Strikes, patient outcomes and the cost of failing to act

Ryan Essex[1], Sorcha Brophy[2], Veena Sriram[3]

1. Institute for Lifecourse Development, University of Greenwich

2. Mailman School of Public Health, Columbia University

3. School of Public Policy and Global Affairs | School of Population and Public Health, The University of British Columbia

Corresponding author:

Ryan Essex

University of Greenwich

Old Royal Naval College, Park Row, London SE10 9LS

r.w.essex@gre.ac.uk

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The issue of patient safety has dominated debates about healthcare strikes–and yet, often overlooked are the broader set of ethical questions at play. These include investment in healthcare systems and the tradeoffs of both striking *as well as* failing to address health workers' grievances. Globally, health workers have become increasingly vocal about their dissatisfaction with the conditions of the healthcare systems in which they work. In the first year of the COVID-19 pandemic there were at least 6500 protests by health workers globally. This number represents a significant increase from prior years–available data indicates a 62% increase in health worker protest activity between the 2019-2020 and 2020-2021 periods [1]. Strike action is one form of protest that often prompts passionate and polarising debate, as worker concerns such as safety, working hours, and compensation are often pitted against the risks of strikes for patients.

This conflict has dominated the academic literature [2]. In the 1970s it was asserted that "grief, distress, physical harm and, almost certainly, unnecessary death" would almost be inevitable consequences of strike action [3]. In the 1980s, strike action was likened to "airline pilots threaten[ing] to parachute from their planes and leave their passengers without a pilot in mid-air" [4]. While not every argument we find is as dramatic, these concerns persist to this day. The question of patient harm is frequently raised by government and regulatory bodies. For example, in 2016, in the UK, the General Medical Council (GMC) instructed junior doctors to call off their planned strike, citing the potential harm patients would suffer. The GMC went as far as threatening sanctions, reminding junior doctors they could be "struck off, for unprofessional conduct" if they participated in the strike [5]. Governments also leverage concerns about patient harm to prevent strike action. In Australia for example, the government "repeatedly used 'patient safety' to name, blame and shame the nurses for their action and to falsely attribute the 'everyday' deficits and failings of the health care system to the industrial action being taken" [6]. In response to the 2022 – 2023 national nursing and ambulance worker strikes in the UK, Health Secretary Steve Barclay accused unions of taking a "conscious choice to inflict harm on patients" [7]. In this article we seek to expand upon and challenge this overly limited framing. First, we highlight the fact that the majority of strike action occurs in response to structural failings of health systems; as such, concerns about patient harm must be contextualized alongside concerns about health system resilience and sustainability. Second, we argue that there are risks in failing to strike, insofar

as strike action has the potential to change the trajectory of failing healthcare systems. Put another way, we challenge the framing of strikes as unquestionably harmful to patients, asking the inverse and often overlooked question–that is, *how might failure to strike adversely impact patients?* We consider this final point in light of the recent industrial action in the UK.

Structural failings and strikes

The drivers of strike action by health workers are multiple and the evidence indicates that this is a complex and multifaceted issue. An exclusive focus on immediate patient safety shifts attention away from the broader structural failings that frequently drive strikes. A number of years ago, Veatch [8] argued against assessments of strikes only considering providers' obligations to their individual patients, arguing that this mindset "oversimplif[ied]... a complex set of social interactions". Making a similar point, Neiman [9] argues that several parties share responsibility for healthcare delivery–the government, hospital management and insurance companies, the public, and others. As such, an accurate assessment of health workers' moral obligations regarding strike action must incorporate the actions of other members of the healthcare community which influence the quality of patient care. An awareness of the interrelatedness of these actors' actions is well reflected in the ways striking health workers frame their grievances. A recent analysis of protest action during the first year of COVID-19 found that while globally, the vast majority (66%) of health worker protests concerned remuneration or working conditions, these issues were frequently framed as part of larger systemic failures [10]. Before the pandemic, Binkowska-Bury et al. [11] found that striking Polish nurses linked concerns about wages and working conditions to government reforms and general neglect of the healthcare system. In many low- and middle-income countries, strikes about remuneration and working conditions also reflect historical patterns of underinvestment in the health sector, and a prioritization of health policies that do not address fundamental questions of governance [12]. Importantly, health workers also use strikes as tools to address public policy concerns (such as military coups or repressive government policy [13])—occasionally for reasons that are at odds with 'progressive' health policy, such as resisting government regulation or expanding medical student enrollment [14 15]. In assessing the legitimacy of strikes, it is also imperative to pay attention to who strikes, as strikes are often indicative of deeper issues of power and hierarchy within the health professions. In many countries, occupational groups that are dominated by women and are responsible for much "frontline" care, such as community health

