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Physicians and Strikes: Can a Walkout Over the Malpractice Crisis Be Ethically Justified?

Autumn Fiester, PhD

Abstract

Malpractice insurance rates have created a crisis in American medicine. Rates are rising and reimbursements are not keeping pace. In response, physicians in the states hardest hit by this crisis are feeling compelled to take political action, and the current action of choice seems to be physician strikes. While the malpractice insurance crisis is acknowledged to be severe, does it justify the extreme action of a physician walkout? Should physicians engage in this type of collective action, and what are the costs to patients and the profession when such action is taken? I will offer three related arguments against physician strikes that constitute a prima facie prohibition against such action: first, strikes are intended to cause harm to patients; second, strikes are an affront to the physician-patient relationship; and, third, strikes risk decreasing the public's respect for the medical profession. As with any prima facie obligation, there are justifying conditions that may override the moral prohibition, but I will argue that the current malpractice crisis does not rise to the level of such a justifying condition. While the malpractice crisis demands and justifies a political response on the part of the nation's physicians, strikes and slow-downs are not an ethically justified means to the legitimate end of controlling insurance costs.

Malpractice insurance rates have created a crisis in American medicine. Rates are rising and reimbursements are not keeping pace. In response, physicians in the states hardest hit by this crisis are feeling compelled to take political action, and the current action of choice seems to be physician strikes. What in the past was a rare event is now becoming almost commonplace. In early 2003, physician strikes took place in Florida, Mississippi, Pennsylvania, West Virginia and New Jersey, and plans are underway for walkouts in many other states. While some strikes, like the one in West Virginia, were confined to a few dozen physicians, other strikes have had hundreds of physician participants, and the New Jersey walkout included thousands. While the malpractice insurance crisis is acknowledged to be severe, does it justify the extreme action of a physician walkout? Should physicians engage in this type of collective action in response to this crisis, and what are the costs to patients and the profession when such action is taken?

Opinions about the moral permissibility of physician strikes differ among American medical societies. While the stance taken by US medical societies was uniformly against such actions prior to January 2003, this is no longer the case. On the traditional side of the issue are the AMA and the American College of Physicians. The AMA's Code of Medical Ethics states: "Strikes reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences is contrary to the physician's ethics. Physicians should refrain from the use of the strike as a bargaining tactic"(Reid 1998). In a position paper published in the *Annals of Internal Medicine*, the American College of Physicians unequivocally stated: "The College opposes joint actions by any physicians that would deny or limit services to patients (including strikes, slowdowns, boycotts, and administrative or other organized actions that would harm patients)…"(American College of Physicians). The hard line that doctors should not engage in this form of political action has softened, however, among other medical societies, especially in the wake of the current malpractice insurance rate crisis. For example, in January 2003, the Medical Society of New Jersey took the opposite position. President Robert S. Rigolosi, MD announced the following resolution passed January 19, 2003: "The Medical Society of New Jersey strongly supports the efforts of New Jersey physicians to communicate their outrage with the failure of the Legislature to take meaningful action to resolve the medical liability insurance crisis. The Society will devote all of its resources to assist physicians, hospital medical staffs, and other physician organizations in exercising their rights. The Society will provide necessary legal services, distribute communications among the various grassroots efforts, coordinate public relations and rally public opinion" (MSNJ Advocacy).

With the considered moral judgment of American medical societies differing so widely, what is the justification for drawing a sharp moral line against physician walkouts? The strategy of this paper is to lay out three arguments that constitute what I will call the "deliberative presumption" against physician strikes. As a deontological prohibition, a deliberative presumption sets a very high bar for those conditions that might justify overriding or rebutting the prohibition. I believe this bar is set by three moral reasons that speak against physician strikes: first, strikes are intended to cause harm to patients; second, strikes are an affront to the physician-patient relationship; and, third, strikes risk decreasing the public's respect for the medical profession. Over-riding these moral considerations requires justifying moral reasons that make equally compelling claims on us. The current malpractice insurance crisis does not rise to this level. The overwhelming toll on physicians of rising insurance rates – with the resultant consequences to patient care -- demand and justify a political response on the part of the nation's

physicians, but strikes and slow-downs are not an ethically justified means to the legitimate end of controlling insurance costs.

