

**SOME ETHICAL AND LEGAL
CONSIDERATIONS CONCERNING STRIKE
ACTION BY DOCTORS IN THE SOUTH
AFRICAN PUBLIC SERVICE**

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**A research report submitted to the Faculty of Health Sciences,
University of the Witwatersrand, in partial fulfillment of the
requirements for the degree of Master of Science in Medicine in the
branch of Bioethics and Health Law**

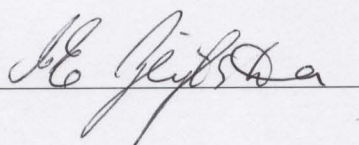
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Declaration of Own Work
Master of Science in Medicine (Bioethics & Health Law)

I, Zeijlstra, Irene Elisabeth, student number: 0353470, am a student registered for the degree of MSc Med (Bioethics and Health Law).

I hereby declare that this research report, apart from the ongoing helpful criticism and encouragement of my supervisors, is my own unaided work. It is being submitted for the degree of Master of Science in Medicine in the branch of Bioethics and Health Law, at the University of the Witwatersrand. It has not been submitted before for any degree or examination at this or any other University.

Signature: _____



Date: 5 MAY 2012

Some Ethical and Legal Considerations Concerning Strike Action by Doctors in the South African Public Service

Research Report Abstract

Doctors in the South African public service went on strike in mid-2007, 2009 and 2010. The main issue related to salaries. In my research report I will present arguments concerning the justifiability or not of strike action by South African doctors.

Thus the laws, codes and oaths subscribed to by medical practitioners in South Africa will be presented. Doctors' obligations stated in such declarations, and some ethical theories will be presented as they relate to the moral justifiability of doctors' strikes, and to the individual doctor-patient relationship. Arguably, the individual doctor-patient relationship is crucial for a flourishing population and social justice.

In the context of this relationship, the potential harms and benefits of strike action for both parties will be discussed. I will suggest that whether justified or not, strikes may not be the right means to achieving the end of excellent healthcare. The aim of the research, ultimately, is optimal health for the South African population with retention of doctors in the public service.

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Some Ethical and Legal Considerations Concerning Strike Action by Doctors in the South African Public Service

Introduction

The middle of years 2007, 2009 and 2010 saw large-scale doctors' strikes at public hospitals in South Africa, with participation particularly by junior doctors. The main issue, certainly not the only one, was salaries. In accordance with the views of Glick (1985: 196; 1986: 43) and Fiester (2004: W12), a definition of strike action by doctors could be "*the deliberate injury (even though that is not the goal) of a third party in order to put pressure on the state to achieve one's own ends*".¹ This research report will address the issue of whether or not doctors can morally justify compromising the safety of members of the public seeking medical care in order to achieve their ends, even if these ends include what the striking doctors deem to be in the public good.

The discussion will focus on firstly, the legal position as regards strike action, followed by the content of the Oaths, Codes and Declarations subscribed to by South African doctors. Practical reasons for strike action and the potential harms and benefits of following this route, will be considered. The critical importance of the doctor-patient relationship will be considered, particularly in how this has undergone alteration in tandem with societal changes, with resulting changes in professional medical practice. Investigation of some ethical theories will be undertaken, with the view of offering ethical justification, or not, of strike action by public service doctors in South Africa. I seek also to demonstrate the importance of the doctor-patient relationship from the perspective of ethical theory.

¹ My addition and emphasis, bracketed.

In conclusion, it will be suggested that even if strike action may be ethically justified, there may be more favourable means in lieu of strike-action to resolving the problems faced by public service doctors. Some practical measures that might help to resolve these difficulties will be considered. This will require the co-operation of the state as employer, the individual institutions and the doctors.

Chapter 1 Legal considerations

1.1 Introduction

In mid-April 2009 members of the splinter group United Doctors Forum (UDF), with no Public Sector Coordinating Bargaining Council (PSCBC) representation, went on an unprotected strike for 12 days that is alleged to have caused the deaths of 3 patients. It was reported then (Kirsch 2009:496), *"The doctors' issue was about feeling supported and valued. When your job satisfaction decreases, salary becomes more and more important. Doctors get frustrated because they see people dying and they're helpless to do anything because the equipment and support infrastructure is not there"*. Medical institutions and the State must bear much of the responsibility for the resultant appalling state of affairs in the healthcare sector. This strike action by doctors was, however, neither legally nor (arguably) morally justifiable.

The South African Constitution with its Bill of Rights is rooted in the concept of universal human rights. These human rights are claims that people are entitled to make simply by virtue of their status as human beings. The foundation for universal, fundamental, so-called inalienable, human rights such as life, liberty, equality and dignity is 'Natural Law' developed from Stoic, Aristotelian and Judeo-Christian thought (Cooney 1998: 879). Kwasi Wiredu (1990: 298) expounds on the cultural traditions of the Akan people of West Africa who, according to their belief system, are born with certain inherent rights that include political rights and obligations (Wiredu 1990: 302).² This African perspective thus also lends support to the concept of 'fundamental human rights'. The notion of rights inherent in one's humanity was

² "When a human being descends on earth he lands in a town. Membership in town and state brings with it a wider set of rights and obligations".

accepted globally in the 1948 Universal Declaration of Human Rights (UDHR) as a protection for individuals in societies where the actual laws are unjust. South Africa has ratified the UDHR and is thus bound by this agreement.

1.2 The Constitution

The Constitution of the Republic of South Africa Act 108 of 1996 affirms the democratic values of human dignity, equality and freedom. Specifically the Bill of Rights, section 27 states that:

- 1. Everyone has the right to have access to
 - a. health care services, including reproductive health care;*
 - b. sufficient food and water; and*
 - c. social security...**
- 2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.*
- 3. No one may be refused emergency medical treatment.*

According to section 23(2)(c) of the Constitution, every worker has the right to strike. This right is, however, trumped by other general rights enshrined in the Constitution. This includes the right to life in section 11 and the afore-mentioned health-related rights. Additionally, section 36 in the Bill of Rights, notes that, *rights may be limited by a law of general application if the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom*. An example of a law of general application would be the Labour Relations Act No. 66 of 1995.

1.3 The Labour Relations Act

The Labour Relations Act No. 66 of 1995 (LRA) has as its purpose the smooth functioning of labour relations. Importantly, it aims to facilitate economic development, social justice and peaceful labour relations. It thus promotes conciliation and negotiation prior to arbitration or collective industrial action. The Commission for Conciliation, Mediation and Arbitration (CCMA) is generally responsible for conciliation and arbitration (Department of Labour: 2002). The LRA also deals with the issue of limiting the right to strike.

The LRA is rooted in international law, specifically in the conventions of the International Labour Organisation (ILO). South Africa has ratified two ILO conventions, (a) the “Freedom of Association and Protection of the Right to Organise Convention” No 87 of 1948 and (b) the “Right to Organise and Collective Bargaining Convention” No 98 of 1949, and is thus bound by them (ILO: 1996; Roskam 2009:7; Bhe 2009:5). In order to comply with the intention of these international conventions, that is, to allow employees and employers the right to organise themselves (including the formation of trade unions) to further their own interests, there is the recognition of a general right to strike. Strike action is the basic means whereby workers are empowered to insist on their demands, so in South Africa this right to strike is restricted only where a public service has been declared essential.

1.4 “Strike”

Section 213 of the LRA defines ‘strike’ as

... The partial or complete concerted refusal to work, or the retardation or obstruction of work, by persons who are or have been employed by the same employer

or by different employers, for the purpose of remedying a grievance or resolving a dispute in respect of any matter of mutual interest between employer and employee, and every reference to "work" in this definition includes overtime work, whether it is voluntary or compulsory.

In law a distinction is made between full strike action and protest. Thus health workers who protested and/or picketed outside of their working hours during the 2007 strike were not held to be in breach of the law (Bhe 2009:16). The South African Medical Association (SAMA) guidelines titled *Doctors' and Patients' Rights and Responsibilities*, though not with the force of law, affirm that emergency treatment may never be refused. They go on to say however that doctors "may exercise their rights to assembly, demonstration, picketing and petitions to such an extent that it does not affect the healthcare of their patients". In addition, the heads of facilities have the responsibility to facilitate and harmonize the employment rights of doctors employed by them (SAMA: 2009). Thus accountability rests also with individual institutions in the event of public service doctors' strikes in South Africa.

1.5 Essential Service

The definition of what constitutes an "essential service" according to section 213 of LRA is:

- (a) a service the interruption of which endangers the life, personal safety or health of the whole or any part of the population;*
- (b) the Parliamentary service;*
- (c) the South African Police Services;*

Legally in South Africa doctors and other essential service providers have no right to strike (Labour Relations Act 66 of 1995 (LRA), section 65(1)(d)(i)). However, collective agreement that provides for a minimum service may be ratified (LRA: 1995, section 72).

When a level of minimum service has been agreed upon, there is discussion about whether it is only those who form part of the minimum service who lose the right to go on strike. A point of contention by those bound by the essential service provision is that very few minimum service agreements have as yet been ratified, none in the health care services (Roskam 2009: 5). Thus strikes are illegal for all persons employed in the South African health services. Despite this, one of the most extensive strikes in South African history, inclusive of nurses and some doctors, began on June 1, 2007. These essential service employees were threatened with disciplinary action by the then Public Service and Administration Minister Geraldine Fraser-Moleketi (Shilton: 2007; Bhe 2009: 15,16).

