

# **The Ethical Principle of ‘Do No Harm’ and Industrial Action**

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# 1 Introduction

- 1.1 Ethics involves identifying what matters and how best to act on it. In this document, the National Ethics Advisory Committee, Kāhui Matatika o te Motu (NEAC) discusses the ethical principle of 'do no harm' and how this applies during industrial action. In doing so, it highlights the widely shared ethical values that can be applied to guide discussions and to inform the decision-making and conduct of all of those involved when industrial action is contemplated or undertaken, including health and disability workers, unions and employers in the health sector.
- 1.2 NEAC recognises that the right of health and disability workers to strike is important and that industrial relations in the health and disability sector are complex and can affect a wide range of groups. NEAC does not wish to interfere in the processes of industrial relations other than in assisting all parties to consider the ethical principle of 'do no harm' when considering industrial action, in contingency planning for industrial action and in the conduct of industrial action.
- 1.3 Industrial action taken by health and disability workers can range from strikes to lower-level sanctions, including working-to-rule, go-slows and overtime bans. This document applies mainly to strikes, which refers to 'a refusal by workers to continue working, usually involving a walk-out or concerted non-attendance at the work place'.<sup>1</sup>

<sup>1</sup> Scott J, Marshall G (eds). 2009. *A Dictionary of Sociology*, 3rd ed. Oxford: Oxford University Press.

## 2 Background

- 2.1 The Code of Good Faith<sup>2</sup> requires district health boards (DHBs) to provide for patient safety during industrial action by ensuring that life preserving services (LPS) – defined as crisis interventions, care required for therapeutic services and urgent diagnostic procedures – are available to prevent a *serious threat to life or permanent disability*. DHBs must develop contingency plans to ensure that LPS can be provided during industrial action and may request union members' assistance to maintain LPS.
- 2.2 This project was initiated following an invitation from the then Minister of Health Hon Hodgson for NEAC to meet New Zealand Council of Trade Unions and DHB officials who were considering the interpretation and application of the LPS provisions in the Code of Good Faith. NEAC sought to assist this work by exploring whether the interpretation and application of LPS provisions are consistent with the ethical principle of 'do no harm'.
- 2.3 This document has been developed following consultation with representatives of health and disability workers and employers in the health sector (see appendix 1 for a full list of participants). The consultation process aimed to discuss the interpretation of the ethical principle of 'do no harm' and how the health sector might aim to ensure that the application of the right to strike is consistent with this principle.

<sup>2</sup> Schedule 1B of the Employment Relations Act 2000.

### **3 All parties have a responsibility to ‘do no harm’ during industrial action**

- 3.1 It is clear from the consultation undertaken by NEAC that all parties seek to avoid or minimise harm to patients in the context of industrial action. Representative bodies, unions and employers in the health sector have all strongly reiterated that the right to strike should be interpreted and exercised nationally in a way that is consistent with the ethical principle of ‘do no harm’. This “commitment to the safety of patients” is reflected in one of the purposes of the Code of Good Faith.<sup>3</sup>
- 3.2 All parties that NEAC has consulted agree that at all times doing the least harm possible to patients in any given set of circumstances is a shared value but that, inevitably, decisions need to be made about the allocation of scarce resources that may impact on patient outcomes. Some groups consulted also expressed the view that, as a result of the processes involved in preparing for and carrying out industrial action, regular access to senior consultants/medical staff had resulted in a high standard of care for patients.

<sup>3</sup> Clause 2 of Schedule 1B of the Employment Relations Act 2000.

## 4 'Do no harm' as a statement of principle

- 4.1 DHBs have an obligation to improve, promote and protect the health of people and their communities.<sup>4</sup> Health and disability workers are also subject to a requirement to 'do no harm' to the health or wellbeing of those whom they serve.<sup>5,6,7</sup> The Hippocratic tradition expresses a long-standing medical-ethical commitment to 'do no harm', which applies primarily to intentional actions but may also apply to non-actions or omissions. The standards for health and disability workers in New Zealand endorse the 'do no harm' principle (see appendix 2). Several other codes for health and disability workers express statements that more closely align with requirements of beneficence, such as acting in the best interests of their patients or putting patients' interests first.<sup>8</sup>
- 4.2 The 'do no harm' principle is also reflected in legal obligations binding on health and disability workers. Right 4(4) of the Code of Health and Disability Services Consumers' Rights<sup>9</sup> (the Code) states that every consumer has the right to have services provided in a manner that minimises the potential harm to that consumer. Minimising harm is also an aspect of the general duty of health and disability workers to exercise reasonable care and skill, in accordance with Right 4(1) of the Code. However, these rights have been interpreted by the Health and Disability Commissioner (HDC) as being subject to circumstances extant at the time the health and disability worker (or their employer) provided care.
- 4.3 A HDC case from 2006<sup>10</sup> provides an insight into these issues.<sup>11</sup> It involved a patient whose diagnosis of cerebellar abscess was delayed because of industrial action. The HDC commented that:

The MRT [Medical Radiation Technologist] strike placed Otago DHB in a very difficult position, and Dr C clearly felt constrained in providing clinical care to Mr A.