In this paper, I will lay out the three moral reasons that set the deliberative presumption against physician strikes. I will argue that the current malpractice insurance crisis, while serious, does not constitute an overriding condition. Then I will point us towards other kinds of cases that might, in fact, rebut a strict prohibition against physician strikes.

I. The Deliberative Presumption Against Physician Strikes & The Current Malpractice Insurance Crisis

The language of "deliberative presumption" comes from philosopher Barbara Herman (Herman 1994). Something of a cousin to W.D. Ross's "prima facie duties" (Ross 1930), deliberative presumptions are the principles that govern our moral life. In contrast to Ross and so-called principlists who conceive of a small set of duties or rules that guide moral life, Herman's account assumes scores of deliberative presumptions, of varying levels of generality or specificity, none of which can be *a priori* ranked in importance. In Herman's view, these principles are "presumptive," because they set our moral standards, but they are not rigoristic, meaning they can be overriden or rebutted on grounds of a stronger moral claim or moral reason. We must presume that a deliberative presumption governs a particular situation until serious moral reflection proves that it must be trumped in that case (and in that case only). Moral life is complex, and – to shamelessly mix philosophical traditions – we must recognize Aristotle's insight that any particular presumption holds only "in general and for the most part." These presumptions are called "deliberative" because their rebuttal requires us to step back from our routine moral goings-on and engage in active ethical dialectic. A deliberative presumption, like any deontological principle, draws a sharp moral line that is not to be crossed simply on grounds of better consequences or self-interest. Deliberative presumptions are justified by the moral reasons that generate them; they can be overridden only by moral reasons of the same weight and seriousness. That call, of course, is one of moral judgment, and it is made on the basis of the justificatory case that is presented. In this section, I will argue that there are three moral reasons that set the deliberative presumption against physician strikes, and I will argue that the possible justifications for such action in this case do not rise to the level of a rebuttal condition.

A. Strikes Are Intended to Cause Harm to Patients

The first moral reason constituting the deliberative presumption against physician strikes is that they are intended to cause harm and threaten even greater harm to patients. This sounds

like a mere provocation, but, in fact, the bare truth is that the whole idea of a physician strike or work slow-down is to cause patient harm: physicians strike to give patients (and the government or hospital officials for whom they are constituents or employees) a little taste of the even greater harms that would befall the specific patient population if the strikers never returned. It is the "Strikers' Strategy:" if no harms were threatened and achieved by strikers, then there would be no efficacy in the collective action of striking. In the case of physician strikes to reduce malpractice insurance rates, the harms are clearly directed at patients, who are in fact innocent bystanders in the struggle with lawyers and insurance companies.

The immediate objection to this radical claim is that the argument must hinge on an idiosyncratic definition of "harm." What definition of "harm" is operating here? Well, an admittedly broad one, but a legitimate one nevertheless. "Harm" to patients ranges from physical injury to psychological stress or anxiety to prolonged pain and suffering to added expense in accessing care. But there are two issues involving harm that should not be conflated: 1) have strikes actually caused patient harm and of what type?; and, 2) what are the intentions of physician strikers towards their patients?

Take the first issue first: have physician strikes actually caused harm to patients? This is clearly an empirical question, and we have only anecdotal data. Certainly the most extreme type of harm that could befall a patient during a strike is death or injury due to a lack of access to care. Organizers of physician walkouts have claimed that to date there has been no such harm done to patients. This is not entirely comforting since the fact that such harm has not yet occurred does not mean that it will not occur in future strikes. This is especially worrisome given the trend of increasing numbers of physician participants in each strike, and the simultaneous participation of more and more specialties. But that there have been other types of harm besides injury or death seems indisputable. In the West Virginia strike in January 2003, trauma patients had to be transferred to hospitals 90 miles away (CBS News.com). In the West Virginia strike, a man suffering from a kidney stone blockage experienced prolonged, severe pain while the ER physician tried to find a surgeon who would treat him in a nearby state (Treaster 2003). In the New Jersey strike, phones ran off the hook as frantic patients called their physicians worried about access to care during the planned work slow-down. These are instances of harm.