workers, have resorted to strikes to voice to deeply unjust workforce policies, wage delays and other challenging working conditions because of their lack of representation in policy platforms [16 17]. Strikes are rarely only about pay or working conditions – they serve as a window into the consequences of austerity, underinvestment and de-prioritization of health, occupational hierarchies and intersectional power dynamics in health services, and larger societal issues.

Patient safety and strikes

While the drivers of strike action are complex, patient safety is still an important factor in considering such action. On this, there is a relatively small body of evidence. A recent meta-analysis [18] for example, which accounted for over 1.8 million admissions or presentations and almost 20,000 deaths, primarily in high-income countries, found that in the aggregate, there were no clear negative impacts of strike action related to patient mortality. Similar results were found in another review that examined a range of patient outcomes (other than mortality), with the majority of studies reporting that strike action had a neutral or mixed impact on patient outcomes [19]. While the headline finding could be that that strike action does not negatively impact patient outcomes, caution is warranted. The studies included in these reviews were highly variable in quality, and also included studies that were unable to rule out the possibility that strikes were harmful to patients. There are several studies that speak to this point. For example, a study from the US that examined patient mortality data from all hospitals in New York State over a 20-year period, finding that in-hospital mortality was over 18% higher for those admitted during a strike [20]. Beyond these studies, further caution is also warranted because of the narrow focus on specific outcomes, and due to the overrepresentation of high-income countries in literature regarding health care strikes. For example, the six studies from low and middle-income countries included in the above reviews suggest substantial variability in patient outcomes, findings that must be interpreted in light of weaknesses in “safety nets” in these contexts to absorb the impacts of strike action through alternative services. Finally, while we know little about the knock-on effects of strike action, a small number of studies suggest strike action in low-resource settings increases mortality in nearby facilities dealing with surges in patient pressures because of strike action, once again, a reflection of systemic concerns around health service access [21].

One further limitation of the above studies is that they say little about the impact of strike action on healthcare delivery. Studies that measure outcomes such as hospital attendance and wait times indicate that strike action is clearly disruptive. Across studies we generally see a substantial decrease in the number of presentations or admission to hospital during periods of strike action; cancellations are also common, along with disruption to other services such as outpatient appointments [22]. In many cases these disruptions are dependent on *who* strikes. When junior doctors strike for example, studies suggest that waiting times and length of stay in hospital either do not change [23] [24] or that services actually become more efficient during strike periods, with patients waiting for less time and staying in hospital for shorter periods [25-30].

Patient safety and failing to act

During the 1982 UK nurse strike, a student nurse wrote to the Guardian, making the point that "we owe it to our patients to strike, to improve their conditions, to improve our morale and to increase the incentive so that more people join the profession" [31]. Two decades later, Jennings and Western [32] argued that for nurses in the UK, the question was "not whether that action is ethical but whether it is unethical not to take action". This question, the inverse of what is often asked, has surprisingly received little attention; what are the potential costs in failing to strike? An answer to this question will depend on a range of contextual factors related to health systems governance, the ability of health workers to make their voices heard within policy processes, and the social and political context in which it is occurring. As such, it is instructive to think about this question in light of recent industrial action by nurses, ambulance workers and junior doctors in the UK. At the time of writing, there are almost daily stories in the UK about lengthy patient wait times, limited equipment, staff and bed shortages [33] with these conditions linked to tens of thousands of deaths [34]. Rather than respond to this crisis, the UK government has, for a number of years, either ignored or dismissed these concerns [35]. While the evidence about the impact of strike action is inconsistent, the evidence about the dire state of the NHS is clear. Reframing the issue in this way, strike action can be seen as an act of patient advocacy that is not only permissible, but in some circumstances may be necessary.