[S]trikes that involve agreements on LPSs [...] disrupt normal diagnostic decision-making and clinical care processes.

<sup>4</sup> Section 22(1) of the New Zealand Public Health and Disability Act 2000.

<sup>5</sup> Callahan J (ed). 1998. *Ethical Issues in Professional Life*. New York: Oxford University Press.

<sup>6</sup> Bayles M. 1989. *Professional Ethics*, 2nd ed. Belmont, California: Wadsworth.

<sup>7</sup> Beauchamp T, Childress J. 2009. *Principles of Biomedical Ethics*, 6th ed. New York: Oxford University Press.

<sup>8</sup> This is the case in New Zealand for doctors, chiropractors, clinical physiologists, dentists, medical radiation technologists, osteopaths, occupational therapists, physiotherapists, podiatrists, speech-language therapists and social workers.

<sup>9</sup> Health and Disability Commissioner. 1996. *Code of Health and Disability Services Consumers' Rights*. Wellington: Health and Disability Commissioner.

<sup>10</sup> Health and Disability Commissioner. 2008. *Otago District Health Board. A report by the Health and Disability Commissioner. Case 07HDC05942*. Wellington: Health and Disability Commissioner.

<sup>11</sup> This case occurred before the LPS provisions of the Code of Good Faith for the Public Health Sector were changed to include prevention of permanent disability as well as the preservation of life.



4.4 The HDC concluded that the DHB had not breached the HDC Code:

Otago DHB had an obligation to ensure that it provided services in a manner that minimised the potential harm to patients like Mr A, and to ensure that patients received well coordinated services during the MRT strike. However, a provider can only be expected to take “reasonable actions in the circumstances” prevailing at the time (see clause 3 of the Code).

4.5 The moral dilemma faced by those involved in the case embodies the heart of NEAC’s discussion below about the chance of harm and whether the interpretation and application of the LPS provisions ensure that all those withholding or withdrawing a service or services through industrial action also adhere to the ‘do no harm’ principle.

## 5 Are current LPS provisions consistent with the ‘do no harm’ principle?

5.1 NEAC has explored whether the current interpretation and application of LPS provisions (in the Code of Good Faith) during industrial action is synonymous with the ‘do no harm’ principle. NEAC’s view is that strict adherence to the LPS provisions, that is, protection against death or permanent disability, might not give full expression to the ‘do no harm’ principle.

5.2 NEAC acknowledges that it is difficult to clearly define the complexities of ‘harm’ but suggests that three aspects be considered: a) degree of harm b) the distinction between harm and hurt and c) chance of harm. The following matrix demonstrates the potential interaction between degree and chance of harm.

		Chance of harm	
		Low	High
Degree of harm	Low	d	c
	High	b	a

5.3 In this matrix, where the degree and chance of harm are both high (a), it seems clear that this would be covered by the LPS provisions – death or permanent disability are likely to occur if health and disability services are not provided. Where the degree and chance of harm are both low (d), it is also clear that this would not be covered by the LPS provisions.

5.4 However, the remaining two scenarios are less clear. Where the potential degree of harm is high, but the chance of harm is low (b), it might be argued, for example, that diagnostic services need not be provided, most likely depending on how unlikely the chance of harm is. Where the potential degree of harm is low, but the chance of harm is high (c), the provision of services may depend on where the distinction is drawn between harm and hurt. These aspects of harm are discussed further below, with examples of where distinctions can be ambiguous.

### Degree of harm

5.5 The degree of harm can vary. In general, to cause death is to do the greatest harm, and to cause permanent disability is to do serious harm. These harms are explicitly covered by the current definition of LPS. However, on the face of it, the current provision does not count as LPS for those services that are needed to prevent serious but non-fatal morbidity or serious but non-permanent disability, or to enable required information to be obtained on conditions that potentially threaten these harms. An example might be a serious injury that is not fatal and does not cause permanent disability but where delaying treatment or diagnosis prolongs suffering and/or substantially complicates recovery, for example a fractured femur in an elderly person.