Essential services employees are not left without any recourse in the law, as regards their employment conditions. When there is a dispute, essential services employees must refer this to conciliation at the relevant bargaining council or commission, or if this fails, to arbitration (LRA, section 74). The Public Service Co-ordinating Bargaining Council (PSCBC), and under its umbrella the Public Health and Welfare Sectoral Bargaining Council (PHWSBC), is the relevant council to which a dispute should be referred when essential service employees have disputes (rather than the Commission for Conciliation, Mediation and Arbitration (CCMA)). This body then negotiates with government on labour issues. If the arbitration award has financial

implications for the state, it only becomes binding 14 days after the award. If Parliament rejects the award within 14 days, the dispute is referred back to the Commission for further conciliation and, if necessary, another arbitration, according to section 74(6) of the LRA.

Conciliation is the process whereby a trade union or an employer may ask the Ministry of Labour (in the case of essential services employees, the PSCBC rather than the CCMA) for help in resolving their differences so that they can reach a collective agreement. Either the employees represented by their trade union or the employer may apply, but when the state is the employer there may not be the will to act, as has been seen in the case of negotiating minimum service agreements (Roskam 2009: 5). Arbitration refers to the process whereby an arbiter or arbitration board makes a judgement in any particular case that is binding on the relevant parties. As stated, an exception applies in the case where a judgement has financial implications for the state.

1.6 The Essential Services Committee (ESC)

The Minister of Labour has the duty to establish an essential services committee, together with the National Economic Development and Labour Council (NEDLAC) and The Minister for Public Service and Administration. It has been determined that the chairperson is to be one of the committee members, all of whom need to have experience and knowledge of labour law and labour relations (LRA, section 70 (1)). The ESC's function is to determine whether any service is partially or wholly an essential service (LRA, section 70 (2)). The ESC serves also to both facilitate and ratify minimum service agreements (LRA, section 72).

1.7 The South African Medical Association as Trade Union

The South African Medical Association (SAMA) is a professional association for medical practitioners, registered as a Section 21 (non-profit) company that acts as a trade union for public sector doctors. The membership in 2009 was 6000 of the 14000 doctors in South Africa's public health service (Bateman 2009: 494). SAMA is affiliated to the federation of trade unions named the Congress of South African Trade Unions (COSATU). SAMA and the nurses' union known as the Democratic Nursing Organisation of South Africa (DENOSA), together have representation on the bargaining council, that is the PSCBC and the PHWSBC (SAMA: 2011; Bateman 2009: 492). The reason for their combined representation is that SAMA has fewer than the required number of members needed (50 000) for a trade union to negotiate on behalf of public sector members on the PSCBC. The result thereof is that being merely part of a larger group of employees, SAMA's influence in the PSCBC is diluted.

During negotiations in the PSCBC in 2007 it was agreed that a process would be started for the implementation of a minimum service agreement. The process was begun but no final agreement has yet been reached (Roskam 2009:58; PSCBC: 2011).³ Concerning wages for doctors, SAMA issued a statement (2011) that the 2011-2012 public service wage negotiations had been settled by the parties in the PSCBC at an increase of 6.8% retrospective from May 1st 2011. This statement is confirmed by the PSCBC resolution 2 of 2011. Thus doctors are subject to the same

³ The PSCBC resolution 2 of 2011 contains the following in relation to minimum service agreement:
"3.4.1 Parties agree that engagement on Minimum Services be elevated to party principals.
3.4.2 The outcome of the engagement referred to in clause 3.4.1 above, will be tabled for consideration at the PSCBC, and implemented with effect from 01 April 2012."

agreement as all other public service employees, as they are represented together with the nurses' union DENOSA in the PSCBC.

1.8 Minimum Service Agreement

Once there is collective agreement necessary for a union to establish a minimum service agreement within the essential services, this must be ratified by the Essential Services Committee (ESC). This follows according to section 72 of the LRA that states,

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 an essential service in respect of the employer and its employees; and*
- (b) the provisions of section 74 do not apply.⁴*

Thus, because of this latter condition, there is confusion as to who (all essential services employees, those who now fall outside the minimum services group and thus regain the right to strike, or only the employees in the group regarded as providing the minimum services) loses the provision in section 74 of conciliation and arbitration in lieu of the right to strike (ibid. 2009:21).⁵

There are a number of possible reasons for the lack of minimum service agreements, according to Roskam (2009: 58). His findings, firstly, were that there was a general lack of comprehension, affecting all concerned (including the PSCBC), as to the

⁴ This is a reference to the procedure that may be followed by essential services workers in the event of a dispute.

⁵ It may well eventuate that public service doctors would be in a better position by not having a minimum service agreement (as most would likely be included within this minimum service group). This would perhaps not be the case for all health care workers.

content of and processes involved in concluding a minimum service agreement. They received no assistance from the ESC in this regard. Secondly employers feared that violation of a minimum services agreement by employees would not result in effective disciplinary action (ibid 2009: 59). After the 2007 strike, letters of dismissal that had been issued were withdrawn (Bhe 2009; 42), so this may be a legitimate concern. Thus the employer might not be sufficiently motivated to reach a collective agreement once there is a designated essential service, even though this would go against the purpose of the Labour Relations Act and the International Labour Organisation. In such a case the union is powerless to proceed. Thirdly, the confusion regarding the interpretation of section 74 with respect to section 72(b) may cause reluctance by employees to reach a minimum service agreement. If too many employees fall within this group, their fear is that they may lose not only the right to strike but also that of conciliation and arbitration.

A further issue is that of the composition and powers of the Essential Services Committee itself. It has been recommended that the present composition of the ESC (three part-time members with no dedicated administrative assistance) be extended to nine or ten suitably qualified individuals with two or three of them on a full-time basis (Roskam 2009: 74). This would be justified by the necessity of having different persons involved in the facilitation of minimum service agreements from those who would be party to ratifying them.

In the public health service in South Africa there is already a bare minimum of doctors available at any time (Sidley 2004: 190). This may not be so for other employees in healthcare institutions, so the challenge is for the relevant trade union to

determine at an individual institutional level exactly what the minimum staff requirement actually should be. This requires the support of management at the institutions, so that the trade union(s) and the PSCBC may achieve success. In turn the ESC is enabled to do its job of determining the scope of essential services and protecting the public. This schema should aim to prevent both long-term and short-term harm to patients requiring urgent treatment, in the event of an unprotected strike. The fear is that such a strike might recur. If a minimum service agreement has been established, there should be less likelihood that patients would be left unattended.

Contemplating a minimum service agreement for doctors within an essential service such as health care may appear ludicrous, considering the existing shortage in South Africa. However, the importance of going through this process would be, firstly, to comply with International Labour Organization requirements ratified by the Republic of South Africa, and secondly, to apply an open and fair procedure, so that essential service workers will not ignore the law prohibiting them from taking part in strike action. Health professionals should ideally perceive that they have “ownership” of the decisions taken. The employer, in this case the State’s role is crucial. There has been a recommendation that negotiations take place before the budget is determined as Parliament is the final arbiter in financial matters (Bhe 2009: 54). However, as mentioned, a lack of integrity was demonstrated, on the part of the employer, even when agreement had been reached and promises made (de Villiers 2009: 201).⁶

The catalyst for further strike action by doctors, begun in April 2009, was neglect on the part of the employer to implement the so-called “Occupation Specific

⁶ This reference is to the so-called Occupation Specific Dispensation (OSD) that was not implemented until after the initiation of strike action by doctors in 2009.

Dispensation” (OSD) promised in 2007 and due in 2008 (ibid. 2009: 201). Doctors went on strike to demand a 50% pay increase, in line with SAMA recommendations. These recommendations were based on research done by an independent organization (M&G, 2009). Government offered approximately a 7% increase according to SAMA calculations (Bateman 2009:492).⁷

1.9 Concluding Remarks

It is the State that has the obligation to provide adequate health services. This it does, within the limited budget made available. Human and other resources are stretched until they can stretch no more. At this point events like strike action, illness, resignation from the public service and emigration occur, while some doctors continue with immense frustration at not being afforded the opportunity to perform their duty at optimal capacity.

The State has bound itself to International Law agreements that include the right of workers to strike. If the definition of essential services is too widely drawn this becomes a reason for employee dissatisfaction, so the scope of essential services must be carefully justified. The various organs empowered by the State to resolve employer/employee disputes need to be supported and educated so that they may gain the capacity to perform their function. This applies to doctors also. The present situation does not live up to the aims of the Labour Relations Act, namely “to achieve a quick, effective and inexpensive resolution of disputes ... reduced level of industrial unrest ... and minimal need for costly legal advice” (Department of Labour: 2002).

⁷“ Doctors’ demands are out of touch with the global reality of a recession, and unaffordable”, was the state’s response.

