**CP: A just government ought to recognize the right of workers to strike except in the instance of medical workers during a public health emergency.**

**Mfutso-Bengu**, Joseph, **and** Adamson S **Muula**. “Is it ethical for health workers to strike? Issues from the 2001 QECH general hospital strike.” Malawi medical journal : the journal of Medical Association of Malawi vol. 14,2 (**2002**): 29-31. doi:10.4314/mmj.v14i2.10766 //SR

Summary Between 5th and 19th October 2001, a general strike in which virtually all workers at the Queen Elizabeth Central Hospital (QECH) were involved was effected. Hospital workers' grievances included low remuneration and poor work environment. The strike resulted in the virtual closure of the QECH, as the 1500-bed hospital was maintained less than a hundred in-patients. The outpatient department was closed. Patients that were still in hospital were being cared for by volunteer workers who included; the Red Cross, medical and nursing students and their lecturers. The two-week strike at QECH has left an almost indelible mark in as far as tertiary level health care delivery in Malawi is concerned. We report on the conduct of the hospital workers strike and discuss ethical issues in the light of the socio-political context of Malawi. While many people suggest that damage has definitely been done and felt, the ethical issues involved remain contentious as ever.  Introduction Malawi has four public tertiary care hospitals of which the largest is the Queen Elizabeth Central Hospital (QECH) in Blantyre. The other referral hospitals are Zomba, Lilongwe, and Mzuzu. The QECH, a 1,500-bedded hospital is the teaching hospital for the University of Malawi College of Medicine, Malawi's only medical school and also hosts the Blantyre campus for the Kamuzu College of Nursing (KCN). The hospital operates at about 120 per cent capacity and functions as the ‘district hospital’ for Blantyre. There are between 10 and 20 deliveries conducted each day, at least 20 admissions are made each day to the medical and surgical wards and over 40 paediatric admissions. The bulk of clinical work is provided by clinical officers 1. The hospital is also served by about 15 intern doctors, 8 medical registrars and about 25 specialist doctors. From 5th and 19th October 2001, the hospital experienced a general strike in which virtually all cadres of workers were involved 2–7. We report the conduct of the strike, its implications and ethical issues pertaining to the general strike in as far as health workers are concerned.  Political History Malawi attained political independence from Britain in 1964 having been under British rule since 1881. For the next 3 decades after independence, the country had one-party dictatorial rule. Political dissent and industrial action such as strikes were firmly discouraged. For the most part of the 30 years immediately post-independent, Malawi had a State President for Life and any attempt to stage a strike or public demonstration was construed as intention to bring down the government and therefore, tantamount to treason. The maximum penalty for treason in Malawi is death.  Significant political change was experienced between 1992 and 1993 when general civil disobedience in form of street demonstrations, riots and strikes were used as tools to put pressure on the government to effect political change. In June 1993, a National Referendum was carried out in which Malawians were to choose whether to continue with the status quo i.e. one-party dictatorial rule or to change to plural politics. The main result of the National Referendum was that Malawians chose to change their political system to political pluralism. With the coming of political pluralism was the rebirth of democracy and recognition and respect of individual and group rights. For once in many years, Malawians had the right to form associations, political or otherwise. The right of collective bargaining and provision to wage industrial strikes was effected in Malawi's statutes. Between 1994 and 2001, Malawi has witnessed more strikes as compared to those witnessed between 1964 and 1994.  The QECH Strike Between October 5th and 19th 2001, a general hospital strike was in session at QECH, Blantyre. Virtually all hospital workers i.e. clinical and nursing; administrative, catering and laundry, security and others refused to work. As has been observed elsewhere8, four main issues ignited the strike and these were dissatisfaction with the amount of; house allowances, monthly wages and risk and professional allowance. The disfranchised hospital workers had argued that they deserved better remuneration as their services were essential. Comparison was made to the Judicial Services where employees have better remuneration packages, as compared to health workers. The government (employer) on its part argued that it was not possible to meet the demands raised by the workers as doing so would have upset the 2001/02 national budget that had already been approved by the National Assembly in August 2001.  During the course of the strike the 1,500-bedded QECH only managed to serve 196 patients mostly in the Burns Unit, Orthopaedics Department, Malaria Research Project ward, and paediatric oncology ward. Other patients were left to find their own care and many had been either encouraged to leave or discouraged from staying earlier. Over 500 patients from QECH were admitted at Mlambe Mission Hospital, which is under the Christian Health Association (CHAM) some 12 kilometres from QECH. Mlambe has capacity only for 250 in-patients and had only three doctors. While the professional health workers were on strike, 104 volunteers, 68 of whom were from the Red Cross, 36 others being nursing and medical students and their lecturers from the University of Malawi provided clinical, nursing and support services at the QECH.  