## Harms versus hurts

- 5.6 At the other end of the scale of harm are inconvenience, nuisance, discomfort and frustration for patients. It might be argued that the 'do no harm' principle is unreasonably demanding because it is not always practicable to avoid causing inconvenience, nuisance, discomfort and frustration for all patients. One way to address this difficulty is to distinguish between harms and hurts:
- hurts are setbacks to interests that are not sufficiently intense, prolonged or repeated to do enduring damage to a person's interests
  - harms are sufficiently intense, prolonged or involve repeated setbacks that *do* damage a person's interests.<sup>12,13</sup>
- 5.7 For example, if a person suffers a short period of discomfort, anxiety or nuisance because a health or disability service is delayed, this is a hurt but is not, in itself, a harm. The harm/hurt distinction implies that hurts do not in themselves breach the 'do no harm' principle. However, setbacks to people's interests form a continuum from the most severe – generally death – to the most mild. This makes it a challenge to draw a sharp distinction of principle between harm and hurt. The greater the intensity, duration or frequency of a hurt, the more difficult it becomes to maintain this distinction. Nevertheless, in order to give effect to a genuine right to strike that also adheres to the 'do no harm' principle, it may be necessary to make and apply in practice a harm/hurt distinction.

## Chance of harm

- 5.8 Many patient tests are done to rule out serious harms that are more unlikely than not. For example, a CT scan might be done for a patient whose persisting symptoms after head injury are probably only part of a benign post-concussion syndrome, but in rare cases might be caused by bleeding around the brain, which is serious and requires prompt treatment. Another example is pulmonary embolism (PE – blood clotting that has travelled to the lungs) where approximately 1-in-10 patients who present with the relevant signs and symptoms will have PE. Unless the patients are tested and treated appropriately and promptly, in a small percentage of cases – perhaps 1-in-100 or 1-in-200 of those who originally present – the patient may die of complications of PE.

<sup>12</sup> Feinberg J. 2001. *Harm and Offence*. In *Encyclopaedia of Ethics*, L Becker, C Becker (eds). New York and London: Routledge.

<sup>13</sup> Feinberg J. 1984. *Harm to Others: Moral Limits of the Criminal Law*. Vol. 1. New York: Oxford University Press.

- 5.9 It is not clear whether a clinically indicated test to rule out a low (eg, 1-in-100, or 1-in-200) chance of a condition that poses an immediate threat to life or permanent disability counts as a LPS. For any given patient, a positive test result is unlikely. Yet if many (eg, 200 or 400) such tests are withheld during industrial action – without giving fair opportunity to have these tests done by someone else, or somewhere else, or by substituting in a different test that does the same job – then for one or two patients, this is *likely* to lead to failure to detect conditions that may cause serious harm. A small chance of harm, arising from not promptly providing a common test, can mean a strong chance that *some* patient will be harmed. Similarly, failing to treat a condition that does not currently pose a risk of death but that may rapidly or easily exacerbate to this point, represents a harm. Such harm is highly probable rather than certain, and one cannot know in advance which patient or patients will be harmed.
- 5.10 In the HDC case mentioned above, a test was not performed that could have diagnosed a condition that represented a risk of harm to a patient. The patient's condition was not thought to be life-threatening, as defined by the DHB contingency plans and the agreement with the striking MRTs and their union (the condition could also have been, and was, disability-causing, although this was not covered by the LPS provisions at the time). Adherence to the Code of Good Faith and its LPS provisions in this case did not guarantee adherence to the 'do no harm' principle, and Mr A suffered significant harm.
- 5.11 NEAC's view is that, if a test is common and is for a condition that is unlikely but seriously harmful, then not providing that test is likely to harm patients. This point is important for diagnostic services, where maintaining patient safety reasonably requires excluding unlikely but serious conditions by diagnostic testing.

## 6 The balance between the right to strike and the ‘do no harm’ principle

- 6.1 One possible logical outcome of health and disability workers adhering to the ‘do no harm’ principle could be that if no harm is ever permissible, no industrial action can ever be taken by health and disability workers because all such action has the potential to cause harm. It could be argued that an obligation to ‘do no harm’ requires, ultimately, that no services be withdrawn or withheld because even a routine test may, in certain cases, be considered ‘life saving’ or contribute to preventing a disability.
- 6.2 However, the right of health and disability workers to strike is important. To deny health and disability workers the right to withdraw their labour would infringe too comprehensively on their rights to undertake industrial action. While the State may restrict the rights of citizens in certain instances, it is generally obligated to maintain their rights wherever possible. It may be better for the common good of society to preserve the rights of health and disability workers to engage in industrial action – even if subject to some restrictions – rather than remove their right to do so in order to eliminate every possibility of harm being done to individuals within that society.
- 6.3 Nevertheless, those involved with industrial relations in the health sector share the objective of finding ways to resolve differences in their respective positions and trying to avoid industrial action where possible. All parties to industrial relations recognise industrial action as a last resort and seek to find ways to resolve difference through negotiation. Right 5 of the Code states that every consumer has the right to cooperation among providers to ensure quality and continuity of services. This seems to be achieved in the context of industrial action by the processes of contingency planning and responses to requests for the provision of LPS during strike.