South African public service doctors clearly have no right to go on strike. The mechanisms in place for them to negotiate a fair deal are not effective. There has been reluctance of the parties, the employer and employee, to go through the process of determining a minimum service agreement. From the employee's perspective this may be a result of uncertainty as to the position of those excluded from 'minimum services' (within the 'essential service') if such agreement were to be reached. From the employer's perspective, the employer is not motivated to seek a minimum service agreement because it may be more favourable if no one has the right to strike.

In the past, the health institutions, The Health Professions Council of South Africa (HPCSA: 2009) and the universities have condemned strike action by doctors (WITS UNIVERSITY: 2009). These bodies might be persuaded to play a constructive role in assisting the combined doctors' and nurses' unions, together with the ESC, to determine exactly what a minimum service should consist of. They might also assist the now effectively voiceless medical practitioners to become more directly instrumental in determining their conditions of service. We have seen that fewer than half of the public service doctors are members of SAMA. More doctors should be encouraged to peacefully state their concerns and then a fair deal might be achieved without resorting to strike action.

Chapter 2 Strikes and Medical Practice

2.1 Introduction

As identified in the previous chapter, there are important legal issues that influence the parameters of collective bargaining available for doctors and other healthcare professionals. Every time doctors go on strike, there is conflict not only between strikers and their managements, but also between the ethics of striking or not doing so (Jesani, 1998). Now I will turn to some issues affecting the practice of medicine that are important for doctors to consider if contemplating strike action.

2.2 Oaths, Codes and Declarations

In South Africa and in many other countries, swearing an oath, accepting a code or publicly stating a declaration, form part of the ceremony of medical graduation. The ancient Greek *Hippocratic Oath* was the first to express the unique duties a doctor has to his or her patient. The original Oath includes the promise,

*I swear by Apollo Physician and Asclepius and ...all the gods and goddesses
... to hold him who has taught me this art as equal to my parents and to live
my life in partnership with him (Edelstein, 1943).⁸*

Ogunbanjo and Knapp van Bogaert (2009: 30,31) argue against a normative role, in this day and age, for the culture-bound and paternalistic Hippocratic oath, as it stands. Loefer (2002: 1463) likewise believes that this oath is not realistic in modern society; that the traditional notion of medical practice differs from a modern view, mainly in its focus on the individual doctor-patient relationship rather than on wider societal

⁸ Translated from the Greek

issues. The widely used, more modern version by Louis Lasagna (1964) excludes reference to any deity and may be more acceptable in modern secular societies.

Codes articulate a set of principles, rules or expectations of a particular profession, such as contained within the World Medical Association's International Code of Medical Ethics (WMA), here partially quoted,

A physician shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity. A physician shall always bear in mind the obligation to respect human life. A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her (WMA: 2006).

Declarations are the most commonly used form of commitment to medical service and may contain elements of the profession's codes of conduct. One of these is that of the World Medical Association (WMA). The 'Physician's Oath' of the Declaration of Geneva ([1948] 1983) exhorts a doctor to,

... Consecrate his life to the service of humanity; to practice his profession with dignity and in good conscience; to be impartial with regard to class, race and religion; to make the health of the patient his first consideration; to maintain utmost respect for human life from its beginning; and not to use his medical knowledge contrary to the laws of humanity ...

Another such declaration is publicly stated during the Health Professions' graduation ceremonies at the University of the Witwatersrand (University of the Witwatersrand: 2011).

As a result of these codes, oaths and declarations society expects that doctors should be readily accessible and not cause any harm. More than other professions, when doctors go on strike, the consequent risk to the life and health of many people evokes an intense emotional response (Naik 1996: 46). Understandably, thus, the spectre of doctors on strike causes great indignation in the mind of the public.

As we see, these oaths, codes and declarations indicate a special relationship between doctor and patient, with doctors called upon to maintain and increase the body of medical knowledge, using this selflessly in the interests of the individual patient, as well as to society generally (Boyton 2008). The expectation is competence together with compassion. Such oaths and declarations emerged from the commonly accepted morality at the time, and, in turn, have determined the moral and ethical basis of professional medical practice (Cruess et al 2000: 1). In swearing or affirming such, a doctor publicly declares his or her dedication to work for the good of humanity. Within this moral base are a number of attributes expected of the doctor in the traditional doctor-patient relationship.

2.3 Medical Professionalism and the Doctor-Patient Relationship

In his article, Stuart (2010: 5) tells us “professionals” are members of a profession that is defined as,

... a vocation founded upon specialized educational training, the purpose of which is to supply disinterested counsel and service to others, for a direct and definite compensation, wholly apart from expectation of other business gain.

Stuart (ibid) also identifies particular features of professionalism that are ideally to be included in practising as a medical professional. Related to the ‘doctor-patient relationship’, the particular features he lists are: autonomous practice, knowledge,

competency, selfless service, compassion, non-abandonment, fidelity, and trustworthiness.

These elements are also included in Calman's (1994:1140) view of the medical profession,

- (a) a vocation or calling that implies service to others;*
- (b) has a distinctive knowledge base which is kept up to date;*
- (c) determines its own standards and sets its own examinations;*
- (d) has a special relationship with those whom it serves - patients, clients;*
- (e) has particular ethical standards – the ethical base;*
- (f) is self-regulating and is accountable to patients and to the profession.*

A relevant question, then, is whether these features of professionalism would prohibit strike action by doctors in the South African public service. A short discussion of some of them follows.

2.3.1 Autonomous practice

Modern professional practice originated in Western society in the mid 19th century, with medical professionals granted 'self-regulation'. This privilege was bestowed in the expectation that service would be moral, unselfish and in the public's interest (Cruess et al 2000: 2). This, we see, is affirmed in the World Medical Association's International Code of Medical Ethics (2006). Such 'autonomous' medical practice has inevitably undergone change as a result of wide-ranging societal shifts and technical advances (Wolfe 1979: 431). The state and large medical corporations have progressively encroached on the regulation of medical practice, so that, in the sense of

medical professionals' regulation of their own profession, there is vastly reduced autonomy.⁹

One of the consequences of doctors working as employees in the state healthcare system is that they cannot directly determine their own fees, requiring assistance to negotiate salary structures. Thus in South Africa the medical association has taken on the expanded role of trade union in addition to the one of traditional professional association (SAMA: 2011). Such unionization carries with it the seeds of forceful confrontation for, generally, one of the recognized trade union bargaining tools is collective action with the threat of total strikes (Cruess & Cruess 2011: 549).

Cruess and Cruess argue that unionization and professionalism could be compatible (2011: 550). To achieve this, they assert, medical professionals would need to become actively engaged in determining their own conditions of service, creating (or effectively using) avenues to exert their influence; remembering that strike action is not congruent with the purpose of the medical profession. Daniels (1985: 128, 129) agrees that unionisation and professionalism may not be incompatible. His view is that the public interest is not necessarily served by the autonomy traditionally granted to members of the medical profession, and that unions also need not be narrowly focused on salary negotiations. In South Africa SAMA does in fact address the broader concerns of doctors, not merely salary issues. If harmony between

⁹ To illustrate this, the Health Professions Council of South Africa (HPCSA) now consists of a maximum of sixteen members designated by the various health professional boards, whereas the Minister of Health, the Minister of Education, the Minister of Defence and the South African University Vice-Chancellors' Association together appoint another fifteen members, nine of them being members of the public who are not registered as medical professionals (Health Professions Amendment Act 29 of 2007). According to this legislation just over half the members are chosen by the health professions, with the theoretical possibility that there might be only one doctor representative on the HPCSA.

unionisation and professionalism were achieved, there might be a sense that, to some extent, professional autonomy had been reclaimed.

In the sense that the term 'autonomous practice' is applied to the individual doctor-patient relationship, doctors can choose to practice according to the professional standards elaborated on earlier. Public service doctors in South Africa, however, tend to have high numbers of patients, randomly allocated, resulting in less opportunity to establish a doctor-patient relationship. On occasion services have been cancelled (Sidley: 2004), for there were too few medical professionals available to maintain these services. Even when treatment is technically adequate, care may be compromised, with resultant deteriorating relationships that have left doctors open to physical abuse by patients. In India, such physical abuse of doctors by patients has been a factor leading to strike action by junior doctors (Thomas: 2006).

The high cost of insurance against medical malpractice has been one reason for strike action by doctors in the United States of America (Fiester 2004: W12-W16). Dhai and McQuoid-Mason (2008: 2) consider litigation to be a means of keeping doctors accountable, in order to promote social justice. However, such litigation has led to doctors avoiding certain specialties and may even deter them from entering the profession at all (Pepper & Slabbert 2011: 32, 33). High insurance cost and the threat of litigation has resulted in the practise of 'defensive' medicine that has increased medical costs. Such a 'defensive' approach to medical practice is effectively a curb on medical practitioner autonomy and is an obstacle to good doctor-patient

relationships (ibid). This applies also in the public service, even though the state indemnifies doctors working in its hospitals in South Africa (ibid: 29).¹⁰

Relative to the doctor-patient relationship, Norman Daniels (1985: 129-135) is of the opinion that public health policies may better promote fair distribution of resources across society, than would be the case when doctors autonomously take decisions in their individual doctor-patient relationships. He is not convinced that the traditional doctor-patient relationship is important enough to justify the extent of autonomy that doctors were accustomed to. In stating such, he minimizes the value of the relationship of trust between doctor and patient as it relates to the healing process, being more focused on providing societal access to healthcare. He also does not explore the link between weak doctor-patient relationships and strike action, especially by junior doctors. His view is that strikes by doctors might very rarely be justifiable, but only if provision were made for individuals requiring urgent medical treatment (Daniels 1978: 28, 29).

