamble of the LRA states that it is:

> "AN ACT of Parliament to consolidate the law relating to trade unions and trade disputes, to provide for the registration, regulation, management and democratisation of

> trade unions and employers organisations or federations, to promote sound labour relations through the protection and promotions of freedom of association, the encouragement of effective collective bargaining and promotion of orderly and expeditious dispute settlement, conducive to social justice and economic development and for connected purposes" (Laws of Kenya CAP 233, p553).

The LRA defines a strike as "cessation of work by employees acting in combination, or a concerted refusal or a refusal under a common understanding of employees to continue to work for the purpose of compelling their employer or an employers' organisation of which their employer is a member to accede to any demand in respect of a trade dispute" (s2). The LRA further defines a trade dispute as a:

> "dispute or difference, or an apprehended dispute or difference, between employers and employees, between employers and trade unions, or between an employers' organisation and employees or trade unions, concerning any employment matter, and includes disputes regarding the dismissal, suspension, or redundancy of employees, allocation of work or the recognition of a trade union" (LRA, s2).

Dispute resolution procedures are covered by the LRA. The Government Minister in the respective trade has a central role in the dispute resolution procedure. When a dispute arises, it is reported to the Minister and he/she activates the disputes resolution process. Within 21 days of receiving a report of a trade dispute, the Minister appoints a conciliator (s65(1)) or a conciliation committee (s66(2)) to resolve the dispute. The conciliator or the conciliation committee strive to resolve the trade dispute within 30 days of the appointment, or for an extended period agreed to by parties to the dispute, s67(1). A trade dispute in essential services may in addition, be referred

to the Industrial Court by the Minister s73(2)(b). When a trade dispute is settled after conciliation, the terms of the agreement are recorded in writing and signed by all parties and the conciliator s68(1). A signed copy of the agreement is lodged with the Minister as soon as it is practicable s68(2). However, if a trade dispute is not resolved by conciliation, a party to the dispute may refer it to the Industrial Court, s73(1). There is provision for a trade union to refer a dispute to the Industrial Court as a matter of urgency if the dispute concerns employees and employers engaged in provision of essential services, s74(c).

A person may participate in a strike if (a) the trade dispute that forms the subject of the strike concerns terms and conditions of employment or the recognition of a trade union; (b) the trade dispute is unsolved after conciliation under this Act, or as specified in a registered collective agreement that provides for the private conciliation of disputes and seven days written notice of the strike has been given to the other parties and to the Minister by authorized representatives of the trade union, s76. A party to a dispute that has received notice of a strike may apply to the Industrial Court to prohibit the strike as a matter of urgency if the strike is prohibited under this part of the LRA, or the party that issued the notice has failed to participate in conciliation in good faith with a view to resolving the dispute, s77(1).

The LRA prohibits strikes if any law, court award or a collective agreement binding on a person prohibits a strike in respect of the issue in dispute, s78(1)(a). It also prohibits a strike if the employer and employees are engaged in an essential service, s78(1)(f). Essential service is defined as "a service the interruption of which would probably endanger the life of a person or

health of the population or any part of the population", s81(1) (p613). Section 81(3) declares that 'there shall be no strike or lock-out in an essential service" (p614), while section 81(4), adds that "any trade dispute in a service that is listed as or is declared to be an essential service may be adjudicated upon by the Industrial Court" (p614). The fourth schedule of the LRA lists hospital services as essential services (LRA, Fourth Schedule, p636).

When a strike complies with the provisions of the LRA part X, it is a protected strike, s79(1). A person does not commit a breach of contract or a tort by taking part in a protected strike or any lawful conduct in contemplation or furtherance of a protected strike, s79(2). It is important to note that an employer is not obliged to remunerate an employee for services that the employee does not render during a protected strike s79(6). The stipulation that trade disputes in essential services are to be adjudicated by the Industrial Court, contrasts with the SALRA which has a more elaborate and inclusive conciliation system for trade disputes within essential services (Republic of South Africa Labour Relations Act No 66 of 1995, s74). According to SALRA section 74, trade disputes in essential services are referred to the appropriate Council or Commission. In the case of health services, the relevant Council is the Public Health Service Welfare Sectoral Bargaining Council of the General Public Service Sector Bargaining Council (GPSSBC, 1999). Unlike the SALRA, the Kenya LRA does not have a provision for Minimum Services Agreement (MSA) which allows for some services to continue being provided during a strike by workers in essential services. Section 72 of the SALRA states that "The essential services committee may ratify any collective agreement that provides for the maintenance of minimum services in a service designated as an essential service, in which case- (a) the agreed

minimum services are to be regarded as essential services in respect to the employer and its employees; and (b) the provisions of section 74 do not apply" (SALRA, s72 p49).

3.4 The Occupational Safety and Health Act 2007

The Occupational Safety and Health Act, 2007 (OSHA), is an Act of Parliament that provides for the safety, health and welfare of workers and all persons lawfully present at a workplace. It states in Section 6(1) that every occupier, which includes an employer, shall ensure the safety, health and welfare of all persons working in his or her workplace. The employer is to provide a working environment that is safe and without risks to health, s6(2)(e).

3.5 The Right to Health

The World Health Organization (WHO) defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO Constitution, 1948, p1). Health is a universal human need and "is necessary for the fulfilment of human potential and to facilitate human thriving. Health care is not only for the individual good but also for the common good of society" (Rowe and Moodley, 2013, p5). As mentioned previously on section 3.2, The Constitution of Kenya requires the State to carry out its obligations to enable the people of Kenya to have the highest attainable standard of health, which includes the right to health care services and reproductive health. The constitution of the WHO states that "The enjoyment of the highest standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic and social condition"

(WHO, 2006, p1). It acknowledges that "The achievement of any state in the promotion of health is of value to all". WHO asserts that, "Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures" (WHO, 2006 p1). Article 12 of the United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR) recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (ICESCR, 1966). The Covenant affirms health to be a fundamental human right and Article 12(2)(d) requires States to create conditions which assure that all have access to medical services and attention in the event of sickness. In the General Comment No. 14, the Committee on Economic Social and Cultural Rights (CESCR) directs state parties "to respect, protect and fulfil the right to health" (General Comment No.14, paragraph 33 p11). It requires states to adopt appropriate legislative, administrative, budgetary, and judicial measures to work toward the full realization of the right to health (General Comment No.14, paragraph 33). The CESCR recognizes that states may have constraints in fulfilling this mandate due to limited resources, but expects them to progressively work towards fulfilment of the right to health for its entire people (General Comment No. 14, paragraph 30). The obligation to fulfil this mandate requires states to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health related facilities (General Comment No. 14, paragraph 36). The CESCR states that violations of the right to health can occur through actions such as suspension of legislation necessary for the continued enjoyment of the right to health. Other acts of violation may be the adoption of legislation or policies which are manifestly incompatible with domestic or international legal obligations related to the right to health (General Comment No. 14, paragraphs 48 and 49). However, some failures may arise from insufficient budgetary allocations, misappropriation of

public resources or adoption of health policies that do not promote equity in distribution of health services (General Comment No. 14, paragraph 52).