One caveat to this point is that we have little evidence of the 'effectiveness' of health worker strikes; there is no systematic data about the number of strikes that have their demands met either in full or partially [36]. If strikes were effective (i.e. resolved quickly with their demands met) it would add to the case for strike

action. While the evidence is sparse, we can still find several examples where strikes have secured important gains. For example, the 1982 UK nurse strike not only led to the government offering a pay increase of over 12.3% by also introducing a national pay review body [31]. Beyond strikes themselves, there are several studies that point to the benefits of industrial action and union membership more generally. There is evidence to suggest that increased levels of union membership are associated with better working conditions for health workers [37] and improved patient safety [38] amongst other benefits.

Strikes as advocacy

Above we have sought to expand and challenge the often-narrow framing of strikes as harmful to patients. While patient safety obviously matters, the almost myopic focus on this by many has shifted focus away from the structural failings that often drive strike action. We have sought to challenge this dominant framing by arguing that when health workers lack other avenues to voice concerns, the *failure to strike* may actually be more harmful to health in the long run. Looking ahead, multiple dimensions of healthcare strikes deserve further attention. Further work is needed to explore how the impact of strike action on patients can be mitigated, with only a handful of studies reporting on contingency planning [39]. More research is needed regarding salient differences in who strikes and where – as well as deeper analysis of policy processes that might be utilized to incorporate the concerns of health workers, and potentially avert future strike action. There is at least one urgent action point that follows from our analysis—many countries, including the UK, are seeking to restrict the right to strike for health workers and others [40]. This should be resisted, not only as a right fundamental to any democratic country, but because strike action can be an act of advocacy to demand better of our healthcare systems.

References

1. Brophy SA, Sriram V, Zong H, et al. Heroes on Strike: Trends in Global Health Worker Protests During COVID-19. 2022
2. Essex R, Weldon SM. The justification for strike action in healthcare: a systematic critical interpretive synthesis. *Nursing Ethics* 2021
3. Dworkin G. Strikes and the National Health Service: some legal and ethical issues. *J Med Ethics* 1977;3(2):76-84. doi: 10.1136/jme.3.2.76

4. Glick SM. Health workers' strikes: a further rejoinder. *J Med Ethics* 1986;12(1):43-4. doi: 10.1136/jme.12.1.43

5. Sparrow A. Junior doctors could be struck off over industrial action, warns GMC. *The Guardian* 2016

6. Johnstone M-J. Industrial action and patient safety ethics. *Australian nursing journal (July 1993)* 2012;19(7):29.

7. Barclay S. Strikes are in no one's interest - least of all patients. *The Telegraph* 2022

8. Veatch RM, Bleich D. Interns and residents on strike. *The Hastings Center report* 1975;5(6):8-9.

9. Neiman P. Nursing strikes: an ethical perspective on the US healthcare community. *Nursing ethics* 2011;18(4):596-605. doi: 10.1177/0969733011408050

10. Brophy SA, Sriram V, Sharma, et al. Vulnerability, protest and medical trainees in the pandemic era: case studies from France, India, Mexico and Pakistan. . Forthcoming

11. Binkowska-Bury M, Marc M, Nagorska M, et al. The opinions of Polish nurses and patients on nursing protests. *Collegium antropologicum* 2013;37(3):691-99.

12. McKeown M. Alliances in action: Opportunities and threats to solidarity between workers and service users in health and social care disputes. *Social Theory & Health* 2009;7(2):148-69. doi: 10.1057/sth.2009.8

13. Head J. Myanmar coup: The doctors and nurses defying the military. *BBC News* 2022

14. Mishra A, Annie Elias M, Sriram V. A Draconian Law: Examining the Navigation of Coalition Politics and Policy Reform by Health Provider Associations in Karnataka, India. *Journal of health politics, policy and law* 2021 doi: http://dx.doi.org/10.1215/03616878-8970895

15. Cha S. South Korean doctors strike over plan to boost medical student numbers. *Reuters* 2020

16. Khan A. Lady health workers and social change in Pakistan. *Econ Polit Wkly* 2011:28-31.

17. Asthana S, Mayra K. India's one million Accredited Social Health Activists (ASHA) win the Global Health Leaders award at the 75th World Health Assembly: Time to move beyond rhetoric to action? *The Lancet Regional Health-Southeast Asia* 2022;3