We notice, thus, a weakening of the doctor-patient relationship, pivotal in autonomous practice, that has seen a shift from the one extreme, as Pellegrino (1979:43) believes the doctor-patient relationship to be,

Unique and hallowed

to the other, according to Baer (1997: 1269),

The withdrawal of service (striking) is not a matter of morality because it boils down to a straightforward contractual dispute between doctor and paymaster ... it was a contract and the government was breaking the contract.

¹⁰ Mtetwa v Minister of Health 1989 (3) SA 600 (D); State Liability Act 20 of 1957

According to the latter view, the doctor's "contract" would now be with the state (society) rather than the individual patient. Thus, for doctors in busy public service hospitals detached from the ability to form a "healing relationship" with their patients (Pellegrino 2001: 563), strike action may appear to be a legitimate means of expressing their dissatisfaction. Sachdev (1986: 53) agrees that strikes may more easily be morally justified in an environment of socialized medicine where the employer does not meet commitments, where litigation is common practice and where a technical rather than a caring doctor-patient relationship is emphasized.

Professional autonomy in the practice of medicine, being truly self-regulated, may no longer be possible. Also, generally it is true that a doctor in private practice has a greater opportunity to practice autonomously compared with public service doctors. Such lack of professional autonomy was not a specifically stated issue in the recent doctors' strikes in South Africa. However, it may have indirectly contributed to the decision to strike. One of the reasons why this could be so is its effect on the doctor-patient relationship. When this relationship suffers, when doctor-patient relationships are impersonal, it may be easier to justify strike action.

2.3.2 Compassion

"His selfless work for the 'Ikamva Labantu' project has won Dr. Keith Wimble a top nomination for the International Grahame Maher World of Difference Award. Such dedication ... exemplifies the selflessness that the medical profession expects from doctors, and celebrates the values of our noble profession," contains a statement issued by SAMA (2011). Susan Black received the 2007 Humanitarian Award for her compassionate and selfless work at a home for HIV infected persons at Nkosi's

Haven in Johannesburg (American Academy of Family Physicians (AAFP): 2007).

Another story of sacrificial, compassionate care for a rural community at the Charles Johnson Memorial Hospital, included the fact that many nurses worked there despite being paid twenty-five percent less than at State hospitals (Cameron, 2010).

There are many, many such tales of selfless, compassionate care by healthcare professionals in South Africa and elsewhere. These are stories of sacrificial service to needy people, consistent with the values and beliefs held. They are consistent also with placing priority on 'healing' relationships and the good for society. Such action is, further, in line with autonomous practice. The individual practitioner or group of practitioners, with the same motivation for action and the same firmly held values, had the autonomy to practice according to their beliefs.

Beneficent action is of course not ruled out in state hospital practice (Richter & Knapp van Bogaert 2008: 9).¹¹ However, healthcare professionals do not necessarily seek employment in state hospitals for such reasons, as they might have been more likely to do in non-governmental organizations of former years. Under such earlier conditions there would have been greater opportunity for individual practitioners to determine, within resource constraints, their own standards of practice. This is not so much the case in our public hospitals (ibid) neither can the employer legally require that employees act sacrificially, merely that the employment contract is adhered to. Clearly, a total strike is incongruent with compassionate care.

¹¹Dr. Colin Pfaff's initiative (2007) in securing independent funding for treatment (according with WHO standards) of pregnant women with HIV infection was not well received by South African health authorities.

2.3.3 Trustworthiness

The distinctive properties of the doctor-patient relationship make strike action by doctors particularly problematic. This is because patients do not seek medical attention when they feel well.¹² A doctor-patient relationship assumes the fact that medicine is a deliberately chosen profession, whereas a patient is a dependent, vulnerable human being who did not choose to be ill (Jotterand 2001: 6). The key element in a doctor-patient relationship is trust. Without trust no healing doctor-patient relationship can exist (Pellegrino 2001: 573). Fidelity to one's patient is a duty and an expectation, so a doctor has a duty to keep as sacred the trust a patient gives to him or her.¹³ Medical knowledge should be non-proprietary and the sharing of it with a patient, in an understandable way, is a duty of the doctor to his patient.

Concerning trustworthiness and doctors engaging in strike action, doctors may lose the trust of patients (Brecher 1986: 414). It is true that society expects doctors to 'always be there' for a patient, for example, when a baby's head is stuck in the pelvis, if an appendix ruptures or an innocent bystander is shot in the chest. As Ogunbanjo and Knapp van Bogaert (2009: 307) put it, "*In social myth or in reality, a doctor is 'there' in the absoluteness of death*". For such reasons, a total strike appears as a betrayal of patients' trust and paradoxically, is also why doctors may be exploited. It was traditionally inconceivable that a doctor would abandon a patient in need. Yet, when resources are stretched or mismanaged or when the exploits of those engaged in strike action may present a threat to their lives, holding doctors to professional values and virtues may in fact represent exploitation (Boyton: 2008; Zaborowski: 2000).

¹² This excludes routine medical check-ups, or visits for prevention of, for instance, influenza, malaria or other travel-related diseases.

¹³ In spite of all the negative and sensationalist media that exists concerning 'bad' doctors, a BBC poll taken in 2006 indicated that doctors ranked number one in the 'most trustworthy' category – at least in the United Kingdom (BBC NEWS: 2006).

2.4 Social responsibility

A doctor's societal duty is seen by some to encompass tending to all patients at all times. Sachdev (1986: 53) disputes this, as does Laplume (Baer 1997: 1269).

However, Laplume (ibid 1997: 1269) speaks from Canada where the strike was a controlled event with maintenance of essential services. Laplume goes on to say that he believes doctors would never let down patients in genuine need. Thus his expectation of doctors differs from his opinion that the doctor's duty is not to the whole of society. This is confirmed by his further statement, "*...we need not be unduly concerned about physicians discharging an ethical responsibility not only to individual patients but also to the greater society in times of need*".

The experience in South Africa, in relation to the broader community of healthcare workers, has been different (Mawere 2010: 11,12; Defenceweb: 2010). Crowd behaviour has been the subject of ongoing research by sociologists and psychologists. Early theories regarded groups engaged in political demonstrations as potentially violent mobs that ought to be controlled with increasing levels of force. It was later accepted that forceful action by police might be the *cause* of such unruly mob behaviour (Schweingruber 2000: 372).

In South Africa, evidence provided at the trial of five men involved in a strike by employees of the South African transport Services (who had participated in killing four non-striking workers) proved mitigating circumstances for four of them (State v. Matshili and Others 1991 (3) SA 264 (A)). These men avoided the death penalty on the basis that relevant psychological factors, in this specific social situation, had led to

diminished responsibility.¹⁴ More recently literature aimed at understanding the actions of people at mass gatherings, concluded that there were two major common factors that led to potentially problematic behaviour, namely (a) a so-called 'seed' and (b) an 'in' and an 'out' group.¹⁵ When such conditions existed, additional factors such as alcohol consumption, rowdiness and signs of violence would predict more problems (Zeitz et al. 2007: 32, 36). There is thus no guarantee that an initiated strike can be controlled. Importantly, when collective action is anticipated, these predictors may be used to minimize bad consequences.

At my own institution in 2010, there was intimidation of staff and destruction of property. This is affirmed by a doctor (Mail and Guardian: 2010), who made the point that at this hospital, at the time, almost all strikers were non-clinical staff working in the healthcare sector. Far from joining in the strike, most health care providers continued to care for their patients at great risk to their own personal safety.

2.5 Factors leading to strike action in South Africa

Factors influencing the decision to strike are not only self-regarding. I will consider several of these, including salary-related factors, for security of income may allow employees to focus on patient care. The immediate issue at hand during talks in mid 2009 and 2010 was the delay in implementing salary scales according to the

¹⁴ Such relevant psychological factors include 'deindividuation' (due to crowding, singing and dancing where the individual takes on the identity of the group rather than focusing on individual responsibility), group polarization (where extreme mob decisions are made), conformity with group norms, extreme frustration and being swayed by the external pressures of the group rather than by one's own reflection and motivation (Colman 1991: 1072- 1075).

¹⁵ There needed to be a small group of individuals within the crowd that set about to influence action that the crowd was willing to participate in, a so-called "seed". Secondly, there was a change in normal patterns of behaviour in a crowd with a common identity, in response to this "seed". This might lead to "in" and "out" groups, where the crowd and those identifying with it would be the "in" group and police, or in the event of a strike, those who refused to participate in strike action, might be the "out" group. The "in" group might thus enlarge as others join in, leading to a sense of empowerment.

‘Occupation Specific Dispensation’ (OSD) agreed on in 2007 and due by mid-2008. It remains true that when agreement was reached on that issue, the strike was halted (de Villiers 2009: 201). Thus the major focus of strike action was self-interested.

