State and Professional Autonomy: Conflicting Rights and Obligations in the State-Profession Relationship

Calvin Ho & Daisy Cheung

Faculty of Law, University of Hong Kong
Goals

• What is ‘professional autonomy’?
  • With focus on nurses and doctors in health care
• How has ‘professional autonomy’ changed?
  • Increasing emphasis on patient autonomy
  • State controls
  • Changing nature of health care practice
• Is ‘professional autonomy’ still relevant?
  • When State and Profession disagree, is ‘industrial action’ (or strike) an ethically justifiable response?
Context

- Socialised / Universal health care system (Britain and Hong Kong)
- Tripartite relations (patient-profession-state)
- When State and Profession Disagree
  - British doctors strike in 2012
  - Junior doctors strike in England in 2016
  - Hong Kong health sector strike in 2020
Caveats & Arguments

- Views expressed are personal to the presenters.
- Academic inquiry into the concept of ‘professional autonomy’ (PA).
  - PA needs to be recognised and sustained
  - ‘Industrial action’ by health care professions is ethically justifiable if certain conditions are met
  - ‘Industrial action’ by health care professions has a qualitatively different character (not merely a collective bargaining tool)
- Law should support different expressions of ‘professional autonomy’.
Professional Autonomy

• The “Golden Age”: Doctors have full control over the content of their work, and as a profession, can govern itself and establish on its own the standards of its performance (Eric Freidson 1970; Fredric Wolinsky 1988; G Freddi 1989).

• Professional self-regulation: A doctor is judged by other doctors based on professional standards, in both technical and ethical terms.

• Professional autonomy is subject to compliance with a code of ethics (includes principles of respect for persons, beneficence and non-maleficence).
Challenges to Professional Autonomy
(Toth 2013)

• Shift towards a more patient-centred model, which requires sharing of responsibility in the patient-doctor relationship.

• Managerialisation of medical practice as public enterprises (with corporatization and decline of private practice in some countries) or managed care arrangements.

• Bureaucratization from increasing regulation of health care professions.

• Politicisation as the State takes a bigger role in intermediating the patient-doctor and patient-nurse relationships.
Role of the State and other interests

• The State as ultimate custodian of resources for health care places constrains on professional autonomy
  • Treatments or medications that may be provided
  • Work conditions / environment that patients and doctors/nurses find themselves in
• Market-based and managerial considerations
• Legal-bureaucratic considerations may be prioritised
  • Increasing demands on the part of patients
  • Loss of trust or prestige in public opinion from media reports of scandals or malpractice
Is Professional Autonomy still relevant?

- Varying degrees of professional self-regulation; code of ethics has been used against attacks from politicians, managers and patients.
- Doctors and nurses take on some responsibility to advocate for all patients in their care to the State
  - Doctors and nurses have a duty to highlight patient-safety concerns and maintain the welfare of their colleagues; even if they are not solely, or even partially, morally responsible for all patients, all of the time.
  - Professional autonomy extends to concerns of population health.
- Basis for industrial action when confronted with serious threats to professional and/or (public) health system?
2016 Strike by Junior Doctors in England

- Four periods of strike action in protest against a new contract: 12 January, 10 February, 9-10 March, and 26-27 April 2016. It was only during the 48-hour strike in April that emergency care was withheld.

- A junior doctor (Rose Penfold 2018) writing about her experience explained the motivation as more than about pay (which she felt has been the focus of the media); but about disempowerment from lack of control (i.e. professional autonomy) over tasks and the work environment (with the abolition of automatic progression, lower pay and longer working hours): “But this unprecedented protest was not just about hours and pay. It reflected deeper rooted dissatisfaction among a group of professionals who felt “devalued and denigrated,” wrote Johann Malawana, former chair of the BMA’s Junior Doctors Committee, and they had no apparent way to communicate this other than by withdrawing labour.”
Impact on Patient Mortality