To quantify the harm involved in physician strikes, consider an argument we might call the "Argument from Pre-Strike Goods:" if a physician was providing patients with quality service and care on the day before the strike and would have provided patients with that same service and care on the day of the strike if s/he weren't striking, then whatever goods s/he isn't providing (or aren't being provided by comparable care) amount to harms for the patients who would have been

treated on the day[s] of the strike. These harms, again, range from physical and psychological suffering due to the lack of access to care that patients count on, to anxieties about how to access care, to financial worries about accessing the type of care now available. These harms are only avoidable if there are enough physicians available to cover all patient care, at the standard of care communities routinely experience and expect, for the duration of the strike. But if there were enough physicians to cover all such care for a strike of any duration (more than a few hours or a weekend), then there would have to be a glut in the market of physicians (otherwise what are the replacement "workers" doing when their colleagues aren't on strike?).

But the second issue has at least as much moral weight as the first: what are the intentions of the striking physicians towards their patients? Let's use Kant-speak: what would the maxim look like that is operating under a strike? It must be something like: "I will that my patients suffer enough from my absence that officials are coerced into action that solves the problem." No striking physician wishes any permanent ill to befall her patients, but a little suffering is necessary to make the strike effective. This quantity of suffering – whatever it is – is what constitutes the difference between a strike and a mere political protest. Imagine that doctors in New Jersey conducted a political protest at the state building in Trenton, but they used their day-off to attend the protest instead of closing their offices. Whatever "bite" this political action seems to be missing that a strike contains is the suffering that ensues or is threatened during a strike. Strikes have teeth. Protesting physicians during the New Jersey strike named those "teeth" when they held signs that read: "Having a Medical Emergency? Try Calling 1-800-LAWYERS" (Johnson 2003). A telling report about strike-strategies proposed by New Jersey physicians in an email forum included this statement by a vice president of one of the state's medical societies: "Cause confusion and inconvenience. Let them know that this is the health care system of the future if it is not fixed now" (Jacobs 2003). In this forum, the suggestion was made, for example, that physicians not call in any prescriptions for sick patients, but make them come to the office to pick them up. Another suggestion was to stop writing inexpensive generic prescriptions and to write prescriptions for very limited quantities so patients had to keep returning to the office. Other ideas were rejected, but suggested nonetheless, speaking to the strike's intention: for example, denying access to healthcare to lawyers and legislators, and their families.

But should physicians intend, let alone cause, any kind of extraneous patient harm or suffering? It is a foundational tenet of medical ethics that physicians must "First, do no harm," *Primum non nocere*. This foundational principle distinguishes physicians from other occupations where strikes are routine and ethically justified. If it is the duty of physicians to relieve suffering, not to cause or threaten it, then strikes violate the first principle of the profession's ethic.

B. Strikes Are an Affront to Two Elements of the Patient-Physician Relationship

The second argument against physician strikes is that they are an affront to the moral obligations of the patient-physician relationship. There are two physician obligations that are thwarted during a strike: the demand of patient respect and the demand of non-abandonment. These two expectations are codified in the AMA's position statement on the "Fundamental Elements of the Patient-Physician Relationship". Take, first, the expectation of respect. The Council writes, "The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs" (American Medical Association). When surgical or medical appointments are scheduled, physicians enter into an implicit contract with their patients. These contractual arrangements are a species of "promises." Patients recognize justifiable reasons for breaking such promises, just as we all recognize extenuating circumstances that force others to break promises to us in everyday life. Justifiable reasons for breaking patient appointments include the urgent needs of other patients, personal and familial emergencies, physician illness, etc. None of the justified reasons involves pure self-interest. Just as in ordinary life, we allow physicians to break promises if they are incapacitated or have a more pressing obligation to someone else. But physician strikes are motivated by the financial interest of the physician, which is a motivation of self-interest. This is not to say that these financial concerns are illegitimate; it is simply to say that concerns for one’s own financial well-being are not grounds for breaking contracts to patients. When promises are broken on reasons of self-interest, the promiser has violated the contractual agreement, which is a type of disrespect.

Are there exceptions to the rule that grounds of pure self-interest do allow others to break promises to us? Yes, when the promising party has a dire personal need, we excuse the broken promise. Say, for example, a friend promised to watch your small children while you went to an important business conference and you were really counting on her, but after making the promise she received a job offer that would finally bring to an end months of unemployment and save her from financial ruin. You would likely excuse her reneging on the promise despite the inconvenience it would cause you. The striking physician might argue that she is in an analogous situation, facing financial peril in the wake of this malpractice crisis.