The ethics of the strike The big ethical question is; is it ethical for medical doctors to strike just like everyone else as was the case at QECH, which implied withdrawing treatment and healthcare to the patients entrusted to them? One would argue that such action undermined the right of patients to healthcare and the profession's duty to protect life and health. If we indeed agree that it is ethical for doctors to strike, then we ought to ask ourselves how should the strike be conducted? If we are against medical strike, then which other viable options do health workers with grievances against the employer have other than strike.  According to World Medical Association declaration of Helsinki, it is the duty of the physician (health worker) to promote and safeguard the health of the people. The health of the patient will be the first consideration of the physician (health worker)9. The main aim of medical practice is to save life, preserve, promote and manage health. It is generally understood that health workers should always desist from harming their patients10 and their actions should always be in the best interest of the patient 11. On the other hand health workers that are employed on agreed remuneration packages have the right to be paid and they have the right to express dissatisfaction and protect themselves from unfair treatment and exploitation 12. However their own rights are limited by their responsibility to save life and promote health as laid down by the medical profession's code of conduct. It is suggested that there is a need to do a thorough risk benefit assessment, before health personnel decide to embark on strike. Is the strike in the best interest of health care delivery system? Patients ought to be notified and be given prior warning about the strike, so as to minimize harm. The Constitution of the Republic of Malawi recognizes that workers should be fairly remunerated and the provision for strike is enshrined13. Just because a thing is legal is not necessarily that it is ethical in all circumstances.  When two rights are in competition or conflict, as was in this case, the right to be adequately remunerated and right for the healthcare the impasse could be solved by resorting to what we call re-evaluation of moral values. Not all-moral values have the same weight and scope; there is hierarchy of ethical norms and principle. Although moral values are hierarchical in nature, they are intermingled. For example, the right to life does not have the same weight as the right to privacy. Therefore the right to health care (and implicitly life) on the part of the patient may be considered overriding the right to better remuneration of health care workers. This is not a universal perception among health workers and it is a matter of controversy in many circumstances.  In the context of a strike, one should ensure not undertake anything that could result in causing harm directly or indirectly to the patient. Any struggle undertaken by medical personnel that violates patient right to health is unethical. The struggle should be centered at improving overall working conditions and environment in the hospital. The problem with this understanding is that it is almost impossible to stage a strike which is not painful and does not hurt the patient as such would in essence defeat the whole effect of the strike. One could rightly argue that, the only ones who could better defend the plight of the patient are the health workers. If they forsake their patient who can then defend them? Therefore if the health workers want to improve their working conditions let them also fight for the living and care conditions of their patients. For the working condition of a health worker is the living condition of the patient, both are two sides of one coin. A health worker and a patient are not the same and yet they cannot be separated; one cannot be, without the other. Therefore government cannot improve the living conditions of patients without improving the working conditions of the health personnel.  The duty and responsibility to protect life is among the first in hierarchy of values. Hence in a strike an attempt should be made to leave a skeleton staff. Some might say this could undermine the effectiveness of the strike. Others might argue that the absence of a skeleton staff could undermine the integrity of the health workers involved in the strike. It might also be argued that to put in place a skeleton staff could do more harm to the patients than good, because the small and less motivated staff could exhibit negligent behaviour being induced by over work, fatigue and stress but also carelessness.  If the government and regulatory services say that it is unethical for medical personnel to strike, because medical service are in category of special services 14–16, where and how can the health personnel express their grievances when they discover that their professional services and good will are being abused in the name of professional ethics? If their work is crucial in our society, why do society not give them what is due to them?