- Strike periods led to fewer hospital admissions, fewer emergency department attendances, and an increase in cancelled appointments, but did not lead to an increase in patient deaths (Furnivall et al. 2018).
- It was noted that many patients may have consciously avoided going to hospital during this period, perhaps due to intense media coverage of the event and explicit instructions from some providers to avoid all non-urgent hospital attendances (Furnivall et al. 2018; 6).
- Mark Toynbee et al. (2016, at 169) argue: “A proposed contract that was felt to endanger the healthcare system by inadvertently reducing the number and quality of doctors might [justify industrial action]… In situations where the care in the short term is not likely to suffer due to inadequate medical cover,… this argument is even stronger….Any group open to exploitation should be empowered to oppose such action. If the junior doctors are accepted to be acting primarily from altruistic motives having exhausted all other avenues of redress against an employer, ultimately the State, who dictates their hours and their wages, then their action can be seen as justified, especially if patient care is adequately covered by their seniors.”
Strike by British doctors in 2012

• Industrial action in June 2012 following a majority vote by members of the British Medical Association (BMA) in support of it. First time British doctors went on strike since 1975. Relatively small scale involving about 8% of doctors in England (Triggle, *BBC News* 2012).

• Industrial action was taken in response to the announcement of the British government in May 2012 that doctors would face cuts to their National Health Service (NHS) pension scheme, with the effect that every doctor (as a public sector employee) would work longer, pay more into their pension schemes but receive less upon retirement (Park and Murray 2014).

• BMA adopts the strategy of “urgent and emergency care” model of industrial action, which aims to ensure that patients received care only if they urgently needed it. Guidance from the BMA indicated that doctors should be at their usual place of work and patients would receive emergency care or other care urgently required that day. All other work would be postponed, including non-urgent surgery, investigations, outpatient consultations, routine appointments in general practice and paperwork. Care should be provided if there is any doubt. The industrial action would only take place for 24 hours, and its effect on patients would be reviewed before any further action would be taken. Careful planning, coordination and notification with managers, other health professionals, doctors and patients have been emphasized as measures to keep patients safe (Robertson 2012; Park and Murray 2014).

• The 24-hour strike on 21 June 2012 in England led to an increase in outpatient appointment cancellations, but no significant differences in mortality between strike and non-strike periods (Ruiz et al. 2013).
Empirical Evidence of Little or No Effect on Patient Mortality

- UK, USA, South Korea, Canada, New Zealand, Israel, Nicaragua, El Salvador, France, Germany, Spain and Ghana (Thompson and Salmon 2006).
- Reasons included substandard service provision, unsatisfactory conditions of work or unfair malpractice payments (Thompson and Salmon 2006); ongoing changes in organization of healthcare services, failure by employers to honour collective bargaining agreements for improved wages and conditions of service, and disempowered doctors and health care workers who feel unable to provide the best possible care for their patients because of inadequate facilities, drugs, and lack of support by employers, especially elected officials (Chima 2013).
- Strikes among doctors in the USA, Israel, Spain, Croatia, South Africa, India and the UK have been shown to have had little to no effect on patient mortality (Metcalf et al. 2015).
  - Only one exception found in a 20-day long strike of all doctors in a single province in South Africa in 2010, where patients who presented in emergency departments were 67% more likely to die than during a normal period.
Justification (or Duty?) to Strike?

- Due to the significance presence and recognition of professional autonomy, “industrial action” by doctors and nurses may be ethically justified.
- Proposed approach by Toynbee et al. (2016) in evaluating the moral justification of “industrial action” being taken by doctors:
  1. All patients must still have access to emergency care.
  2. Maintenance of patient well-being must be a goal.
  3. Strikers must feel that all possible other forms of communication have failed.
- Additionally for doctors’ “industrial action” to be **morally imperative**, as well as points 1 to 3, there must be: (4) An imminent threat to patient well-being.
- Query: Imminent threat to the health system?
“Industrial Action” in Health Care

• Strikes are generally considered as a fundamental right or entitlement during collective bargaining and labour negotiations (Okene 2009).

• If doctors and nurses are treated no differently from any contract staff, it follows that they cannot be expected to have a genuine ethic of service to their patients, since other contract staff are not expected to put anyone else’s interests over and above their own (Editorial 1985). In this scenario, industrial action by doctors and nurses should be justified even when such strikes can be foreseen to result in preventable deaths (Cooper 1985).
Professional Autonomy constrains “Industrial Action” in a Conventional Sense

• Due to the presence of (and recognition for) professional autonomy, “industrial action” by doctors and nurses should not be simply construed as retaliatory action, or purely a question of employment rules.