The WMA Medical Ethics Manual states that physicians and other persons or bodies involved in the provision of healthcare have a joint responsibility to recognise and uphold rights of patients. It requires physicians to pursue appropriate means to restore patients' rights in the event that legislation, government action or other institutions deny these rights (WMA Medical Ethics Manual, 2015). The WMA Declaration of Lisbon on the rights of patients confirms that patients have a right to medical care of good quality and exhorts physicians to accept responsibility for being guardians of the quality of medical services (WMA, 2005).

3.6 The Right to Strike

Chapter 4, section 41 of The Constitution of Kenya provides for the protection of the right of workers to strike. Kenya has ratified ILO Convention No. 98 on the Right to Organise and Collective Bargaining (ILO, 1949), but so far, has not ratified ILO Convention No. 87 which provides for the freedom of association of workers and the protection of their right to organise (ILO, 1948). However, by being a member of the ILO, Kenya has an obligation to promote and ultimately realise the principles of Convention No. 87 (ILO, 1998). The ILO recognises the concept of essential workers, and its Committee on Freedom of Association attests to the fact that hospital services are essential services in which workers may be restricted or prohibited from going on strike (ILO, 2008). A number of writers have challenged the principle of legislating

against strike action for certain categories of workers (Gernigon, Odero, and Guido, 2003). The ILO Committee on Freedom of Association (CFA) stated that denying workers the right to strike constitutes a significant restriction on the opportunities for trade unions to defend the interests of their members (ILO, 2006). The ILO Committee of Freedom of Association reaffirmed the right of workers to strike in its publication entitled "Freedom of Association- Digest of Principles of the Freedom of Association Committee of the Governing Body of ILO". Paragraph 521 states that:

> "The Committee has always recognized the right to strike by workers and their organizations as a legitimate means of defending their economic and social interests". While paragraph 522 adds that "The right to strike is one of the essential means through which workers and organizations may promote and defend their economic and social interests". Paragraph 523 reiterates that "The right to strike is an intrinsic corollary to the right to organize protected by Convention No. 87" (ILO, 2006, p109)

The International Trade Union Council (ITUC) asserts that "the right to strike is one of the essential means available to workers and their organisations for the promotion and protection of their economic and social interests" (ITUC, 2014, p19). Okene (2009) contended that denying employees the right to strike subjects them to work under conditions akin to enslavement. He claimed that strike action was a fundamental right of workers enabling them to participate in labour negotiations and collective bargaining for their entitlements. Without the right to strike, Okene stated, that workers would be forced to work under any conditions that they are subjected to. He added that such a situation was both morally and ethically indefensible (Okene, 2009).

Strikes are part of the process of advocating for employees' demands ranging from economic issues to those related to working conditions and other issues which affect their lives. Loewy (2000) declared that strikes provided a mechanism for managing deadlocks in negotiations between employees and employers. He further claimed that the right to strike and the ability to do so are necessary for collective bargaining of labour movements to be effective. Yule Jr. (1982) argued that without the ability to strike, workers would be greatly handicapped and their collective bargaining would merely be collective begging. This sentiment is echoed by other commentators who argue that for democratic societies to function well, the workers' fundamental right to strike must be protected (Okene, 2009).

The ILO regards a strike as a fundamental right, which is subject only to the restrictions that may be imposed by law. This is the position held by The Constitution of Kenya and Constitution of South Africa and their Labour Laws. A landmark ruling by Lord Wright in 1942 asserted the right of workers to strike and set a legal precedent. He declared that:

> "Where the rights of labour are concerned, the rights of employers are conditioned by the rights of the men to give or withhold their services. The right of workmen to strike is an essential element in the principle of collective bargaining. It is in other words an essential element not only of the unions' bargaining process itself; it is also a necessary sanction for enforcing agreed roles" ([1942] AC 435).

The ruling can be perceived as highlighting a fundamental truth which is pivotal in the chain of reasoning in the qualification of employers' rights by rights of employees thereby introducing a significant legal principle. This principle was affirmed by The Constitutional Court of South

Africa in the case of *NUMSA v. Bader Pop (Pty) Ltd* when it referred to s23 of the Constitution stating as follows: "it is through industrial action that workers are able to assert bargaining power in industrial relations. The right to strike is an important component of a successful collective bargaining system" ([[2003] SA 513 (CC) CCT 14/02 (13)). Section 64 of the ruling stated that "The right to strike is essential to the process of collective bargaining. It is what makes collective bargaining work. It is to the process of bargaining what an engine is to a motor vehicle. Section 64(1) of the LRA confers this right upon every worker. The Constitution guarantees this right to every worker in section 23(2)(c)" (Constitutional Court of South Africa Case CCT 14/02 p43). The South African Medical Association (SAMA) guidelines affirm the right of doctors to assembly, demonstration, picket and petition as provided for in the Constitution of South Africa. However, SAMA asserts that the actions are allowed only as long as health care of patients is not jeopardised. SAMA reiterates that emergency treatment may never be refused (SAMA, 2013).

3.7 Unionisation

Doctors in Kenya had been denied the right to form or join unions for decades (Mwenda, 2012). With the promulgation of the new Constitution, the right of assembly and association was re-established (The Constitution, s37). Doctors, like other workers, were free to form or join trade unions. After prolonged and concerted efforts, a doctor's union, KMPDU was registered in 2012 (Mwenda, 2012). Unlike in the past, the attitude among doctors towards unions, collective bargaining and collective action had become more positive from 2010. This was driven by the enthusiasm of Kenyans to embrace the expanded democratic space provided by the new Constitution. Faced with non-responsive government systems and a desire to continue working in

public health institutions, doctors undertook to utilise the power of unionisation and collective bargaining to assert their demands (Mwenda, 2012).

There are multiple pressures bearing on doctors in relation to wages, conditions of work and their advocacy role in respect of provision of health services to society. These demands compel them to move towards unionisation. In circumstances like those in Kenya where health services are centralized or socialized, with the state providing most of the services and employing doctors, unionisation is of great benefit. Doctors in the private sector who work as employees or are self-employed practitioners may also benefit from collective action through unions. Doctors' unions tend to be primarily for advocating the interests of doctors. However, some doctors' unions advocate for the interest of patients and the public, demanding and pressurizing governments and other healthcare institutions to improve services to the public (Daniels, 1978). Daniels observed that trade unions enabled workers in many countries to experience fair returns for their labour because of the strength of collective bargaining. He emphasized that in collective bargaining, justice is achieved through the fairness in demands not in the mere triumph of the collective bargaining action. Daniels (1978) in the same report contended that a strong union may skew the results of the agreement in its favour without regard to what is just. Similarly, a weak union may find its members oppressed unjustly because they did not have enough influence in collective bargaining altercations.