If we look at the malpractice insurance rates and the median incomes of American physicians, it is undoubtedly the case that the financial picture for some physicians is that dire. It is entirely possible that there are physicians (especially starting physicians) who earn a salary at the low end of the income range, while having premiums at the high end. In those cases, the

physicians will not even break even – they will run an income deficit. For physicians in this horrible financial situation, or shades of it, it is certainly the case that their patients will excuse them if they need to cancel appointments or surgeries to engage in a walkout that will secure their financial survival.

But how many striking physicians are in this boat? Much more common is the physician who is seeing her income decline, while still making many times the national median income. As stressed earlier, this income-decline gives physicians a legitimate cause for protest, but the question is, does it give physicians a justification to strike, or specifically in this part of the argument, a justification to cancel appointments and surgeries? Malpractice insurance rate hikes are often quoted in the media, but these figures are never cited relative to the individual physician's income, the only truly meaningful figure. A look at national income figures can be instructive in helping one keep perspective on the malpractice crisis. The median income in this country for a family of four (which in many cases means "two-earners") is about $63,000. Having a household income of $280,000 puts one's family in the top 5% of all households in the nation; a household income of $160,000 puts the family in the top 20% (U.S. Census Bureau). So when a physician tries to justify a strike to his patients, the individual physician's financial picture becomes relevant. Any American would excuse a physician who is struggling to earn the national median (fairness dictates that physician-salaries be significantly higher than that, given the extensive training they receive and long hours they work), but it is unclear how patients would feel about their physician striking because of an income (after expenses) of, say, $126,000 or $160,000, or higher. What is the income level that allows a physician to claim a “dire financial need”?

A striking physician may also defend her or his actions by arguing that the motivation for strikes is not pure self-interest. For example, a physician may say that she is striking so that she can afford to continue to give care to her patients; therefore, her motivation is actually altruistic or other-regarding. This rings false as a motivation for taking such drastic action as striking or participating in a work slowdown: it would be analogous to the striking teacher saying that she is striking so that her students can continue to learn (because otherwise she will leave the field of education). If access to medical care is the true motivation for physician strikes, then it seems as if American physicians have bigger fish to fry than physician-flight due to malpractice insurance rates, namely, the 40 million uninsured people in this nation who don’t have access to basic medical care. But there are not a lot of strikes for that worthy cause. If physicians are truly motivated by concern for patient care and safety, this may well constitute a justifying condition

for the radical action of a strike. But there is little evidence that our current epidemic of physician strikes is so motivated.

A second way in which physician strikes thwart obligations of the patient-physician relationship is that they undercut the expectation of non-abandonment. Again quoting from the AMA's statement on the patient-physician relationship, "The patient has the right to continuity of health care…The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care" (American Medical Association). As a patient, I have a right to expect my physician to treat me or to aide me in securing care elsewhere. During a strike, my physician severs (at least temporarily) our relationship without giving me an opportunity to find another practitioner or assisting me in doing so. This issue of abandonment is what distinguishes physician strikes from physician flight. Some proponents of physician strikes argue that there is no moral difference between a physician who strikes and a physician who leaves the geographic area for better wages or conditions somewhere else; in fact, some argue that strikes are much less ethically problematic than physician flight because the physicians will return to the area. The first response to this argument is that with physician flight the patient has time and opportunity to find other care, either with the physician's help or without it, whereas in a strike, the patient is simply left "high and dry." When strike organizers assure their communities that there will be medical coverage during the walkout what they mean is that emergency rooms will still be open (even if, in some cases, the personnel needed to treat certain patients won't be available). This is not adequate to fulfilling the physician's obligation of non-abandonment.

The second response to the claim that physician flight is much worse than physician strikes is that this argument is premised on the notion that flight, in the absence of a strike, is inevitable. On this argument, strikes are a necessary evil. The problem with this line of thought (besides being empirically unproven) is that it too quickly allows the ends to justify the means. Proponents of strikes don't argue that strikes are a noble means to an important end; they argue that physician walkouts are the lesser of two evils. But before we resort to a type of reasoning that justifies crossing an important moral line to reach a certain goal, we must be that strikes really are the only means to that goal. Is there really no other possible way to avoid physician flight? Has every other means been tried?