• Doctors and nurses (or indeed health workers more broadly) voluntarily take on special (supererogatory) moral obligations that set them apart from tradespeople, for instance.

• When a strike is called, doctors and nurses have a moral responsibility to consider competing loyalties to patients under their care or to their colleagues; arguably, professional autonomy favours the former.

• Benn-Rohloff (1997): “...in the case of a strike, I would not – even in a paediatric ward – serve the children’s food, wash their dishes or make their beds when the parents are living on the ward with them, but I would continue to care for the children in every other way.”
The Hong Kong context

• Recent strike in February by healthcare workers in response to COVID-19 pandemic
• Implications for state-profession relationship and the upholding of professional autonomy
  • Lines of communication / feedback mechanisms?
• Is a different approach to the state-profession relationship preferable?
Some background

- Hospital Authority Employees Alliance (HAEA) – formed in Dec 2019
  - Membership includes medical frontline staff (doctors, nurses, allied health professionals, patient care assistants etc.) and backend support staff
- EGM on 1 Feb – more than 3000 members voted in favour of strike
- Announcement of intention to strike:
  - Five demands, strike plan, request to invite CE as Chairperson of the Emergency Response Level Steering Committee cum Command Centre to participate in negotiations
Five demands

- To forbid all travelers from entering Hong Kong via China
- To implement constructive measures to ensure a sufficient supply of masks
- To provide sufficient isolation wards, to stop all non-emergency services
- To provide sufficient support and facilitation for healthcare staff caring for patients under isolation
- To publicly commit to not taking any disciplinary actions in retaliation
Strike Plan

• 5 day plan:
  • First stage (Day 1): suspension of non-emergency services of Hospital Authority
  • Second stage (Days 2-5): all members of HAEA regardless of rank/specialty would participate, with only limited emergency services provided under the Hospital Authority
• 1\textsuperscript{st} day – 2700 workers, 2\textsuperscript{nd} day – rose to 7000 workers
• CE did not take part in negotiations with HA
• Strike ended after 5 days
• No concessions made directly, but additional measures implemented
  • CE denied measures in response to strike
  • Called strike “irrational act”
  • “Those using extreme means to try to force the government’s hand will not succeed.”
Professional autonomy and state-profession relationship

- Responsibility to advocate for all patients and duty to highlight patient-safety concerns and maintain welfare of colleagues (see further slide 8)
- Advocate role → requires feedback mechanisms between state and profession (including, in extreme cases, IA)
- Fundamental differences in IA in healthcare context (see further slide 14)
  - Hong Kong: Lo, a 29-year-old operation room assistant who works at Caritas Medical Centre in Cheung Sha Wan, said she was “greatly sorry” about the strike, pledging to put in more effort to deal with cases once she returned to work.
When is IA morally permissible/required?

- Toynbee et al approach
  - 1. All patients must still have access to emergency care.
    - HAEA strike plan
    - Effects on HA services
    - No known patient mortalities as a result of strike
    - “Yu added that, if there is a major community outbreak in Hong Kong, the union will review the situation and halt the strike.”
• 2. Maintenance of patient well-being must be a goal.
  • Purpose/motivation of strike?
  • No personal or financial gain – concern with own physical well-being, well-being of colleagues, and patients / larger society in light of public health crisis
“Hong Kong is an extremely densely-populated city with immensely crowded living conditions. These are all factors that facilitate the spreading of any infectious disease… The healthcare workers in Hong Kong have learnt the hard lesson through SARS, that preventive measures are the only way to stop a massive outbreak of disease in our community. The initial symptoms of the Wuhan Pneumonia can be mild, and if such invisible patients may enter Hong Kong without any control at the borders, they would bring with them the deadly virus that could infect many in Hong Kong. Also, currently we do not have any curative treatments or vaccines that could tackle the Wuhan Pneumonia, thus preventive measures implemented decisively are our only way to ensure the safety of the citizens of Hong Kong.