There has been a definite move globally for unionisation with more doctors joining trade unions. In the USA, as far back as 1972, there have been trade unions for doctors (Keith, 1984). In some

countries, professional doctors' organizations form divisions for negotiation on behalf of doctors or register themselves as trade unions (Keith, 1984). The American Medical Association (AMA), The British Medical Association (BMA), and SAMA reorganised their statutes to enable them to act as trade unions for their members (AMA, 2001, BMA, 2016, SAMA, 2011). The question arises as to whether participation in union activities by doctors is in conflict with their professional and ethical obligations. Unionisation in the medical profession raises concerns about conflict between dedication of service to patients and collective bargaining for the interests of doctors. Some writers postulate that unionisation of doctors is not compatible with their professional work. The common reason given is that doctors have a special relationship with patients that commits them to provide the best possible care to their patients with self-effacement; always giving preference to the patients' interest over their own. These obligations of doctors, it is argued, are in conflict with involvement in union activities whose primary aim is to advance the interest of their members (Daniels, 1978). Daniels stated that in contrast, unions can serve the interest of doctors, as well as that of the profession and society. He asserted that unions need to move away from their narrow interest in specific issues of welfare and economic matters to broader social concerns involving doctors, the profession and the society. This would strengthen doctors' unions and attract the support of the society at large (Daniels, 1978).

The KMPDU embraced the concept of concern for doctors' interests as well as the interests of the society. The union widely publicized its advocacy for improvement of health services in the public sector through the print and electronic media as well as social media platforms (Hannali, 2011, Pontillo, 2012). Daniels (1978, p26) concludes that "just as it is incorrect to paint unions as necessarily bereft of social concerns that make good medicine, so too it is incorrect to paint

professional organisations or "the profession" as standing above the socio-economic concerns of the doctors". Recent developments in the field of health care provision exposed a greater need for doctors to have strong representation through trade unions. Issues such as the increasing presence and influence of third party payers, the growing assertiveness of consumers to hold doctors accountable, and increased frequency of litigation are beyond the capacity of individual doctors to tackle alone. Unions may also play important roles as consumer advocates and protect the rights of patients as well as those of physicians. The collective strength of unions makes them well placed to counter government and other third party decisions or policies that adversely impact health care services (Daniels, 1978).

3.8 Discussion: Legal Aspects of Doctors' Strike

The laws of Kenya clearly prohibit strikes for workers in essential services such as hospital services. The doctors' strikes were in violation of section 78 of the Labour Relations Act. The Government of Kenya, who was the employer in the trade dispute with doctors, took the matter to the Industrial Court as provided for in section 71(1)(a) of the LRA. The Industrial Court declared the strikes illegal, citing section 78 of the LRA.

The LRA provides for a conciliation process which involves appointment of a conciliator by the Minister. A conciliation process was initiated before the strikes were declared in 2011. However, the KMPDU and the Ministry of Health team failed to reach an agreement and the union proceeded to declare the strike (Orengo, 2011, Matendechero, 2012). As mentioned in section 3.3

above, if the conciliator is not able to resolve the trade dispute, the matter is referred to the Industrial Court by the Minister or the striking workers. In the case of a strike by Government employees, the Minister who receives the strike notice is also the employer involved in the trade dispute. It is the same Minister who appoints a conciliator to resolve the dispute in which he/she is the employer involved in the trade dispute (LRA, s62 and s70). This arrangement may hinder impartiality in the conciliation process. The conciliation process in the LRA is inadequate and differs significantly from the process in South Africa where a trade dispute is referred for conciliation to the Public Health and Welfare Sectoral Bargaining Council as described in section 3.3.

During the doctors' strike the Government did not proceed with the legal process after the Industrial Court declared the strike illegal or unprotected. Further court action would have resulted in arrest orders for the striking doctors with the likelihood of a public outrage against the Government. Boyton (2008) observed that contractual or legal obstacles do not prevent doctors from going on strike. She stated that such clauses were likely to be unenforceable. This appears to have been the dilemma of the Government of Kenya during the doctors' strikes. A similar situation was experienced in South Africa where doctors went on a nationwide strike in spite of a legal prohibition of strikes in essential services.

Interruption of health services during strike action causes much suffering and may result in deaths of innocent patients. It is therefore prudent to have good processes for mediation and conciliation to resolve trade disputes in health services before they result in strikes. A more inclusive process similar to that in South Africa offers better opportunity for negotiation and

conciliation. With the increased democratic space provided by the new Constitution, Kenyans are more aware of their legal rights and are more assertive in demanding for them. The Constitution encompasses consultations with the people generally and more specifically those affected by specific decisions and action. Therefore, in keeping with the letter and spirit of The Constitution, a consultative approach with more opportunity for discussion with the parties in a trade dispute, is encouraged.

3.9 Conclusion

It is important to provide adequate processes for conciliation of trade disputes within health care services. The goal of conciliation should be to avoid or avert strike action. The participation of various organisations involved in patient welfare and rights, in the conciliation process is essential. Keith (1984), writing about unionisation in the medical profession concluded that:

> "Despite their altruistic dedication to service and patient care, despite arguments that professionals should not feel the necessity to resort to labourers' tactics, and despite the critical importance of their contribution to maintaining the health of all people, physicians should continue to be able to act collectively to address and resolve issues. They should continue to bargain for their own betterment. Only as a last resort should physicians withhold their services to emphasize their concerns and then only with the undertaking to continue attending to emergencies. "In truly critical situations physicians must always respond" (Keith, 1984, p1121).

I concur with Keith's conclusion and I am of the opinion that as long as the consequences of their collective activity do not cause harm, physicians should have the same rights as other workers and professional groups for collective bargaining, union activity and strike action. During the strikes in Kenya, doctors withdrew all their services and did not make any provision for services for emergency treatment. It is my opinion that such strike action cannot be justified. The LRA of Kenya clearly prohibits strikes for workers in hospitals, and therefore the strikes by doctors were unlawful. Enforcement of the law was however not appropriate because of the sensitive nature of medical care. It is therefore important for the development of dispute resolution processes that enable strikes to be averted.

CHAPTER 4: ETHICAL CONSIDERATIONS

4.1 Introduction

The doctors' strikes resulted in much suffering to patients and some deaths occurred as a result of lack of services in hospitals (Daily Nation, 05 December 2011). All services including emergency services were suspended during the strike. In this chapter the ethical implications of the strikes by doctors are discussed under the following headings:

a) Professionalism

b) Deontology

c) Consequentialism

d) Virtue Ethics

Professionalism as it pertains to doctors and the medical profession is discussed. The unique elements of the profession of medicine are expounded to facilitate understanding of the unique nature of medical work. The professional obligations of doctors to patients and the society are examined. The importance and significance of professionalism in the doctor-patient relationship and in the reciprocal relationship of the doctor-society interactions are considered. Various professional codes relating to medical practice are taken into account in ascertaining the ethical implications of the doctor's strikes. Ethical theories of deontology, consequentialism and virtue ethics are applied to analyse the dilemmas resulting from strikes by doctors. Possible ethical justifications and violations are explored.