**The counterplan is key to pandemic containment**

S **Damery et. al.**, H Draper, S Wilson, S Greenfield, J Ives, J Parry, J Petts and T Sorell. Healthcare workers' perceptions of the duty to work during an influenza pandemic. Source: Journal of Medical Ethics, Vol. 36, No. 1 (January **2010**), pp. 12-18 Published by: BMJ Stable URL: [http://www.jstor.org/stable/20696709 //SR](http://www.jstor.org/stable/20696709%20/SR) \*HCW = health care worker\*

The duty to work is presently under scrutiny because of the current swine flu pandemic. Pandemic influenza is, according to the National Risk Register, the potential emergency that is likely to have the greatest impact in the UK,6 and the serious nature of the threat is widely recognised internationally.710 Health services in the UK are already strained, and the situation is set to worsen as winter?the traditional influenza season? approaches. HCWs are at the forefront of both pandemic response and exposure to infection. An effective public health response that ensures that appropriate standards of conventional and critical patient care can be maintained depends on the majority of uninfected HCWs continuing to attend work, despite the risks they might face in doing so. We recently published research suggesting that absenteeism during an influenza pandemic may be significant, depending on the severity of the pandemic and the combination of adverse circum stances that arise as a result.11 In common with others, we have found that there are barriers to both the willingness and the ability to work.11-15 Pandemic preparedness plans typically focus on reducing barriers to ability (such as employers providing HCWs with transport to and from work if they are redeployed to an alternative site, or allowing greater flexibility of working hours).16 These plans assume that ability and willingness are discrete and complementary, such that addressing barriers to ability to work will have a corresponding positive influence on will ingness to do so. However, willingness may not necessarily be increased by the implementation of practical or pragmatic solutions but may be instead more deeply rooted in a number of factors, such as the extent to which HCWs feel included in preparedness planning, or various sociodemo graphic and family issues. These are likely to influence HCWs; willingness to work during a pandemic or other emergency.15 1718 The main findings of a large-scale survey of professional and non-professional HCWs in the West Midlands, which aimed to investigate the factors associated with willingness to work during an influenza pandemic, have been published elsewhere.11

**Disease causes extinction - defense is wrong**

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Historically, disease events have been responsible for the greatest death tolls on humanity. The 1918 flu was responsible for more than 50 million deaths,1 while smallpox killed perhaps 10 times that many in the 20th century alone.2 The Black Death was responsible for killing over 25% of the European population,3 while other pandemics, such as the plague of Justinian, are thought to have killed 25 million in the 6th century—constituting over 10% of the world’s population at the time.4 It is an open question whether a future pandemic could result in outright human extinction or the irreversible collapse of civilization.  A skeptic would have many good reasons to think that existential risk from disease is unlikely. Such a disease would need to spread worldwide to remote populations, overcome rare genetic resistances, and evade detection, cures, and countermeasures. Even evolution itself may work in humanity’s favor: Virulence and transmission is often a trade-off, and so evolutionary pressures could push against maximally lethal wild-type pathogens.5,6  While these arguments point to a very small risk of human extinction, they do not rule the possibility out entirely. Although rare, there are recorded instances of species going extinct due to disease—primarily in amphibians, but also in 1 mammalian species of rat on Christmas Island.7,8 There are also historical examples of large human populations being almost entirely wiped out by disease, especially when multiple diseases were simultaneously introduced into a population without immunity. The most striking examples of total population collapse include native American tribes exposed to European diseases, such as the Massachusett (86% loss of population), Quiripi-Unquachog (95% loss of population), and theWestern Abenaki (which suffered a staggering 98% loss of population).  In the modern context, no single disease currently exists that combines the worst-case levels of transmissibility, lethality, resistance to countermeasures, and global reach. But many diseases are proof of principle that each worst-case attribute can be realized independently. For example, some diseases exhibit nearly a 100% case fatality ratio in the absence of treatment, such as rabies or septicemic plague. Other diseases have a track record of spreading to virtually every human community worldwide, such as the 1918 flu,10 and seroprevalence studies indicate that other pathogens, such as chickenpox and HSV-1, can successfully reach over 95% of a population.11,12 Under optimal virulence theory, natural evolution would be an unlikely source for pathogens with the highest possible levels of transmissibility, virulence, and global reach. But advances in biotechnology might allow the creation of diseases that combine such traits. Recent controversy has already emerged over a number of scientific experiments that resulted in viruses with enhanced transmissibility, lethality, and/or the ability to overcome therapeutics.13-17 Other experiments demonstrated that mousepox could be modified to have a 100% case fatality rate and render a vaccine ineffective.18 In addition to transmissibility and lethality, studies have shown that other disease traits, such as incubation time, environmental survival, and available vectors, could be modified as well.19-2