Despite the professionalism of the Hong Kong healthcare workers, if our government continues to ignore the significance of prevention, there is little way for us to battle the invasion of this deadly disease.” (HAEAP announcement, 23 Jan 2020)
“In 2003, the first patient (Liu Jianlun), who introduced the SARS virus to Hong Kong and subsequently caused the massive outbreak in our community, travelled to Hong Kong by a Cross Border Bus to attend a wedding of his relative [1] [2]. The travel route he took (Cross Border Bus) and the reason he used to enter Hong Kong (visiting relatives) are still not restricted by the Hong Kong government. This means that another Liu Jianlun could enter Hong Kong today with the usual means, and induce another SARS tragedy in Hong Kong.” (HAEA announcement, 28 Jan 2020)

Ms Ng, a frontline medic at Queen Mary Hospital, said some of her colleagues who work outside the isolation wards without full-body protective gear felt unsafe treating patients who may not fully disclose their medical and travel history. “We don’t really know if a newly admitted patient is withholding any information or not, so some staff members, especially the ones working in medical admission, are really scared.” (https://hongkongfp.com/2020/02/04/coronavirus-hong-kong-medics-escalate-strike-demand-full-shutdown-chinese-border/)
• HAEA Vice-Chair Ivan Law said...“None of our demands have been met. Asking medical professionals to go back to work is like pushing them to their deaths” (https://hongkongfp.com/2020/02/06/coronavirus-hong-kong-medics-tell-govt-offer-support-face-mass-resignations/)

• Mr Chan, a 30-year-old registered nurse, said: “We have limited weapons to fight an endless war... Our frontline colleagues are attempting to minimise replacing personal protective equipment.” (https://hongkongfp.com/2020/02/05/limited-weapons-fight-endless-war-hong-kong-medics-strike-third-day-coronavirus-border-closure/)

• Asked if it was irresponsible to abandon patients, Leung, the anaesthesia assistant, said it was a dilemma. “Of course it is our duty to help patients,” he acknowledged. “But if we fell sick too, who would be there to help the patients?” (https://www.scmp.com/news/hong-kong/politics/article/3048705/hong-kong-hospital-strike-kicks-top-doctor-backs-mainland)
• 3. Strikers must feel that all possible other forms of communication have failed.
  
  • “The HAEA believes the decision to strike is not an easy one. In fact, we believe such actions are our last resort.” (HAEA announcement, 1 Feb 2020)
  
  • “We don’t want to go on strike, but the government has been ignoring the demands of the frontline medical workers. We have no choice,” Yu added.” (https://hongkongfp.com/2020/02/02/no-choice-hong-kong-medical-workers-agree-strike-mainland-border-closures/)
Moral imperative?

• 4. Imminent threat to patient well-being?
  • Pressing public health concerns in light of confirmed cases from mainland
  • Other countries had temporarily closed borders as well
    • (https://hongkongfp.com/2020/02/02/no-choice-hong-kong-medical-workers-agree-strike-mainland-border-closures/)

• Industrial action of healthcare workers in light of COVID-19 pandemic ➔ moral imperative
Punishment/retaliation

• Reports of calls for punishment (see e.g. calls by lawmaker/ExCo Regina Ip
  [https://news.rthk.hk/rthk/en/component/k2/1519571-20200408.htm])

• Industrial action in healthcare context of fundamentally different nature →
  usual options of punishment/retaliation should be replaced with more
  constructive measures to uphold professional autonomy and trust in state-
  profession relationship

• In light of conclusions re morality of strike – punishment/retaliation not a
  moral response
Implications for state-profession relationship

- Mechanisms to support a robust and meaningful state-profession relationship? Extreme nature of strike suggests need for better feedback mechanisms
  - CE’s hard stance and refusal to negotiate + HA’s lack of transparency suggest current lines of communication ineffective and state-profession relationship top-down in nature
• **Collaborative** relationship as a preferable approach
  
  • Better maintaining of professional autonomy and promotion of more constructive state-profession relationship
  
  • Why valuable?
  
  • Experience of healthcare professions (in particular in relation to public health emergencies)
Contacts

• Covid-19 in Asia: Law and Policy Contexts, edited by Victor V. Ramraj, Faculty of Law & Centre for Asia-Pacific Initiatives, University of Victoria, Canada; contact: ramraj@uvic.ca

• Please feel free to find out more about the Centre for Medical Ethics and Law at HKU
  • Email: cmel@hku.hk
  • Twitter: @HKU_CMEL
  • Facebook: @CMELHKU

• Also feel free to get in touch with us!
  • Daisy Cheung: dtcheung@hku.hk
  • Calvin Ho: cwlho@hku.hk
Thank You!