4.2 Professionalism

Medical professionalism is the set of attitudes, values and conduct exhibited by medical providers as a result of them placing patients' and society's interests above their own (Diaz, 2004). Professions are characterized by dedication to the well-being of others, high moral standards, a body of knowledge and skills and high levels of autonomy (Wynia, et al., 1999). Medical professionalism includes relationships between the patient and physician, the physician and society, as well as relationships with colleagues and other health professionals (Williams, 2015). The American Board of Internal Medicine defines professionalism as "constituting those attitudes and behaviours that serve to maintain patient interest above physician self-interest", (Sethuraman, 2006, p1). Cruess, Cruess and Johnston (2000, p157), provides a more detailed definition of professionalism as follows:

> "An occupation whose core element is work based on the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning, or practice of an art founded on it, is used in the service of others. Its members profess a commitment to competence, integrity, morality, activism and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the privilege of self-regulation. Professions and their members are accountable to those served and to society."

They further state that professions and society have reciprocal obligations. The society grants the professions monopoly over the use of a body of knowledge, considerable autonomy, prestige and financial rewards. On the other hand society expects competence, altruism, and integrity in the conduct of the profession (Cruess, Cruess, and Johnston, 2000). The knowledge held by

professionals is for service to others. Altruism requires physicians to consistently place the interest of individual patients and society above their own. Physicians are accountable to their patients, their profession and to society (Cruess, Cruess and Johnston, 2000). Dhai (2008) claimed that the moral contract between the public and the profession relies on professionalism and professional integrity. She further stated that

> "the purpose of health care practice is to always care for the ailing and the sick, promote well-being and strive towards healing environments. In health care practice, scientific knowledge and clinical skills are used together with technical expertise. However the care of patients goes beyond clinical and technical excellence and encompasses experiences, feelings and interpretations involving human beings at times of great vulnerability and moments of fear and anxiety. It is recognized that the practitioner's knowledge is acquired through the cooperation of society and often through financial subsidy for medical education by the public. Medical knowledge is, therefore, not individually owned and should not be used primarily for personal gain, prestige and power" (Dhai, 2008, p2).

It is the practice for those entering the medical profession to publicly pledge to adhere to the tenets of their profession by reciting and taking an oath. Professional codes and oaths are important in setting out obligations and responsibilities of physicians in their dual role as healers and professionals. One of the best known is the "Hippocratic Oath" which has undergone modifications by various professional medical bodies over the years. The World Medical Association developed a modified Oath referred to as the Declaration of Geneva (WMA, 1948). The "Good Medical Practice" of the General Medical Council (GMC) of the United Kingdom

(GMC, 2013), and "Guidelines for Good Medical Practice" of the Health Professions Council of South Africa (HPCSA) are other examples of professional and ethical codes (HPCSA, 2009), albeit these not being publicly recited at graduation. In Kenya the MPDB has a "Code of Professional Conduct and Discipline for Medical and Dental Practitioners" which all registered doctors and dentists in Kenya must uphold (MPDB, 2012). A cardinal principle upheld by these codes is that physicians must act at all times in the interest of patients. In doing so, the physician must act in beneficent ways and avoid harm to patients. The physician must be trustworthy, and hold in confidence all information pertaining to management of patients. In addition many codes include competency, continued learning and the virtues of integrity, compassion and veracity as important for the practice of medicine. The GMC's Good Medical Practice, in paragraph one states that, "patients need good doctors and good doctors make the care of their patients their first concern" (p4). It requires doctors to be competent and to maintain sound relationships with patients and colleagues. It encourages doctors to be honest, trustworthy and to act with integrity and within the law (GMC, 2013). Doctors are urged to respect the rights of patients to privacy and dignity and show respect to human life. The MPDB of Kenya requires doctors to respect human dignity and human worth at all times and to strive to preserve and protect the patient's fundamental human rights. It states that the "a doctor should have respect for person-hood of patients, always adhere to confidentiality and to give such advice and treatment necessary to reduce suffering of his patients" (MPDB, 2012 chapter 5, s2, p34). HPCSA (2009) is more explicit in its ethical guidelines. The HPCSA affirms that the practice of a healthcare professional is based upon a relationship of mutual trust between patients and health care practitioners. It asserts that "the practice of medicine is a moral enterprise that requires life-long commitment to sound professional and ethical practices and overriding dedication to the interests of individual

patients and society" (HPCSA, Booklet 1, pi). The HPCSA requires healthcare practitioners to have respect for persons, and to always strive for the best interest and well-being of patients in a manner demonstrating beneficence and non-maleficence. The HPCSA calls upon doctors to be truthful and compassionate and to respect human rights. Doctors are urged to maintain confidentiality, integrity, and a high regard for justice. It requires that doctors are competent, committed to continuous self-improvement and to aspire to work for the betterment of society (HPCSA, Booklet 1 and 4, 2009).

An editorial in the Journal of Medical Ethics (Editorial, 1985, p59) offered a view that "Professions have substantial moral commitments to the welfare of their clients. They are groups of like-minded people sharing certain relatively arcane knowledge and skills who have an ethic of service to their clients". The editorial declared that "an altruistic concern for their clients and a self-imposed duty of beneficence is a central and necessary feature of professionals" (Editorial, 1985, p59). The traditional model of the medical profession lays emphasis on trust which is essential for the patient to reveal personal and confidential information that is vital for treatment. The professional must be worthy of this trust and capable of refraining from taking advantage of vulnerable patients, (Editorial, 1985). Edelstein (1956) claimed that physicians had a special moral duty of beneficence and of doing good for their patients. He stated that "a physician must never neglect the love of humanity and all the duties it entails" (Edelstein, 1956, p394). Professionalism by its definition requires reciprocal obligations of the society to the profession. The society holds the profession in high regard and accords it special status of honour and provides fair remuneration, often above that of average earners in the society.

The doctor is bound by the professional obligations espoused in the various codes of medical practice. The codes emphasise the importance of the commitment of the doctor to beneficence and non-maleficence and to always work towards the best interest of the patient. Doctors involved in the strikes in Kenya in December 2011 and September 2012, violated their professional responsibilities by not providing emergency services during the strikes.

