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Ethical dilemmas of the doctors' strike in Israel

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Editor's note

The authors discuss some of the moral dilemmas confronting Israeli doctors in the context of their strike in 1983. Concern for their patients militated against a strike. On the other hand their salaries were far below the mean standard of the country. To earn as much as nurses and radiographers doctors were forced to work 65–75 hours a week.

The authors argue that if a doctor is underpaid and forced to work excessively the quality of medical care and ability to act in the best interests of patients is adversely affected. To avoid 'the necessity to strike' doctors' salaries and working conditions should be set by independent bodies in those countries where doctors are paid by the State.

Several circumstances exist in which the physician is faced with the difficult decision of withholding medical treatment. The deliberate and prescient denial of treatment to patients who serve as the controls in randomised placebo clinical trials, to the terminally ill, to severely defective newborns, or to those who refuse treatment, is generally defended on the basis of medical and/or moral principles but remains a highly debatable issue. A situation in which medical treatment is withheld on grounds other than those involving clinical or moral judgements highlights another aspect of this controversial ethical issue. Such a situation is hereby presented in reference to the recent doctors' strike in Israel.

Medical care in Israel is almost entirely socialised. It is provided by approximately 8000 physicians, most of them employed by the Ministry of Health or by the Labour Federation's health insurance scheme (Kupat Holim) which is subsidised by the government. In early March, 1983, an estimated 90 per cent of Israel's physicians went on strike in a wage dispute following a year and a half of fruitless negotiations. In a pyramid system under which an intern earned a basic salary of $300 a month and a specialist with 20 years' experience, an average of $500 a month, the doctors were demanding both a reduction in working hours and an average 100 per cent increase in the basic wage (1). Under the existing conditions their salaries were far below the mean standard of the country. In order to earn the equivalent salary of a nurse or an x-ray technician, a doctor was forced to supplement his 45-hour work week with six to eight additional night shifts (16 hours each) per month.

From the beginning of the strike the physicians in Israel were preoccupied with the moral obligation to their patients and the imminent deleterious effects of the strike. An alternative fee-for-service system was organised independently by the Israel Medical Association for the care of outpatients. Inpatient treatment in private hospitals was also available. Public hospitals were maintained by one-third the usual staff of doctors. This drastic cut in medical service surprisingly failed to spur the public or the Government to react, and negotiations stagnated. In May 1983, three months into the strike, approximately 4000 doctors participated in a three-day exodus from the hospitals leaving a skeleton staff of 10 per cent. The government immediately responded by issuing back-to-work orders. Although many of the doctors were prepared to disobey the injunctions, the majority opinion was that the patients should not be deserted. By special agreement, the doctors returned to the situation that had existed prior to their leaving the hospitals, ie one-third of the usual number of doctors working. In June 1983, in a final effort to end the dispute, 12 doctors spontaneously began an unprecedented hunger strike. Within ten days nearly 3000 physicians in hospitals throughout the country had joined the hunger strike and thus were unable to function. Only matters of life and death were dealt with; to all intents and purposes the medical system was paralysed. After twelve days the hunger strike ended with the Government agreeing to mandatory arbitration.

One of the unique features of this strike was the provision of an alternative medical service. By definition, when a strike occurs all services provided by the strikers cease and responsibility is relinquished. When physicians strike a deep moral conflict arises because matters of life and death are at stake. For many of the striking doctors their traditional Jewish

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upbringing played a role in this conflict. 'The religious duty to preserve health' as exemplified by the precept that 'any doctor who refuses to attend to those in need is guilty of bloodshed' (2) weighed upon the consciences of the strikers. The alternative fee-for-service medical system circumvented this moral obstacle. While it effectively disrupted the existing socialised medical structure, it enabled the physicians to uphold their responsibility as healers.

As the strike progressed, an unanticipated moral conflict emerged. On the one hand, it became evident that not all patients were receiving proper medical care, despite the alternative fee-for-service system. Even more disturbing to the physicians was the fact that the entire public health structure was on the verge of collapse after nearly four months' disruption of normal services. The principles upon which the public health care structure was based were fundamentally supported by the vast majority of striking doctors who were raised with the belief that socialised medicine is the best system for delivering medical care to the entire population of Israel. Yet to abandon the original goal and cease striking meant returning to inadequate working conditions under which efficient medical care could no longer be delivered. In addition there was imminent danger that frustrated physicians would emigrate or turn to private practice on a larger scale, thus undermining the public services.

The moral conflict could naturally have been resolved by the Government acquiescing to the doctors' demands. However, because the negotiations reached an impasse, another option had to be considered: to completely deprive the population of all medical services. But this would constitute an abuse of power granted to the physician by society and serve to aggravate the moral dilemma.

The essence of a moral dilemma has been discussed by others: 'Although the commitment to the whole set of values remains steadfast, the decision made in the face of an ethical dilemma often requires letting go of one value . . . to realize another . . .'(3). The physicians made their decision in the face of this conflict. They collectively left the hospitals at one stage and later went on a hunger strike that paralysed the health system. The intention was to prevent further irreparable damage to patients and abruptly end the dispute, even if this meant implementing extreme measures and withholding medical treatment temporarily. There is no doubt that this act, in and of itself, contradicted the physicians' responsibility to act in the best interest of the patient.

The question then remains: where does the responsibility for the care of patients actually lie? There are always at least four elements in the patient-doctor relationship: the physician, the patient, the disease, and the art of medicine. In modern communities one must add a fifth element – society in the form of a political structure, for medicine cannot function today without the financial support of society (4). Society confers great powers on the physician because it believes he will use them for the benefit of the people, but society also constrains the physician by making him financially dependent and legislating the length and conditions of his work. Society essentially determines the nature of the patient-doctor contract, for example if a doctor is underpaid and forced to work excessively, the quality of medical care and the ability to act in the best interests of patients is adversely affected. As Nilsson comments: 'I have never been convinced by the view that the physician's idealism is created or the patient-surgeon contract preserved by the ordeal of slaving long hours' (5). Today, responsibility for the patient no longer rests solely upon the physician. Actually a contract exists between society and the patient. Depriving physicians of proper wages constitutes a breach of contract and justifies a walkout. Therefore, society must take measures to prevent such a situation from occurring.

It is our opinion that in countries where physicians receive their salaries from society, an independent body should set the wages and working conditions in such a manner that the physicians are able to act in the best interest of their patients. Thus the necessity to strike among this group will not arise.

References

(1) Anonymous. Heal thyself [article]. *Time* 1983; 27: 18.

(2) Jakobovits I. Jewish medical ethics – a brief overview. *Journal of medical ethics* 1983; 9: 109–112.

(3) Smith K E. Competing ethical values in medicine. *New England journal of medicine* 1980; 303: 1482.

(4) Bayes M D, High D M, eds. *Medical treatment of the dying: moral issues*. Cambridge, Massachusetts: Schenkman Publishing Company Inc, 1978: 12–14.

(5) Nilsson F. Limitation of the surgical contract. *Journal of medical ethics* 1980; 6: 64–67.