The issue of staff shortages led to a demand to increase employee numbers and to make available the ‘frozen posts’ so that more doctors could be employed.¹⁶ Lack of and mal-functioning medical equipment (Bailey 2011: 2) and medicine shortages, such as the absence of anti-retroviral medication in Bloemfontein (Thom, 2009), were also issues to be addressed. Long working hours, not a problem specific to South Africa needed to be shortened in the interests of patient safety, as well as for doctors’ health and optimal performance (Eaton 2006: 772). Unsafe working conditions are a cause for much concern after the rape of a medical student at a large teaching hospital (Mail and Guardian 2007), the death of a doctor stabbed by a patient (SAMA: 2011), and the burgling of a doctor’s home, twice, on hospital property in Johannesburg. Doctors, as well as other employees, are entitled to a safe and secure working environment, according to the Occupational Health and Safety Act 85 of 1993.

The self-injury of medical personnel when working with needles, particularly hollow-core injection needles (Karstaedt & Pantanowitz 2001: 57-61; O’Connor et al. 2010) is a major cause for concern.¹⁷ One second-year intern at my institution, in 2010, claimed to have had six such needle-stick injuries during her first year of internship.¹⁸ Prophylaxis against HIV transmission may cause side effects severe enough to

¹⁶ Health Minister Dr.A. Motsoaledi on 11 October 2011 announced the ‘Human resource Strategy for Health’ that includes the advertising of posts for nationwide ‘district teams’ of doctors (Department of Health 2011).

¹⁷ To my knowledge this is the only reported study relating to doctors with needle-stick injuries in South Africa.

¹⁸ The particularly high risk of hepatitis infection also, is a danger that tends to be overshadowed by the focus on HIV transmission.

warrant sick leave (Medical Protection Society: 2011). In tandem with the high burden of HIV infection, tuberculosis is rife in South Africa and doctors are not immune. A recent publication (O'Donnell, Jarand, Cagney et al. 2010: 516-522) reported the incidence of multi-drug resistant tuberculosis (MDR-TB) hospitalization in the province of Kwa-Zulu Natal as being in a ratio of 64.8/11.9 per 100,000 in healthcare workers compared with non-healthcare workers. The ratio of extremely drug resistant tuberculosis (XDR-TB) was 7.2/1.1 per 100,000 in health care workers over non-health care workers, in the period 2003 to 2008. Thus health care professionals are at high risk of contracting tuberculosis.

These are problems that make the task of the public service doctor in South Africa particularly onerous. It may be argued that difficulties should be expected. However, there is much that could be done to alleviate the problems, so that there might be a measure of contentment in a job well done. Specifically, there is a need for both physical and emotional support in the event of exposure to and affliction with the diseases mentioned (Medical Protection Society: 2011).

Sadly, the general perception is that there is a lack of concern regarding doctors' welfare on the part of the employer, so violating the right to dignity (Waters 2009; Bailey 2011: 2). This lack of respect, for doctors and patients alike, is the root cause of much dissatisfaction that, in turn, affects the doctor-patient relationship. Such malcontent is demonstrated by the fact that three thousand five hundred and fifty so-called 'certificates of good standing' were issued by the Health Professions Council of South Africa (HPCSA) during the preceding year (de Villiers 2009: 201). Thus

approximately ten percent of doctors registered to practice in South Africa either left or intended to leave the country – in one year!

The eventual effects of such an exodus are likely to be far more serious than those of a limited strike. Thus the concerns of the doctors need to be taken seriously by the state, for when the doctor-patient relationship is weakened, when doctors have the perception that they are underpaid – or not paid at all (SAMA: 2011), effectively voiceless and disrespected, a decision may be taken to strike. The patients, who are the victims of strike action, are then doubly harmed, being held to ransom in an already compromised healthcare system with death deemed to be the worst possible outcome (Sachdev 1986: 412). Doctors also suffer harm, yet if successful in strike-action their benefits may, arguably, be several (Siegel-Itzkowitch 2000: 1561).

2.6 Harms and potential Benefits

Although the victims, the patients affected by the strike action, are harmed, this may be negligible in comparison with the problems ensuing on an exodus of healthcare professionals from the South African public service (Bateman 2011: 700).¹⁹ Thus, if striking results in substantially improved conditions of employment and retention of doctors in the public service, on utilitarian grounds, such a course of action might plausibly be justified (Boyton: 2008).

The ultimate harm resultant on strike action in the public service is the avoidable death and unnecessary suffering of vulnerable, innocent patients, including babies,

¹⁹ The result of loss of healthcare professionals since 1998 is now, October 2011, being recognised.

children and their parents.²⁰ This is in addition to existing compromised social circumstances. Lesser harms to patients include a negative impact on health due to delays in treatment as well as waste of time and resources when traveling to clinics or hospitals only to find that no service is being offered. There is a negative impact on the public's perception of doctors as unselfish healers that harms individual doctor-patient relationships (Sachdev 1986: 412). Doctors themselves suffer, physically, from the violence that may accompany strike action and from the possible loss of jobs and remuneration. Emotional suffering may be the result of breaking ethical codes and seeing others harmed as a result. Tensions may result between striking and non-striking doctors that lead to deterioration of staff and student relationships at healthcare institutions (Cruess and Cruess 2011: 550).

There are, however, certain possible good outcomes of strike action. It may be that some unnecessary consultations are cancelled. Studies in Israel (Siegel-Itzkovich 2000: 1561) demonstrated decreased mortality during strikes, thought to be due to the performance of fewer surgical procedures. If these findings were due to cancellation of unnecessary surgery then there was a true positive outcome, not so, however, if the adverse occurrences were merely delayed.

In the event that the employer seriously considers all the legitimate grievances of striking healthcare employees there are many possible improvements to conditions of service that could be made. These include better management of existing resources, leading to improved conditions of service such as enhanced morale, decreased fatigue,

²⁰ With regard to the 'sanctity of life' argument Sachdev (1986: 413) and Brecher (1986: 41) assert that this criticism in relation to doctors' strike action is hypocritical, for the death of an individual is commonly treated as a relative evil in society. Examples given include war-related deaths, capital punishment and motor vehicle accidents. Loefer (2002: 1463) adds to this list, abortion and euthanasia.

improved supply and maintenance of equipment and thus a better service to patients. Increasing the health budget would allow better salaries, improved staff-patient ratio, less fatigue, retention of existing staff and the recruitment of new employees. Ultimately the aim is decreased immigration and increased numbers of medical students.²¹ Mutually respectful attitudes of employer and employee would reduce tension in the working environment. Such improved relations between doctors and their employer could be facilitated by more effective use of negotiation structures, so minimizing the perceived need to strike.

2.7 Concluding remarks

Dealing constructively with adverse conditions of service, is work that must be undertaken by the employer, employee and the professional associations and unions, in order for the broader South African public to flourish. Here the healthcare institutions might play a constructive role, as could the universities, particularly where joint appointment of doctors with the university and the hospital exists. Merely demanding one's rights will not get the job done, and abuse of positions of power, whether by government, doctors or union leaders, inevitably has destructive consequences. It is evident that there are many legitimate reasons for dissatisfaction. These reasons may account for strikes by public service doctors but they do not justify such action. Thus using patients as pawns in the negotiation process, even if possibly justifiable on utilitarian grounds, is morally prohibited from other ethical perspectives. Some ethical theories will now be considered.

²¹ The recently announced 'Human Resource Strategy for Health' includes the proposed provision of places at Medical Schools countrywide for increased numbers of medical students (Department of Health, 2011).

Chapter 3 Overview of Strike Action from Some Ethical Perspectives

3.1 Introduction

Kant tells us that the only action with moral worth is the one arising from the motive of duty, rather than inclination (Kant 1996: 389). For the doctor, dutiful action would be synonymous with practicing medicine according to the avowed oaths, codes and declarations discussed. One of the three versions of Kant's 'categorical imperative' is, "*Act in such a way that you always treat humanity whether in your own person or the person of any other, never simply as a means but always at the same time as an end*" (Kant 1990: 91). Thus using patients to achieve the doctors' ends would not be morally justifiable and strike action would be rejected, on Kantian grounds.

Theories of Justice have as their aim the provision of equal opportunity for individuals to live their lives optimally. A measure that will improve health, a 'special good' as it allows members of society to flourish, would tend to promote social justice (Daniels 1985: 17, 39- 58). Strikes may not be a justifiable means to this end.

Rawls (Casal 2010: 16) and Daniels (1978: 24-29) address the question of whether salary demands of relatively affluent doctors are reasonable in a society with much poverty. In relation to strike action by medical professionals, Daniels insists that the question to ask is not, as a priority, whether it is justifiable to participate in strike action, but whether the demands of doctors are just. Will these demands promote optimal healthcare equitably, especially under conditions of resource constraint? Winning gains at the bargaining table or as a consequence of strike action merely

demonstrates the power of the particular professional body or union, it does not promote justice if the demands are not fair, he argues.²²

The most plausible candidate for ethically justifying strike action by doctors is the principle of maximum utility, if one could demonstrate such. I will briefly consider whether one might, from this perspective, justify strike action by South African public service doctors. The major focus will, however, be on the Virtues, for situated here, I propose, is where we find the motivation, strength and the endurance required for moral action, particularly when viewed in the light of the self-effacing attitude morally required by the doctor as professional. Virtue theory may also be an appropriate context within which to consider and appreciate the value of a good doctor-patient relationship.