4.3 Doctor-Patient Relationship

Professionalism protects patients from exploitation that may occur as a consequence of the power imbalance present between a doctor and a patient (Stuart, 2012). It is important that interactions in the doctor–patient relationships are "morally based and professionally protected so that shared legitimate expectations are honoured" (Stuart, 2012, p5). Wynia, (1999, p1613), asserted that the unique nature of the relationship between a patient and a physician required a well-defined moral base anchored on an "inestimable value for life and health". Pellegrino (1987, p1939), affirmed that physicians have obligations towards patients because illness does not come by choice and its treatment depends on the knowledge and skills of a doctor. The physician's knowledge is acquired through the cooperation of many patients who allow invasions into their privacy. Sulmasy (1993) further added that medical knowledge and skills are non-proprietary and should be used for the best interest of the patient. The doctor-patient relationship demands special obligations to individual patients under the doctor's care. The relationship obliges the doctor to be committed to provide beneficent service with self-effacement and to avoid harm to the patient. The physician-patient and the physician-society relationships are established by the physician being a member of the medical profession which pledges to be devoted to the service of

providing health care to all in need. The physician is bound by the commitment promised by the profession to society. There are situations when conflicts may arise because of the dual obligations of the physician to an individual patient and to society.

The traditional doctor's practice where doctors offer their services directly to patients is more appropriate for the classical doctor-patient relationship. Health care service provision is changing and many doctors are employees of hospitals or health management organizations or the state. In circumstances where the state owns medical facilities with doctors working as employees, the doctor-patient relationship becomes more complicated (Chima, 2013). Disputes related to employment contracts may occur and greatly jeopardize the obligations of the doctor to the patient (Rowe and Moodley, 2013). Stuart (2012) stated that as more doctors work as employees, their level of professionalism may decline because of the altered doctor-patient relationship. The employed doctor has a dual responsibility; to the patient and to the employer. In some circumstances, the requirements of the employer may not be in the best interest of the patient.

A strike by doctors therefore, touches on the very essence of professionalism. The duty to work for the good of society and the commitment to always put the interests of the patient above that of the physician weigh heavily against strike action. Denying medical services to patients is anathema to the professional obligations of the doctor.

4.4 Doctor-Society Relationship

Certain aspects of health care such as containment and prevention of infectious diseases, are in the realm of public good (Woodward and Smith, 2011; Farnham, 2013). Hence doctors have a social responsibility through a "social contract", which obligates them to advocate for social justice, and improvement of quality of care (McKenzie, 2007). Social responsibility has gained much interest within the medical profession as demonstrated by publication of a Charter on Medical Professionalism by the American Board of Internal Medicine (ABIM Foundation, 2005). The Charter lists social justice among its fundamental principles. It recognises the physician's duty to serve the individual patient while discharging the profession's broader social responsibilities. Barondess (2003) supported this concept and reiterated that medical professionalism goes beyond the doctor-patient relationship with obligations to a greater public. A report of the Working Party of the Royal College of Physicians of London recognised that medical professionalism has multiple commitments: to the patient, fellow professionals, to the institution or system within which healthcare is provided and to society. The report stated that a doctor's corporate responsibility is shared with managers, governments and institutions, who have a reciprocal duty to help create an organisational infrastructure, and a political and social environment to support doctors in the exercise of their professional responsibilities (Royal College of Physicians, 2005). From the perspective of their responsibility to society, the striking doctors in Kenya showed some degree of societal concern, beneficence and altruism by demanding for the Government to improve the state of public health services. These may provide some ground for justification of the strike action by the doctors.

4.5 Discussion: Ethical Implications of Doctors' Strikes

In the preceding section, professionalism and ethical obligations of doctors were addressed. A discussion on their relationship to strike action is dealt with in this section. Brecher (1985) observed that it was commonly held that doctors serving in the National Health Service (NHS), were under a moral obligation not to go on strike. He opined that "unless sainthood is demanded, the obligation not to go on strike is untenable" (Brecher, 1985, p66). He reasoned that some disputes leading to strike action were related to medical ethics but by far the main problems arose from the nature of medical work (Brecher, 1985). He disagreed with the common argument that healthcare workers should not go on strike because it may result in deaths or suffering of patients. Brecher reasoned that if this was to be demanded of health care workers it must be applied to other workers whose decisions may result in death or suffering of people. He explained that decisions of politicians, for example, may result in death and suffering of large numbers of people. Cannell (1985) disagreed with Brecher's opinion stating that health workers voluntarily accept their work knowing the obligations medical work entails. He maintained that such workers implicitly undertake not to strike as striking is not compatible with the services they have voluntarily committed to provide. Cannel further stated that it was wrong to inflict suffering on innocent and already sick third parties in order to achieve one's own economic ends. Jotterand (2005) affirmed the concept that doctors enter the profession by choice but illness comes to patients without choice. He added that a sick person was vulnerable and dependent on the doctor. The Code of Professional Conduct and Discipline of the MPDB of Kenya (chapter 5, s2, p34),states that "it is the humanitarian duty of a doctor to give emergency care to patients unless he/she is assured that others are willing and able to give such care". Entry into the medical profession is a conscious decision and implies willingness to uphold the principles and ethical

obligations irrespective of the situation. On the contrary, strike action violates cardinal principles of professionalism and medical ethical codes (Stuart, 2012). Boyton (2008) however explained that self-effacement did not mean doctors should allow themselves to be exploited and be powerless to stand up for their rights. She explained that professional obligations and ethical codes may be used to exploit doctors because the means available for use in advocating for self are restricted by professional and ethical obligations. She countered that the fact that doctors enter willingly into their professions did not mean they should not take action if they believed their conditions of work were unsatisfactory. Boyton (2008) asserted that doctors, too, have rights and should be treated with respect. It is evident that doctors who went on strike in Kenya were involved in unprofessional conduct and violated medical ethical codes. Arguments can be made that such disregard for professionalism and breach of medical ethics abrogates any moral justification for their strike actions.

4.6 Application of Ethics Theories

I have discussed reasons for, and demands made by doctors during the strikes and examined some of the benefits and harm that resulted from the strikes. Despite the suffering experienced and some deaths, the strikes resulted in very significant gains to the doctors, patients and society. In this section theories of deontology, consequentialism and virtue ethics are applied to ascertain whether there could be moral justification for the strikes by doctors.

4.6.1 Deontology

Deontology focuses on doing that which is right from the conviction of one's moral duty in a specific situation (O'Toole, 2009). The profession of medicine exists for the care of those in need and to serve them with the goal of promoting health and alleviating suffering related to ill health and disease (WMA, 2015). The cardinal duty of a doctor is the duty of care which obliges the doctor to always act in the interest of the patient, and to desist from causing harm. The objectives and values of the profession are affirmed in codes of conduct and medical ethics which all members of the profession must honour (HPCSA, 2009). The doctor publicly swears an oath to abide by aims, values and obligations of the medical profession contained in the codes of ethics (WMA, 2015). The doctor has obligations to the individual patient under his care and to the society at large. Strike action is contrary to the doctor's avowed professional duty to act in the interest of the patient in a beneficent manner. Hence from a deontological perspective strike action by doctors cannot be morally justified.

