The Ethical Principle of 'Do no harm' and Industrial Action

Submission to the National Ethics Advisory Committee

Principal Author

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ABOUT NZNO **About the New Zealand Nurses Organisation**

The New Zealand Nurses Organisation is the leading professional and industrial organisation for nurses in Aotearoa New Zealand, representing over 46,000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. Te Runanga o Aotearoa comprises our Māori membership and is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals comprising half the health workforce.

The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the National Ethics Advisory Committee (NEAC) draft paper: *The ethical principle of 'do no harm' and industrial action.*
2. NZNO acknowledges the committee's sound consultative processes in the development of this document, which explores whether current provisions for life preserving services (LPS) provisions in the Code of Good Faith (the Code) are consistent with the 'do no harm' principle.
3. While the paper does contribute to this discussion , in general we do not consider:
    - that strike action poses a different risk from any situation necessitating prioritisation or rationing of services for which sound contingency plans must be in place; or
    - that a single principle can, or should, be considered in isolation from other principles.
4. The paper offers a clear exposition on the principle of 'do no harm' and explores the practical questions it raises in the current regulatory environment.
5. However, it does not make clear that the key responsibility for safety during strike action rests with the employer, and it is somewhat equivocal about the rights of health workers to withdraw their labour.
6. NZNO generally supports the paper, and recommends that the Committee:

- strengthens the phrasing around the legitimate right of workers to withdraw their labour;
- clarifies that the responsibility for patient safety in all situations, including strikes, lies with the employer;
- supports the development of a robust training model for providers to establish collaborative processes for sound contingency planning for LPS in emergency situations; and
- notes that NZNO welcomes continued liaison with the NEAC on this issue.

DISCUSSION

7. NZNO agrees that strict adherence to the LPS provisions to protect against death or permanent disability may not give full expression to the principle of 'do no harm', but that that 'high threshold' risk is balanced by established codes of practice, shared expectations and robust contingency plans that maintain clinical oversight of patient wellbeing.
8. Accordingly we submit that the 'do no harm' principle cannot, and should not, be considered in isolation from other principles.
9. The harm matrix and harm/hurt discussion both provide useful ways of approaching the complexities involved in prioritising/rationing services where strike action is taken, but we would challenge any inference that the legitimate withdrawal of labour constitutes a different risk from other situations in which there are insufficient health staff/resources, particularly since patient risk is a motivating factor for strike action at times.
10. We suggest that the paper overestimates the level of risk clinicians are prepared to tolerate for serious harm.
11. We applaud the paper for its clarity, but are somewhat concerned by the weakness of its affirmation of employees right to strike and, more importantly, its failure to affirm that the key responsibility for safety during strike action rest with the employer.
12. We note that while some District Health Boards (DHBs) have developed excellent contingency plans, others have not; the situation in the increasing number of privately owned health facilities is not known.
13. Since many of latter concern vulnerable people, those in acute aged care services, for example, and since escalating privatisation has led to corporate and international ownership of many of Aotearoa's essential

health services and facilities - district nursing services, primary health clinics, imaging and diagnostic testing laboratories, etc. - it is essential that sound collaborative processes are established to ensure robust, integrated contingency planning for LPS.

14. To facilitate this, NZNO recommends a training programme for providers to develop collaborative clear processes.
15. NZNO notes that Guidelines for addressing the LPS provisions in the Code of Good Faith have now been agreed by all parties. We recommend that these are appended to the paper.
16. Specific comments on the text follow.

Introduction

Page 1 paragraph 2.

17. The right of health and disability workers to strike is a fundamental tenet of employment law and should not be qualified with a value judgment relating to its importance, the complexity of industrial relations in the sector, or who is affected, since such self-evident qualifications detract from the affirmation.
18. NZNO recommends the sentence is amended to read: *NEAC recognises the right of health and disability workers to strike.*

Are current LPS Provisions consistent with the 'do no harm' principle?

Page 4 Matrix

19. The matrix may not capture the escalation of harm over time i.e. that (d) low risk low harm, may escalate to (b) low risk high harm if the delay is extended, or the difference in urgency for tests/time periods.
20. For example, delaying a meningitis blood test on a floppy baby, a scan on an unconscious RTA victim, or a blood cross match during an operation, are all different from diagnostic tests, where delays are often caused by lack of access to an x-ray machine or someone taking time off work to organise and get a test.
21. Such complexities need to be reflected in the paper. Contingency plans must be sufficiently flexible to capture and address differences in the levels of risk over time, including urgency periods for tests. As pointed out in the following section, that "one cannot know in advance which patient ...will be harmed", but increasing risk can be calculated over time risks over time, if provision is made to do so.

Degree of harm

22. We are cautious about NEAC's conclusion that not providing a common test for a seriously harmful condition constitutes a violation of the 'do no harm' principle. Since most testing is done to exclude serious illness, this interpretation may suggest that health professionals providing diagnostic testing are ethically bound not to strike, and the paper neglects to mention that this, in effect, conflicts with the right to strike.
23. The NEAC's decided view on the potential harm from an unspecified delay is at also odds with the earlier example given of actual harm where suffering is prolonged and/or substantially complicates recovery as for example with an elderly person with a fractured femur. Despite the LPS provisions, most clinicians would classify this as a 'serious harm' situation, whereas they may not do the same with, for example, a test that is delayed for a short period.

Chance of harm, page 5

24. We note that an 'acceptable' level of risk varies with the condition and other factors, including patient preferences, and clinical judgement. We suggest that 1-in-100 or 1-in-200 seriously overestimates the level of risks clinicians are prepared to tolerate for serious harm.

The balance between the right to strike and the 'do no harm; principle

Page 6, paragraph 1

25. An additional consideration to be noted is that industrial action may be undertaken to prevent potential harm, for example where conditions for workers or patients are unsafe or not in the best interests of patients individually or collectively.

Paragraph 3, last sentence

26. Re "*This [consumers' right to cooperation among providers] seems to be achieved in the context of industrial action by the processes of contingency planning ...".*
27. As indicated above, contingency planning is of variable quality and collaborative processes are not consistent in the health sector. We recommend that a more proactive statement is needed to the effect that "All providers must have robust, collaboratively-developed contingency plans to accommodate the wide spectrum of predictable risks to health services to ensure consumers' right to cooperation among providers is achieved. "
28. We also recommend that a training programme for providers to develop/enhance collaborative processes for contingency planning is

established, along with national guidelines for addressing the LPS provisions of the Code.

CONCLUSION

29. We trust that the above comments are useful and reiterate our continued interest in liaising with the committee on this and other issues.
30. In conclusion we recommend that the Committee:

- notes NZNO support of the paper;
- agrees that strike action does not pose a different risk from any situation necessitating prioritisation or rationing of services for which sound contingency plans must be in place;
- agrees that a single principle cannot, and should not, be considered in isolation from other principles;
- agrees to strengthen the phrasing around the legitimate right of workers to withdraw their labour;
- clarifies that the responsibility for patient safety in all situations, including strikes, lies with the employer;
- supports the development of a robust training model and guidelines to assist all providers to develop collaborative processes for formulating sound flexible contingency plans for maintaining LPS in emergency situations;
- appends the agreed guidelines for addressing the LPS provisions in the Code to the paper.

26. NZNO welcomes continued liaison with the NEAC on this issue.

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