18. Essex R, Weldon SM, Kalocsanyiova E, et al. The impact of healthcare strikes on patient mortality: a systematic review and meta-analysis of observational studies. *Health Services Research* 2022
19. Essex R, Milligan W, Williamans G, et al. The impact of strike action on patient morbidity: A systematic literature review. *International Journal of Healthcare Management* 2021
20. Gruber J, Kleiner SA. Do strikes kill? Evidence from New York State. *Am Econ J Econ Policy* 2012;4(1):127-57. doi: 10.1257/pol.4.1.127
21. Adam MB, Muma S, Modi JA, et al. Paediatric and obstetric outcomes at a faith-based hospital during the 100-day public sector physician strike in Kenya. *BMJ global health* 2018;3(2):e000665. doi: 10.1136/bmjgh-2017-000665
22. Essex R, Ahmed S, Elliott H, et al. The impact of strike action on healthcare delivery: A scoping review. *The International Journal of Health Planning and Management* 2022
23. Griffiths P, O'Mahony K, Wilson P. An analysis of patient outcomes during industrial action resulting from the junior doctors' contract dispute 2016: a district general hospital perspective. *Future healthcare journal* 2017;4(Suppl 2):s1. doi: 10.7861/futurehosp.4-2s-s1
24. McNamara JJ, Greene M. An evaluation of emergency room services during the New York City house officer strike. *Am J Public Health* 1976;66(2):135-8. doi: 10.2105/AJPH.66.2.135
25. Montero-Pérez FJ, Calderón De La Barca-Gázquez JM, Calvo-Rodríguez R, et al. Impact of a residents’ strike on the efficiency of a teaching hospital’s emergency department. *Emerg* 2014;26(6):443-49.
26. Salazar A, Corbella X, Onaga H, et al. Impact of a resident strike on emergency department quality indicators at an urban teaching hospital. *Academic emergency medicine : official journal of the Society for Academic Emergency Medicine* 2001;8(8):804-8. doi: 10.1111/j.1553-2712.2001.tb00210.x
27. Sim J, Choi Y, Jeong J. Changes in Emergency Department Performance during Strike of Junior Physicians in Korea. *Emergency Medicine International* 2021;2021 doi: 10.1155/2021/1786728

28. Harvey M, Al Shaar M, Cave G, et al. Correlation of physician seniority with increased emergency department efficiency during a resident doctors' strike. *The New Zealand medical journal* 2008;121(1272):59-68.
29. Robinson G, McCann K, Freeman P, et al. The New Zealand national junior doctors' strike: implications for the provision of acute hospital medical services. *Clinical medicine (London, England)* 2008;8(3):272-5. doi: 10.7861/clinmedicine.8-3-272
30. Thornton V, Hazell W. Junior doctor strike model of care: Reduced access block and predominant Fellow of the Australasian College for Emergency Medicine staffing improve emergency department performance. *Emergency medicine Australasia : EMA* 2008;20(5):425-30. doi: 10.1111/j.1742-6723.2008.01117.x
31. Arnold-Forster A. When NHS Workers Fought Back Against Thatcher. *Tribune* 2022
32. Jennings K, Western G. A right to strike? *Nursing ethics* 1997;4(4):277-82. doi: 10.1177/096973309700400403
33. Lintern S. A&E crisis: Portable oxygen running out as patient waits 99 hours for bed. *The Sunday Times* 2023
34. Thomas R. Revealed: Crisis in A&E departments drives 15,000 deaths. *Independent* 2022
35. Boyle A. Unprecedented? The NHS crisis in emergency care was entirely predictable: British Medical Journal Publishing Group, 2023.
36. Kallas J. Retooling militancy: Labour revitalization and fixed-duration strikes. *British Journal of Industrial Relations* 2022
37. Ahmed AM, Kadakia K, Ahmed A, et al. Trends in Labor Unionization Among US Health Care Workers, 2009-2021. *JAMA* 2022;328(24):2404-11.
38. Weaver MD, Landrigan CP, Sullivan JP, et al. National improvements in resident physician-reported patient safety after limiting first-year resident physicians’ extended duration work shifts: a pooled analysis of prospective cohort studies. *BMJ Quality & Safety* 2022
39. Daga SR, Shende SR. Neonatal care during a residents' strike. *Tropical doctor* 1999;29(2):73-5. doi: 10.1177/004947559902900204
40. Crerar P, Stacey K. Union fury as Rishi Sunak unveils anti-strike laws for ‘minimum service levels’. *The Guardian* 2023

Contributors and Sources

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