4.6.1.1 *Kantian imperatives*

Emmanuel Kant declared that there were categorical imperatives that are necessary for an action to be morally right or that lack of compliance with the categorical imperatives rendered an action morally unacceptable. The first of these imperatives is that it must be possible to apply the action or rule to all similar situations all the time without exception. The second imperative is that one must act in such a way that he/she treats other human beings including himself always as an end and never merely as a means to an end (Rachels and Rachels, 2012a). In applying the first imperative it is evident that strike action when universalized can be disastrous and untenable. In

applying the second categorical imperative it may be shown that the striking doctors are using patients as means to achieve their desired goals of better salaries and better conditions of service. The fact that patients and society may gain from the outcome of the strikes does not count from a deontological point of view. Consequences are not considered in analysing situations from a deontological perspective. It can be further argued that doctors are using themselves as a means to an end by subjecting themselves to act in violation of their professional calling in order to increase their earnings and improve their conditions of work; the second categorical imperative prohibits the use of self as a means to an end.

Rachels and Rachels (2012b) expound on the second imperative and explain that treating people as an end means treating people well; to promote their well-being and avoid harming them. They further assert that treating people as ends requires that people are treated with respect and are not manipulated to achieve other people's goals, no matter how good those goals are. Glick (1986) regards the idea of a strike in which a third innocent party is deliberately punished in order to apply pressure on someone else as a bizarre ethic which, to his knowledge, cannot be justifiable under any ethical theory. Stuart (2012), states that striking doctors exert pressure on their employer by withholding services to patients. Such denial of care to patients is contrary to the professional principle of placing the interests of patients above all else. Since patients are used as the major force to effect changes in favour of doctors, it amounts to using patients to achieve the desired ends of the doctors. This is inconsistent with professional virtues and codes of practice and in violation of deontological ethical principles. Strike action by doctors is in conflict with the Kantian categorical imperative not to use others merely as a means to an end but always as an end. It may also be demonstrated that self-effacement by doctors is in conflict with Kantian

imperatives. Such action implies that the doctor is using himself as a means to an end contrary to the second categorical imperative of Kant. The act of sacrificing everything for the good of his patients amounts to using self as a means to achieve another person's goal.

In circumstances where the motivation for the strike action is improvement of health services and patient care, strike action may appear justifiable (Stuart, 2012). However, the participation of patients in the strike is not voluntary and therefore it amounts to patients being used as mere means. Strike action by doctors is discordant with the two categorical imperatives of Emmanuel Kant, and thus cannot be morally acceptable from a deontological perspective.

4.6.1.2 Advocacy duty of doctors

In considering the duty of doctors as advocates of patients and society in respect of health matters it is pertinent to ask how strike action may be viewed from a deontological perspective. The Government had been unresponsive to repeated demands for improvement of health care services in the public sector. The Government's inaction amounted to injustice to the suffering masses that depended on public health care services. One of the main demands of the doctors during the strikes was improvement of the public health services which had deteriorated progressively over several years and were in an appalling state. The Government was fully aware of the situation but made no efforts to rectify the situation. It was apparent that financial constraints were not the reason for neglect in the health sector. The Government was known to spend large amounts on less essential services and furthermore wasted financial resources through corruption (Martini and Chene, 2012; Ogalo and Marsden, 2013; Nga'ni, 2011).

The demand for improvement of health services was motivated by the professional duty of doctors as advocates for patients and the society. Individual doctors, and the medical profession as a whole, have an advocacy role through their social contract with society. When the status of health care in public facilities is so poor that patients risk being harmed in the course of receiving health care, the compulsion for doctors to use strike action to pressurize the Government to undertake necessary action may find justification. Oppression of the poor and vulnerable in society amounts to a great injustice and one of the roles of the professions is to protect vulnerable people and vulnerable values in society (Daniels, 1978). Chima (2013) declared that in circumstances where the health of patients is threatened by omissions or commissions of other parties such as the Government, a hospital or other agency, doctors are obliged to take action to avert adverse consequences on the health of patients. Such situations may arise when there is failure to provide adequate drugs, essential supplies and other facilities to facilitate adequate care of patients. The doctors' professional and ethical duty demands that they intervene on behalf of patients in such circumstances. The action may ultimately result in extreme measures like strike action or withdrawal of services to put pressure on the relevant authorities to improve health care. Such strike action, in response to professional responsibility to the society, may be justified from a deontological ethical perspective subject to patients not suffering harm in the process.

4.6.2 Consequentialism

Consequentialism is a group of ethical theories in which the assessment of moral action is based on the consequences or outcome of the action (O'Toole, 2009). The theory views morally right actions as those that result in good all round or that which avoids bad outcomes. In its original

form, the actions were judged by how much pleasure they caused or how much displeasure the actions averted. Utilitarianism is the most prominent consequentialist theory; it proclaims that happiness is the sole intrinsic value for consideration in determining the right action. Hence the action which promotes the greatest happiness is regarded to be the morally right action. For actions which cause harm, the action that causes the least harm or minimises harm is the morally right action (Rachels and Rachels, 2012c). In essence the morally right action is that which produces the best overall favourable or good consequences. The motives for actions do not matter. An important aspect of utilitarianism is that each individual's happiness is equally important (Brink, 2014). The agent has to act in an impartial manner and relationships and circumstances are disregarded. Rachels and Rachels, quote John Stuart Mill who stated that, "utilitarianism requires the moral agent to be as impartial as a disinterested and benevolent spectator" (Rachels and Rachels, 2012d, p116). In the utilitarian moral theory, actions in themselves hold no intrinsic value; it is the consequences alone that matter (Rachels and Rachels, 2012e).

4.6.2.1 Reflecting on benefits and harm

In applying the utilitarian theory to strike action by doctors in Kenya, outcomes of the strikes were taken into account. The main benefits were increased salaries and allowances to doctors, and payment of salaries to doctors in specialist training. In addition, more doctors were employed and the Government agreed on a plan to buy new equipment, improve supplies of drugs and improve infrastructure of the public health facilities. The Government allocated money for the purchase of equipment and for employment of additional doctors. As a result of these

undertakings by the Government, patients were expected to benefit through improvement in the quality of services from "happier" doctors working in better equipped facilities. The increased number of doctors, better supplies of drugs and other materials would result in better standards of health care services. However, harm also resulted from the strikes and deaths of patients occurred. A number of patients suffered pain and other ills due to lack of services in public health facilities during the strike. Many patients suffered financially by paying for costly health services in the private sector (Atwoli, 2013). Many relatives and friends of patients suffered psychologically as they watched dear ones suffering.

The question to be asked is whether the gains from the doctors' strike in Kenya justified the suffering and deaths of innocent patients. In applying the theory of utilitarianism, the gains from the strike benefited doctors, patients and the society, both in the short-term and the long-term. It was expected that better salaries and allowances would motivate doctors to provide better health care with commitment to serve in the best interest of patients and society. Daniels (1978) contended that higher salaries did not always result in better services from doctors. However, many commentators believe that well paid doctors are more likely to provide better services than poorly paid doctors (Boyton, 2008).