3.2 Utilitarianism

Utilitarian theory avers that that which results in the best overall consequences should be the over-riding motivation for any act. Originally this was stated in terms of happiness and pain, as in J.S. Mill's "Utilitarianism",

... actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure and the absence of pain; by unhappiness, pain and the privation of pleasure (Mill 1996: 299).

This ethical theory takes several forms, but two main principles (Sher 1996: 295) are:

²² Glick (1986: 43) likewise asserts that strikes do not guarantee justice, but reward the strong.

- (a) The principle of utility, which sees the right act as being the one producing the greatest amount of happiness (and absence of pain), satisfaction, or the greatest good for the greatest number, and*
- (b) Each individual's happiness is equally important, so there is impartiality when considering how to act.*

If the overall positive consequences of strike action by doctors could be shown to outweigh the negative ones, then the principle of utility would allow that such action is justifiable, even if some were to suffer as a consequence. The second principle requires strict impartiality, which is taken to mean that no one is favoured above another in the utilitarian calculation; it is the aggregate utility that matters. Thus the first principle is upheld. However, if this second principle were interpreted to mean that each individual's happiness is equally important, there could be a conflict between the first and second principles (Kymlicka 2002: 37).

The variant of Utilitarianism known as 'rule-utilitarianism' as distinct from 'act-utilitarianism', would consider that killing one individual for the good of many could not conform with a generally accepted set of rules that would lead to as much utility as any other set of rules (Brandt 1996: 328). Thus, for some branches of utilitarianism, killing one/some for the overall good may not be morally condoned. Rawls (1996: 352) argues that utilitarianism fails in that it extrapolates 'what is good for one' to 'what is good for all'. Though it is rational for an individual to attempt to maximize the sum of his own preferences, he concludes that it is not similarly rational for a society to attempt to maximize the sum of all individuals' preferences, for this results in some persons' interests being sacrificed in the process.

Considering the ethical dilemma of doctors on strike, it is impossible to calculate whether the eventual long-term positive outcomes will outweigh the negative ones. Some negative outcomes and some positive ones that could eventuate have been explored. The example of salary negotiations following the doctors' strike in 2007 is instructive. Strike action at the time was halted following the conclusion of a settlement that allowed for 'Occupation Specific' remuneration with a plan for career advancement (de Villiers 2009: 201). However this settlement was only implemented after further strikes in 2010. A look at salary negotiations concluded for 2011-2012 shows a reversion to a general public service salary increase of 6.8%, with no specific reference to career paths at all (PSCBC: 2011). Thus the ultimate benefits, might not, for the utilitarian, outweigh the sacrifices.

Against this is the possibility that doctors' strikes may have influenced the launching, by South Africa's Minister of Health Dr. Aaron Motsoaledi, of the 'Human Resource Strategy for Health', coinciding with the WHO's focus on 'Human Resource for Health' in Africa. It was announced that the University of the Witwatersrand (WITS) will be accepting forty additional medical students in their next intake, and that other universities are considering the same. Additional posts for doctors have also been advertised (DOH: 2011). The forty additional students at WITS' Faculty of Health Sciences will cost the country an additional eight million Rand, as negotiated with the Minister of Finance. This demonstrates that a degree of budgetary flexibility is indeed possible. Plausibly, strike action may have contributed to these positive actions.

In summary, if we view the demands of striking doctors as being in the overall interests of society, the principle of utility may allow that strike action is justifiable.

One might then accept the risk of adverse events. However, 'rule-utilitarianism' could be invoked to morally proscribe strike action. According to this variant of 'utilitarianism' it would not be in the interests of utility to accept a set of rules that allows deliberate harm to some individuals for a merely possible eventual benefit to others, unless minimum services were in place to prevent misfortune to patients. [A different set of rules (such as one that demands a process of negotiation between relevant parties with settlement of a dispute, within a stipulated time, with the aid of arbiters where necessary) could eventuate in better utility.] Thus, even from a utilitarian standpoint (i.e. rule utilitarianism) the actions of striking doctors may be viewed as morally wrong. I would suggest that even if strike action resulted, overall, in more good than bad consequences, a different *modus operandi*, that is, effective negotiation that rules out coercion from the outset, would result in even better consequences. This we have seen is the stated aim of the Labour Relations Act (Department of Labour: 2002). Doctors, healthcare institutions, universities and the public, need to engage with the State to advocate for effective implementation.

3.3 Virtue Ethics (Teleology)

An ethical theory ideally has as its purpose, not merely ethical reflection, but also the promotion of moral behaviour. There is no theory, however, that can implement such morally worthy action. This will always be dependent on individuals who are willing, not only to accept a particular notion of 'the good', but who are also sufficiently motivated to put those beliefs into practice. This is where virtue ethics finds its place. Virtue ethics may be regarded as teleological or non-teleological (Parry 2002: 239). In the sense in which it will here be discussed (in line with Aristotle (1996: 476, 477)) the achievement of the virtues by habitual action, though intrinsically good (non-

teleological), is also purposeful. The purpose is human health or 'flourishing', the Aristotelian 'eudaimonia' (teleological). This accords with the view of Oakley and Cocking (2001: 74-94) who regard a virtuous doctor as one who promotes and works to fulfill the purpose of the medical profession.

The focus of virtue ethics is on the character of the agent and not, as a priority, on the motivation for actions or the consequences of actions (Aristotle 1996: 478). How then is this strength of character, the motivation and ability to persevere despite obstacles, developed in an individual? Aristotle (1996: 476, 477) tells us that the virtuous person becomes so by a process of habituation; a long process resulting from disciplined practice, whereby a virtue becomes a state of character, allowing work to be done well. It is the virtues that enable persons to pursue their notion of the good. One can deduce from this that education and good habits formed early in life are of critical importance to a flourishing society. These habits may of course not be virtues, but so-called vices (ibid: 490). Thus there needs to be a foundation for good habitual action, a system of moral values, that for Aristotle is the achievement of human happiness and fulfillment, so-called 'eudaimonia'. Virtuous action is often relative to culture and time, as a look at Aristotle's list of virtues demonstrates (ibid: 489- 490).²³ He believes in the importance of attaining 'the mean'; so in the case of courage, this would be the mean between foolhardiness and cowardice (ibid: 478, 482- 484).

In South African society, where 'demanding one's rights' is a negotiating tool, the 'culture of entitlement' becomes internalized as part of the nation's value system and

²³ Martha Nussbaum (1996: 496- 515) argues that a closer look demonstrates that Aristotle's position is not a relativistic one (or not so relativistic as to justify discarding it), for his list of virtues is related to universal "spheres of human experience". There is much overlap of values in different cultures, she avers, and Aristotle is concerned with 'eudaimonia', which is the flourishing life or 'the good' for humans, generically.

may thus determine behaviour, such as strike action, even by doctors (and others who are relatively privileged). One might argue, in line with Aristotle, that strike action by doctors would be an extreme action, not a mean. Negotiation, or even petitions and picketing might be seen as the mean between the extremes of passive acceptance and strike action. It is, unfortunately, not always the abused, poor and uneducated, those who are in especial need of the protection afforded them by their constitutional rights, who are in a position to demand those rights.

When the already privileged use their rights to further enhance their position, at the expense of the impoverished, the virtue of selflessness is lost. Apart from the required virtues of fidelity, self-effacement, acquisition of knowledge and beneficent action, the virtuous doctor should set limits to treatment so as to avoid harm, thus demonstrating the virtue of non-maleficence, and discipline and understanding in applying the mean (Lasagna: 1964). Doctors may also be required to display the virtue of courage in pursuing just ends for the patient and society generally.

Consideration of the virtues within the context of a tradition, or as they relate to an individual's own life story, is the subject of discussion by MacIntyre (1996: 534-537). It matters how life is lived, as an integrated whole, displaying the virtues that have become internalized as part of one's disposition. Thus a doctor should demonstrate those virtues, with integrity, as wife, mother, friend, teacher, doctor and so on. The virtues are not restricted by time and place. In a good doctor-patient relationship, the doctor may assist a patient to reach autonomous decisions that are congruent with his life history and family tradition. MacIntyre's thought may also be applied to the hypothetical situation where a young doctor finds himself in a group (of

doctors, burdened by huge patient loads under difficult circumstances, physical exhaustion, and angry at only a minimal wage increase) that is proposing strike action to highlight their plight. In such a situation an ingrained disposition to balanced virtuous action, by even one member, could sway the group thinking against a decision to strike.²⁴

Dworkin too, expounds on the concept of living life with integrity, crucial when dealing with issues such as end-of-life decisions. As he states, "*We worry about the effect of his life's last stage on the character of his life as a whole, as we might worry about the effect of a play's last scene or a poem's last stanza on the entire creative work*" (Dworkin 1994: 199). Such considerations demonstrate the value of the doctor-patient relationship, a relationship that is harmed when strike action occurs and which is not possible under conditions of employment that do not allow for such relationships in the first instance.