C. Strikes Risk Decreasing the Public's Respect for the Medical Profession

Physicians are viewed as a profession that has a calling to serve others. This idea of medicine as a vocation is exemplified by the oaths physicians take upon entering the field. Take

as examples some of the oaths currently used in US medical school graduations. In the "Physician's Oath" from the Declaration of Geneva, one recites: "I solemnly pledge myself to consecrate my life to the service of humanity" (General Assembly of the World Medical Association). In the Oath of Maimonides, one states, "Oh God, Thou has appointed me to watch over the life and death of Thy creatures, here am I ready for my vocation and now I turn unto my calling" (Oath of Maimonides). In the Modified Hippocratic Oath, the physician promises: "Now being admitted to the profession of Medicine, I pledge my duty to those trusting in my knowledge and training" (American Medical Association Oath registry). All of this bespeaks the ideal of the physician who has chosen this work in order to help others.

The public's great esteem for the medical profession is based on this ideal of dedicated service. But the self-serving nature of strikes conflicts with the image of the devoted physician and may justifiably call into question the physician's commitment to serve. Strikes seem incompatible with the noble purpose of medicine. Think of the change in the reputation of public school teachers once they began to conduct strikes over wages; it became implausible to argue that their true mission was the education of America's youth. Strikes may "dethrone" physicians as professionals who hold themselves to a higher standard than we routinely see in other fields. Words that have been used publicly to describe physician strikes include "disappointing" and "irresponsible." Strikes risk undermining the public's faith in the medical profession, and that faith and esteem should be valued by the nation's physicians.

II. Overriding the Deliberative Presumption Against Physician Strikes

As with any deliberative presumption, the one that constitutes a prima facie prohibition against physician strikes can be overridden by justifying conditions that meet the moral reasons underlying this presumption with other, equally compelling moral reasons. Since what constitutes justified defeasibility in any context is a matter of moral judgment, talk of defeasibility takes us into gray areas. But, in general, to rebut a presumption against physician strikes, the reasons and motivation for the walkout would need to address the issues of intending harm to patients in a strike, the moral obligations of the doctor-patient relationship and the reputation of physician as a class. What would a justifying condition look like?

Imagine the following case: a strike is organized by hospital physicians to end unsafe practices in a particular institution and to demand adequate resources to properly treat patients. In this case, assume serious attempts have been made to secure these necessary changes, and protests had fallen on deaf administrative ears. In this strike, the sole motivation by the physicians is to prevent harm to the very same population that will be experiencing the effects of

the strike. And this motivation is made clear to the patients who will be involved in the strike. Build into the case that patients who receive care at this institution have complained for years about the care they receive there, and they are grateful that physicians have taken up their cause. The hospital has threatened to dock the physicians' pay if they strike, and they are nevertheless resolved. The press makes this a well-known fact in the city.

In this case, the strikers' motivation is the enhancement of patient care, and while the strike intends some measure of patient-harm to make its point, physicians are calling on patients to make this sacrifice in the care they receive for a short time to achieve a vast improvement in that care post-strike. Rather than this strike being a case of promise-breaking, it is a case of patients' temporarily releasing physicians from a contractual agreement. While continuity of care will be interrupted for the duration of the strike, patients see this interruption as a re-commitment of physicians to non-abandonment. That physicians are championing a patients' cause enhances the patients' esteem for the medical profession; they feel honored by the action. In such a case, the moral considerations that set the prohibition have been met, and the presumption is justifiably rebutted.

There may be other overriding cases that trump the deliberative presumption, like a cause of healthcare justice or deplorable physician working-conditions. But the current cause of reigning in malpractice insurance rates is not one of them.

III. Conclusion

Because physician strikes intend harm to patients, challenge the obligations of the physician to her patient, and risk decreasing the public's esteem for the profession, I argue that a walkout over the malpractice crisis cannot be ethically justified as a legitimate political action. The crisis presents a serious problem to both physicians and the patients whose doctors are affected by it, but the medical community needs to rethink its current political strategy and find an alternative route to bringing insurance rates back under control. Protests, strategic use of the media, and lobbying efforts should all be tried – with the same level of commitment and effort as physicians have put into walkouts and strikes.

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