Since poor health services may cause deaths, the strike action by doctors to pressurize the government to improve health services could be justifiable as necessary to prevent deaths and suffering. In my opinion, deaths which resulted from the strikes by doctors could be regarded as an unpleasant but worthwhile cost of a just struggle. However, the striking doctors may be faulted

for not providing emergency medical services to minimize death and suffering during the strikes. The overall benefits of the strikes for society, the public health sector and doctors were very significant. Although the gains came at a high cost, considering that some patients died, justification for the strike from a utilitarian perspective is plausible. Ogunbanjo and Bogaert (2009, p307), writing about the doctors' strike in South Africa, concluded that "if there is evidence of great long-term benefit to doctors and their families and positive improvement in the health care delivery and the concurrent increase in benefits to those who are most in need of health care, then strike action may find justification". Brecher (1985) observed that deaths of patients that occur as a result of doctors' strikes may be justifiable as in other circumstances, such as in just wars, when deaths of humans are justifiable. He admitted that human value must be regarded highly but contended that in practical terms, loss of human life was not a completely overriding value in all circumstances. He asserted that justification for deaths which occur during strikes by doctors may be possible on account of overall beneficial consequences of the strike and prevailing circumstances. Brecher (1985) concluded like Ogunbanjo and Bogaert that strike action by doctors may be justifiable if there were long-term benefits to doctors and patients and a positive improvement to health care services. Veach (1975) added that a concurrent increase in benefits to the most vulnerable sector of society who most depend on public health services would further give reasons for justification for a strike by doctors. Sachdev (1986) stated that in the public health system, working conditions of doctors may deteriorate so much that strike action is understandable. He added that such action would be morally justifiable only "if the long-term benefits to physicians and their families were great, health-care delivery improved considerably as a result, more lives were possibly saved in the long run and the benefits were passed on to the physician-less members of the society" (Sachdev, 1986, p53). In section 2.3.2

and 2.3.3, benefits and harm arising from the strike were discussed. The benefits were very significant and both doctors and society benefited. However, harm resulting from the strike was also very weighty and underscored the heavy cost of the benefits achieved by the strike. The majority of the public supported the strike action by doctors and was hopeful that it would result in improvement of public health services (Ayienda, 2011). When gains are weighed against harm there is sufficient reason to justify the strikes. Consequentialist theories offer a strong case for justification of the strike under consideration because of the overall gains for patients, doctors and society. From a consequentialist perspective the strikes by doctors in Kenya were justified.

4.6.3 Virtue ethics

Virtue ethics focuses on the character of the moral agent rather than the actions (Pellegrino, 2006). Some of the virtues expected of a physician are compassion, trustworthiness, integrity, conscientiousness and veracity. They are incorporated in various professional codes of ethics. A key virtue is to act always in the best interest of the patient. Pellegrino (2006) stated that virtues protect patients from undue exploitation which may occur due to the imbalance of power when an ill person is under the care of doctors who possess knowledge and skills that are necessary to relieve the suffering of the patient. He asserted that character, based on good virtues, is extremely important. Experience has shown that the good of the patient cannot be protected sufficiently by rights and duties alone (Pellegrino, 2006). Rachels and Rachels (2012f, p159), define moral virtue as "a trait of character manifested in habitual action that is good for anyone to have". Pellegrino, (2006, p73), declared that:

> "We expect the virtuous person to do the right and the good even at the expense of personal sacrifice and legitimate self-interest. Virtue ethics expand the notions of benevolence, beneficence, conscientiousness, compassion and fidelity well beyond what strict duty and legal statutes may require. It makes some degree of supererogation mandatory because it calls for standards of ethical performance that exceed those prevalent in the rest of society".

Such idealism is echoed in the Oath of Maimonides which states in part that, "May the love of my art actuate me at all times; may neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children. May I never see in the patient anything but a fellow creature in pain" (as quoted by Tan and Yeow, 2002, p553).

The character of the virtuous doctor should compel him or her not to deny necessary care to patients. A caring, compassionate, kind and conscientious disposition is incompatible with strike action. Demands for increased salaries and better working conditions are legitimate, but strike action for these reasons would be contrary to the virtues expected of doctors as they reflect self-interest above that of patients. Strike action is incompatible with virtues required of a physician. While emphasizing the value of virtues, Pellegrino (2006, p74) stated that,

> "It is when the choice of a right and good action becomes more difficult, when the temptations of self-interest are most insistent, when unexpected nuances of good and evil arise and no one is looking, that the differences between an ethics based in virtue and ethics based in law and/or duty can most clearly be distinguished".

4.7 Conclusion

Ethical theories of deontology, consequentialism and virtue ethics were applied to the strike action by doctors. Doctors have duties and obligations to their patients and to society. Professional codes of ethics and conduct affirm these obligations and urge doctors to abide by them. While engaging in strike action, doctors in Kenya acted against the tenets of their profession and ethical codes. The abdication of their core duty of care during the strikes abrogated any moral justification from a deontological perspective. Strike action involves using patients and self as a means to an end, making such action morally wrong from a deontological ethical perspective. Doctors have a responsibility to advocate for the provision of appropriate health services to society. The strike action by doctors was partly to canvass for improvement of health services. On the basis of the advocacy role, the strike action could have been justifiable from a deontological perspective if patients had not been harmed and lives lost.

When applying consequentialist theory it was acknowledged that the strikes resulted in increased salaries, improved working conditions and an undertaking by the Government to improve public health services. Despite the harm caused to patients and society, the gains were remarkable. Therefore, from a consequentialist perspective, the strikes were justified, albeit at a very high cost. Virtue ethics defines the essence of the character of the doctor and the uniqueness of the doctor-patient relationship. The virtues required of a physician and the nature of the doctor-patient relationship espouses care and compassion. Strike action is not compatible with these virtues and the strikes by doctors cannot be morally justified from a virtue ethical point of view.

CHAPTER 5: CONCLUSION

In this research report I have described the circumstances prevailing at the time of the strikes. The doctors were underpaid and subjected to long working hours under conditions which hampered provision of appropriate professional services to patients. The OSHA requires work places to be safe environments for workers. However, conditions in public health facilities exposed doctors to high risks of contracting infections.

The health services in the public sector were substandard due to under-financing and poor management. The reasons for the strikes included those for the benefit of doctors as well as for improvement of health services for the benefit of society. The Task Force report showed that the demands of doctors had merit and deserved attention by the Government who was also the employer of doctors in the public sector. The strike resulted in significant gains for the public as well as the doctors.

Both the Constitution of Kenya and the LRA protect the rights of all workers to fair remuneration and to use strike action where necessary to address economic and social issues. However, the LRA prohibits strike action for workers in essential services such as hospitals. It was noted that the Task Force report showed that the demands of doctors had merit and deserved attention by the Government who was also their employer.