When reflecting on the basis for virtuous action in the medical profession, the concept of 'professionalism' dependent on the codes, declarations and oaths previously considered may provide such norms.²⁵ Pellegrino and Thomasma (1996: 32- 39) consider the virtue of 'charity' as a basis for the doctor-patient encounter, thus seeking to emulate the lifestyle promoted by Jesus Christ. The Muslim organisation 'Gift of the Givers' unselfishly does the same in their global outreach to individuals in crisis conditions requiring medical care (Muslim Organisations in South Africa: 2012 & Gift of the Givers Foundation: 2011), as does the secular organization 'Medicins san Frontieres' (Medicins san Frontieres: 2009)

²⁴ It is of course also possible that he might be victimized as part of the "out-group", as seen earlier in relation to crowd behaviour (Zeitz et al. 2007: 34).

²⁵ This is debated (Ogunbanjo, Knapp van Bogaert 2009: 30, 31; Jotterand 2003: 5).

From a secular perspective Pellegrino (2001: 561) argues for an “internal morality” of medical practice arising out of the individual ‘doctor-patient’ relationship.²⁶ The reason that an entity such as ‘medical practice’ exists at all, he avers, is because universally, humans experience illness and seek healing. Other reasons for entering the medical profession, such as status in society, financial reward, academic recognition or political power are not internal to that practice, but externally determined, is Pellegrino’s assertion. In relation to what Pellegrino (2001: 563) refers to as a social construct or external determinant of medical practice, Oakley and Cocking (2001: 89) accept that something other than “the purpose of the medical profession focused on the good of the patient” could plausibly become the basis for medical practice. When that point is reached, ‘Medicine’ should possibly no longer be regarded as a ‘Profession’, is their contention.

Operating according to the ‘internal morality’ of medical practice demands attention to the needs of the individual patient *as a priority*. Thus the end of Medicine, avers Pellegrino (ibid: 566) is the ‘good of the patient’; that is centred on beneficent action in line with the oaths and codes of medicine previously outlined. Pellegrino emphasizes that the ‘good of the patient’ (ibid: 569) consists in:

- (a) *the medical good, or physical health of the individual,*
- (b) *the patient’s perception of the good (her perceived needs, in relation to her life story),*
- (c) *the good for humans (her needs in relation to society) and*
- (d) *the spiritual good of the patient.*

²⁶ Jotterand (2003: 6) is in agreement with this perspective.

Thus, again, it is apparent that to provide care that encompasses this total 'good', a superior doctor-patient relationship is of paramount importance, crucial in attending to that particular individual within the context of her life story.

This is demanding, particularly when including the patient's perception of the good for him/herself, and in relation to spiritual good. Once again we see that the doctor-patient relationship built on trust is vital, for this has particular value for the healing process and in motivating healthy behaviour (Pellegrino 1999: 253). Without this relationship of trust, a patient would be unlikely to have the confidence required to express intimate needs. More than that, the doctor would have insufficient knowledge of the patient to be able to perceive subtle nuances of physical change that might give clues as to unexpressed physical and emotional needs and preferences.

A look at Pellegrino's (2001: 569) features of 'the good' in medical practice, demonstrates a similarity to the World Health Organization's definition of health (WHO: 1948). According to Oakley and Cocking (2001: 74-94) a virtuous doctor might be seen as one who promotes and works to fulfill the purpose of the medical profession.²⁷ As this is a profession of critical importance for the health of individuals and their flourishing in society, its goals and ends are worthy of support, and so may legitimately be termed a 'profession', is their contention. The purpose of the medical profession could be defined as the achievement of health, "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (WHO: 1948). This goal is not achievable by an individual medical practitioner, including as it does, the social determinants of health.

²⁷ A profession rooted in an 'internal morality' of medical practice.

Though the WHO definition of health has not been amended since 1948 (WHO website: 2012), in 1996 the WHO published the 'Health Promotion Glossary' containing 69 definitions of 'core concepts' aimed at facilitating communication in the interests of global health promotion (Smith, Tang & Nutbeam 2006: 1). This was revised in 1998 (WHO: 1998). An even more demanding 2006 update, that presents 10 new terms to be included in the glossary, defines the term '*wellness*' (ibid. 2006: 5) as, "*The optimal state of health of individuals and groups. There are two focal concerns: the realization of the fullest potential of an individual **physically, psychologically, socially, spiritually and economically**, and the fulfillment of one's role expectations in the family, community, place of worship, workplace and other settings*".

The WHO (WHO website: 2012) also includes in its definition of 'Palliative care' a focus on the *spiritual* as well as *physical* and *psychosocial* aspects of the patients needs. Again thus, the extremely demanding goal of providing total healthcare is shown, a goal that is dependent on a good doctor-patient relationship. Interaction and co-operation with other healthcare and allied professionals is essential to promote such total health, for the individual and society.

From the perspective of the virtues in medical practice, it is inconceivable that even the idea of strike action, which might cause harm to patients, could be entertained. The primary goal in pursuing the practice of medicine is to promote health and cure disease, a goal that is achieved optimally for the individual within a good doctor-patient relationship. Disputes that may occur with regard to working conditions thus need to be resolved, resolutely and creatively, while avoiding harm.

3.4 Concluding remarks

A discussion of the virtues in relation to strike action must include the fact that there are legitimate limits to self-effacing action (Pellegrino 1996: 153). Strike action has been morally supported in a situation such as that described in Israel (Grosskopf et al. 1985: 70-71), in certain African states (Ghana News 2007; Oguntayo 2011; UNICEF 2010) and in India (Naik 1996: 47). In Israel doctors worked as much as 75 hours per week to earn the same as nurses. They started by cutting their services by one third, after arranging an alternative fee-for-service system for their patients. After several months and further service cuts, with finally 12 days of hunger strike by 12 doctors, the state eventually agreed to mandatory arbitration. In Ghana junior doctors suffered delays in salary payments and were eventually remunerated at a level less than that agreed upon. The strike by junior doctors in rural India began after 8 months of negotiation. They suffered working and living conditions as well as remuneration inferior to that of their colleagues in the central government teaching hospitals. Doctors in these examples worked under extremely difficult circumstances, with negotiation and collective action having been implemented without resultant just treatment of healthcare workers. The good of the patient ought always to be the first consideration of any doctor, but it is possible that there may come a point where doctors are abused, where justly earned minimal expectations are not met.

The Kantian claim is that it would be morally wrong for the doctor to treat even herself 'merely as a means' (Kant 1990: 91). How to set such limits to self-effacement, to achieve the correct balance is one of the tasks of a virtuous doctor (Pellegrino 1996: 153). From an Aristotelian perspective it is a matter of attaining the 'mean'. This is an ongoing, lifelong challenge. Under conditions such as those in

India, Africa and Israel mentioned above, when all negotiation has failed, strike action by doctors may be morally justifiable. Allowance ought always, however, to be made for acute emergencies. When such intolerable conditions exist, the state and health institutions may plausibly be held accountable for the unfavourable results of strike action, for such a state of affairs constitutes extreme exploitation; it is an injustice and an abuse (Naik 1996: 47).

Chapter 4 Conclusion

4.1 The present status

During negotiations in the Public Service Co-ordinating Bargaining Council (PSCBC) in 2007, it was agreed that a process would be started for the implementation of a minimum service agreement. The process has now begun, with an agreement expected in May 2012 (PSCBC: 2011).²⁸ At the end of the strikes in 2010 the 'Occupation Specific Dispensation' was implemented and both junior and very senior doctors gained substantially greater remuneration packages, leaving mid-level sector doctors dissatisfied (Bateman 2009: 690). Doctors' wages for the 2011-2012 period (SAMA: 2011) have seen an increase of 6.8% retrospective from May 1st 2011: this is confirmed by the PSCBC resolution 2 of 2011. These salary negotiations concluded for 2011-2012, however, demonstrate a general public servants' agreement with no specific reference to career paths at all (PSBC: 2011).

The Minister of Health in October 2011 launched the 'Human Resource Strategy for Health' (DOH: 2011). Accordingly forty additional places for medical students have been granted at the University of the Witwatersrand. Additional posts for doctors have also been advertised (DOH: 2011), demonstrating some leeway in budget allocation. Such initiatives may conceivably be attributable to past strike action.

²⁸ The PSCBC resolution 2 of 2011 contains the following in relation to minimum service agreement:
"3.4.1 Parties agree that engagement on Minimum Services be elevated to party principals.
3.4.2 The outcome of the engagement referred to in clause 3.4.1 above will be tabled for consideration at the PSCBC and implemented with effect from 01 April 2012."

4.2 The way forward

Doctors, as a group of employees, cannot plausibly be held solely responsible for improving conditions of service such that the chance of strike action is minimized, though each one is personally accountable for his actions, regardless of provocation. Doctors may of course become much more active in lobbying for greater powers in the negotiation process. Achieving a positive state of affairs, so that there would be no reason even to consider strike action, will undoubtedly require assistance, co-operation and expertise from other sources. There are several measures that may usefully be applied.