Health is a basic right recognised by the WHO and the ICESCR, as well as The Constitution of Kenya. The Government of Kenya has the responsibility to ensure the progressive attainment of the highest standard of healthcare for all its citizens. This responsibility requires that facilities for healthcare are available in sufficient numbers and well distributed throughout the country. It also requires that health facilities are well equipped and provided with sufficient medicines and other necessary supplies. In addition, the health facilities should be adequately staffed and competently managed. Having adequate numbers of doctors who are well paid is an important prerequisite for the Government to fulfil its mandate in enabling Kenyans to have access to healthcare services. The Government of Kenya further needs to commit to provide the budgetary allocation for health as recommended by the Abuja Declaration (Abuja Declaration, 2001). In addition, it needs to fulfil its responsibility demanded by the endorsement of the United Nations' ICESCR. The charge to address social determinants for health, to repeal legislation that hinders access to health care and to take action to eliminate shortages of supplies and staffing in public health facilities is binding on all States that are signatories to the Covenant.

Unionization of health care workers is a new phenomenon in Kenya. It is increasingly necessary for doctors and other health care workers to deal collectively with emerging issues related to their work. Doctors are faced with changing working relationships with employers, managed care organisations, and third party payers. Such issues are best addressed through representative bodies like unions and professional associations. Unions also provide leadership which other parties such as the Government and consumer organizations can negotiate with on issues concerning health workers.

It is acknowledged that trade disputes may occur between doctors and their employers which should be resolved through available dispute resolution channels. However, the current LRA does not provide an adequate process for resolution of trade disputes in essential services such as health care. I have proposed that the LRA be revised to make it more inclusive with the aim of averting strikes within essential services. I have also suggested that the incorporation of an MSA in the LRA, similar to that in South African law, will provide a means to minimize harm to patients in the event of a strike by health care workers.

Doctors work within a professional framework which provides adequate guidelines for ethical conduct in carrying out their professional work. The Hippocratic Oath, which all doctors in Kenya swear on graduating from medical school, has stood the test of time. The Code of Professional Conduct and Discipline of the MPDB of Kenya, articulates what is necessary for doctors in Kenya to practise medicine in a professional and ethical manner. These codes emphasise the centrality of the best interest of the patient, as well as the beneficent nature of health care. I agree with other authors that some extreme circumstances may pressurise doctors to act contrary to what is advocated in the codes of ethics and professional conduct. Some of these exigencies are poor remuneration to the level where the doctor and his family are suffering, and a work environment that endangers the health or life of the doctor. It has also been demonstrated that the sense of duty and obligation to self may force doctors to violate some aspects of the codes of conduct and ethical obligations. In the current study, the duty to advocate for better public health services was an additional compelling reason for strike action.

The doctor-patient relationship is a unique relationship, bringing together a patient with medical needs and a doctor who has the means and knowledge to take care of the patient's problem. It is an unbalanced relationship between a vulnerable patient and a more powerful doctor with potential for exploitation of the disadvantaged patient (Sulmasy, 1993). Professionalism and the codes of medical ethics provide protection for the patient against exploitation in the unbalanced interaction between the doctor and patient. In the relationship of doctors and the society, it is acknowledged that there is a reciprocal relationship between the public and the medical profession. Society must undertake its obligations to ensure it benefits from the medical profession and vice versa. In this respect I agree with Ochieng's statement that the Government should be able to remunerate doctors well as part of its duty to "reward service men and women according to the necessity and quality of their contribution" (Ochieng, Daily Nation, December 21, 2012, p2).

The ethical theories of deontology, consequentialism and virtue ethics were applied to ascertain whether there is a justification for strikes by doctors. Applying the ethical principle of deontology exposed the disregard of professional obligations and violations of medical ethical codes by striking doctors. The strike actions were also shown to violate the two Kantian imperatives making such action morally unacceptable. On this premise, the strikes were ethically wrong and could not be justified from a deontological perspective. However, consequentialist theory provides strong grounds for justification of the strikes as there were remarkable gains by the

doctors and the Kenyan society despite some suffering and deaths of patients. Moral justification of the strikes is therefore plausible from a consequentialist perspective.

Applying virtue ethics provided a viewpoint focusing on the virtues espoused by the medical profession and those inherently considered valuable by society. Virtue ethics emphasizes the character of the agent. Analysis of the virtues expected of doctors showed that strike action was incompatible with virtues esteemed by the medical profession. The strikes by doctors in Kenya could not be justified from the virtue ethics perspective. Application of these ethical theories to doctors' strikes revealed that the consequentialist theory provided the strongest justification for the strikes, while virtue ethics strongly opposed any justification of the strikes.

This ethico-legal inquiry into strike action by doctors in Kenya showed that doctors had compelling reasons to go on strike, but Kenyan laws prohibited strikes for doctors working in essential services. Ethical theories provided some reasons for justification of the strikes but also point out that there were constraints against moral justification of strike action by doctors. The inquiry also revealed that strikes caused much disruption of health services and exposed doctors to ethical dilemmas and legal violations. The MPDB, and the Kenya Medical Association (KMA), have no specific guidelines for doctors regarding strike action. These organizations should work with other stakeholders to develop an appropriate ethical framework based on ethical theories and principles to address the issue of strikes by doctors and to find ways to avert them. It is noteworthy that the South African Medical Association (SAMA) has clear guidelines for doctors regarding strike action (SAMA, 2006).

I conclude by stating that strikes by doctors can only be morally acceptable if the reasons are compelling enough and arrangements are made for emergency and urgent services to be provided to patients. A total withdrawal of services, such as what happened with the doctors' strikes in 2011 and 2012, is morally unjustifiable. I submit that moral justification for strikes is untenable when emergency services are withheld. Provision of emergency services is a prerequisite for moral justification of any strike by workers in essential services. Such arrangements to provide emergency services are possible and were undertaken by striking doctors in Israel (Grosskopf, et al. 1985), in New Zealand (Sachdev, 1986) and in Canada (Baer 1997). However, the ultimate goal is to avoid or avert strikes in essential services. This calls for involvement of all actors responsible for provision of health care, including the MPDB, KMA, the Government, private healthcare providers, healthcare financiers and faith based organisations. As Glick (1985, p197), stated "there are no winners in a doctors' strike". The reflections of Park and Murray should challenge all of us to address the important issue of doctors' strikes. In their joint article in the Journal of Medical Ethics entitled "Should doctors' strike?" they concluded that:

> "This issue has no clear right or wrong answer. But there needs to be greater and serious engagement and debate, especially with younger training students and doctors, on the vocational and ethical responsibilities held by doctors and the moral defensibility of strike action. In the light of the growing power and influence of large medical organisations such as the BMA on new younger members, we call for greater discussion and debate on strikes, including other ethical issues that we will face in informal, formal and academic circles. By engaging together, we should at least be able to build a better future as informed, involved and engaged members of the profession," (Murray and Park, 2014, p342).

STATUTES

The Constitution of Kenya 2010

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Labour Relations Act No 66 of 1995 (South Africa)

Laws of Kenya Cap 233

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