4.2.1 The Doctor-Patient Relationship

The relationship of healthcare professionals to patients, ideally 'their' patients, needs deliberation, for the quality of the doctor-patient relationship has relevance with regard to strike action. When doctors are expected to care for numerous individuals who they may only see once or very few times, their practice of medicine becomes impersonal, not so purposefully focused on the good for particular people. It may then be easier to justify going on strike, because those who are harmed through such action are unknown and 'faceless'.

Patients who see doctors not known to them participating in collective action, may view them as uncaring and self-seeking and thus not deserving of trust. They may not provide the doctor with information that could be crucial to their health. Such a negative view of doctors (who are in the main assumed by the public to be relatively privileged and affluent) may then be extended to doctors as a group, which, especially in the public service, would tend to harm the population as a whole. If, however, a

relationship of trust were to exist at the outset, patients might possibly be more sympathetic to a doctor's genuine predicament, maybe to the extent of supporting them in agitating for improved conditions of service (Cruess; Cruess 2011: 550).

A good individual doctor-patient relationship may be difficult to achieve in large urban institutions where specialists in training frequently rotate through several hospitals. An attempt to maintain a permanent core of medical professionals in an institution might be helpful in this regard, as might decentralization to smaller units. This requires that doctors should be attracted to, and retained in such posts for a reasonable period of time.

Providers of medical care in the public service in South Africa deal with heavy patient loads, often with uncertainty as to how their daily schedule will progress. There have been attempts to overcome these obstacles. Cellular telephone technology is being effectively used, in at least one urban hospital with which I am familiar, to reschedule appointments that need to be cancelled. A World Health Organisation (WHO) report stated that half the problems of compliance at a health facility could be attended to at the local facility, without additional funding. Implementing this suggestion at a North West Province hospital reduced pharmacy queues by sixty percent within a week, with similar results subsequently seen in other places (Bateman 2011: 296). More effective communication at outpatient clinics might cut waiting times there also, and allow better continuity of care with healthcare professionals.

The attitudes of healthcare professionals should be addressed in the interest of improved relationships (Bateman 2011: 294). Doctors and other health care providers

need to pay careful attention to, first of all, their demeanour. It is easy when there is a long queue of patients waiting, to become impatient, not to pay careful attention to the individual at hand. Time constraints may likewise be an impediment to truly informed consent, leaving patients with a sense that they may have been coerced. Language barriers and cultural differences may play a significant role in misinterpretations, misunderstandings and difficulty in gathering much needed information. In a country like South Africa that has eleven official languages, the need for interpreters is a major obstacle to the requirements of privacy and confidentiality (Oosthuizen, Verschoor 2008: 37). This is especially true where very often the interpreter is a cleaner who has been summoned, maybe against her wishes, to perform this function (Schlemmer, Mash 2006: 1085). In such a case there is great potential for misunderstanding. Thus, clearly, what may have been regarded as bad attitudes could be remedied by attention to practical difficulties and improvement of communication skills: so also improving the doctor-patient relationship.

4.2.2 Incentives

The South African Medical Association (SAMA) proposal of a fifty percent increase in doctors' wages (Bateman 2009: 490; SAMA in M&G: 2009) is based on independently performed research in line with the norm for individuals with that level of skills in South African society. It takes into account the earning potential of other professionals in the public service. This does not necessarily make it a fair wage in the light of socio-economic circumstances in South Africa generally.

Rawls (1996: 456) states, in what is known as the 'difference principle', that "*Social and economic inequalities, for example, inequalities in wealth and authority, are just*

only if they result in compensating benefits for everyone, and in particular for the least advantaged members of society". Thus it is not unjust for some to enjoy greater benefits if the lot of the less fortunate is thereby improved. On this basis an incentive such as a salary increase for doctors in South Africa could be tolerated, despite the high levels of unemployment. Such a measure might be deemed acceptable, for the doctors would benefit, and better health for the population would be to the advantage of the worst-off, in turn possibly increasing productivity and raising the living standards for all. Daniels (1978: 29) however is very sceptical of the idea that better remuneration for doctors would result in better medical care for patients. He states that the reverse might be true, for the profession and the public would benefit more by attracting doctors who embarked upon their profession primarily with the intent of healing and prevention of disease in mind, rather than for monetary gain. There needs to be a calculation as to what constitutes a fair wage in the light of South African socio-economic circumstances. This does not apply only to doctors in the public service, but to all healthcare providers in the country, and, indeed, to other professions also.

South African public service doctors' demands are both self-interested and in the interests of improved patient care. There are many South Africans who are in need of better employment conditions and opportunities. However, there is a need to look at the situation as it is: good healthcare is essential for a flourishing community, there is a shortage of doctors particularly in the rural regions of South Africa, and doctors have not been attracted to these positions. This could change, particularly the aspect of job satisfaction, if the conditions were more conducive. Inducements might include a substantial rural allowance, but of equal importance would be a good

standard of accommodation, recreational and child-care facilities, and improved hospital infrastructure and management. A good support system that includes the availability of web-based resources, adequate referral avenues and accessible senior doctors, is crucial. Allowances for career progression and extended leave would also be favourably received (Kotzee & Couper 2006: 1- 10).

Thus, in the South African situation, we may plausibly require Rawls' concession regarding incentives. If such incentives are to be regarded as concessions, the implication is that this is not something to be claimed as a right. It is a concession that may be requested and worked for without resorting to strike action, in order to be to the advantage of all our people. Such a course of action, that precludes holding individuals to ransom, is a likelier path to a healthy society.

Concerning the intention of doctors to re-locate to other countries, one might extend the concern for societal good in South Africa to the need for a global improvement in healthcare. There is a global need to provide incentives for good healthcare in unattractive regions. One such initiative originating in the United States of America (USA) has committed itself to funding the training of 140,000 health care workers on the African continent. The University of KwaZulu-Natal is the recipient of some of these funds (Associated Press: 2009). Sadly, however, incentives for healthcare have, in the main, been used to tempt health care professionals to countries that fare the best (Krotz: 2008).

4.2.3 Application of the Law

As regards the law, clarity should be sought with regard to interpretation of the LRA as it affects 'minimum service agreement', for reaching such an agreement (or justifying not reaching such an agreement) is believed to be critical to employee satisfaction (Roskam 2009: 5). The department of health together with individual institutions must determine their actual ideal staff requirement, so that it may be known whether or not it is even feasible to apply for a minimum service agreement in the health services, or whether the essential service as presently determined, actually, in fact, is the minimum service. The job of the Essential Services Committee is to determine the composition of an essential service, and then to ratify a minimum service agreement when approached to do that. This it cannot do without adequate numbers of staff and without expert advice. The process of determining this minimum service should be seen by all interested parties to be fair, and the outcome just, in order to prevent unprotected strike action in the future.

If one holds the belief that 'strike action' is morally unjustifiable, going through the process of determining a minimum service agreement is (merely) the means to preventing unprotected strikes, and to protect patients in the event that such a strike occurs. Acquiring a legal right to go on strike would not thereby make it morally defensible. Thus more avenues for negotiating fair employment conditions must be explored, for example, greater direct representation of doctors in the Public Service Co-ordinating Bargaining Council (PSCBC). Doctors themselves are responsible for becoming more active within their own trade union i.e. the South African Medical Association. Institutions as direct employers, and universities, having trained the striking, and non-striking interns and being the joint employers of many doctors,

might usefully play an advocacy role, lending their skills so that the voice of healthcare professionals may be heard.

4.3 Concluding Remarks

In South Africa there is no legal right for healthcare professionals, who operate within the essential services, to go on strike. The Oaths, Codes and Declarations espoused by doctors, and the traditional concept of medicine as a 'Profession', is contrary to risking harm to patients in order to promote doctors' interests. The 'principle of utility' might plausibly accept the moral permissibility of strike action if it could be demonstrated that the eventual outcomes for the majority would outweigh the harmful consequences. Kantian theory, theories of justice and virtue ethics would not allow the moral acceptability of strike action by doctors, except in the most extreme circumstances, and then only under controlled conditions with provision for the protection of patients with urgent needs.

There is good reason to accept that there are legitimate complaints by doctors, and that improvement in working conditions and provision of the means to provide quality healthcare are justifiable demands. This would be in the interests of: (a) fulfilling the obligations implicit in professional oaths, codes and declarations; (b) the purposes of medical practice to facilitate 'healing' doctor-patient relationships; and (c) optimally using resources to implement the right to progressively improved healthcare and social justice. It is the means whereby those demands are made that is at issue.

The South African Labour Relations Act (LRA) has as its stated purpose the intention, "to achieve a quick, effective and inexpensive resolution of disputes ... reduced level

of industrial unrest ... and minimal need for costly legal advice" (Department of Labour: 2002). It has the framework that would permit peaceful resolution of conflict. These avenues have not, I believe, been exhausted, allowing me to conclude that presently strike action by doctors in South Africa is not morally justifiable. Thus, the challenge now is to bring to fruition the intent of the Labour Relations Act. The fear is that strike action may recur. It is the responsibility of all, the state and its various representatives, healthcare institutions, universities and the healthcare professionals, to ensure that harm to members of the public is avoided.

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