## 7 Conclusion

- 7.1 The current system of contingency planning for the provision of LPS, when industrial negotiations fail to resolve differences between parties and industrial action ensues, has (naturally) matured and continues to evolve since the provisions were first introduced in 2004. NEAC was advised that, in the context of industrial action, requests made to striking health and disability workers to provide LPS are never denied, and services are not withheld, and further discussions about whether a request falls under the definition of a LPS are deferred until after the fact and do not delay provision of services.
- 7.2 This highlights the important shared expectation that there should be robust processes to ensure appropriate resources are in place during industrial action to respond to patients' needs – either through the availability of health and disability workers undertaking industrial action or through the provision of alternative services.
- 7.3 All parties have a responsibility to 'do no harm' during industrial action, both in relation to the planning for, and conduct during, a strike. This means that as well as avoiding the risk of death and permanent disability during a strike, health and disability workers, unions and employers must also consider how to avoid:
- a. other serious harms that are non-fatal and non-permanent, for example where delaying treatment or diagnosis prolongs suffering and/or substantially complicates recovery
  - b. an immediate threat to life or permanent disability from conditions that are unlikely but where not providing a common test can mean a strong chance that *some* patients will be seriously harmed.
- 7.4 These considerations must be taken into account in the decision-making and conduct of all of those involved when industrial action is contemplated or undertaken. That the right to strike should be interpreted and exercised nationally in a way that is consistent with the ethical principle of 'do no harm' is a common goal for health and disability workers, unions and employers.
- 7.5 Other sources of information and advice are listed on page 13.

# Appendix 1: Consultation participants

Association of Professional and Executive Employees (APEX)  
Association of Salaried Medical Specialists  
Chief Advisor Employment Relations, Ministry of Health  
Clinical Physiologists Registration Board  
DHB Shared Services  
Medical Council of New Zealand  
National Secretary (RDA, MLWU, APEX)  
New Zealand Medical Association  
New Zealand Medical Laboratory Workers' Union (MLWU)  
New Zealand Nursing Council  
New Zealand Nurses Organisation  
New Zealand Resident Doctors' Association (RDA)  
Office of the Health and Disability Commissioner  
Public Service Association  
Service and Food Workers Union

## Appendix 2: New Zealand statements for health and disability workers endorsing the ‘do no harm’ principle

Examples of statements include the following:

- The New Zealand Medical Association’s Code of Ethics states in its preamble “non-maleficence implies a duty to do no harm” (New Zealand Medical Association 2008).
- The New Zealand Nurses Organisation’s Code of Ethics states that, in the ethics of nursing practice, non-maleficence is fundamental, including “avoidance of harm and the prevention of future harm. In a situation where harm is unavoidable, the harm is minimised” (New Zealand Nurses Organisation 2010).
- The New Zealand College of Midwives’ Code of Ethics states that “midwives have a responsibility to ensure that no action or omission on their part places the woman at risk” (New Zealand College of Midwives 2006).
- The New Zealand Dietitians Board’s Code of Ethics states that “non maleficence is the principle that Dietitians avoid harming others. Harm can be physiological, mental, and reputational, to personal property or increased risk of harm” (New Zealand Dietitians Board 2003).
- The Pharmacy Council of New Zealand’s Code of Ethics advises pharmacist to “take appropriate steps to prevent harm to the patient and the public” (Pharmacy Council of New Zealand 2011).
- The Code of Ethics for the Psychologists Working in Aotearoa/New Zealand contains as one of its value statements the principle of “promotion of wellbeing: psychologists’ recognise that a basic ethical expectation of [their] discipline is that its activities will benefit members of society or, at the very least, do no harm” (New Zealand Psychologists Board 2002).
- The Psychotherapist Standards of Ethical Conduct states that psychotherapists will “uphold their clients’ best interests and seek to avoid doing harm in all their professional work” (Psychotherapists Board of Aotearoa New Zealand 2011).



## Other sources of information and advice

*The Contingency Planning Process: An Overview*  
Health Sector Relationship Agreement Steering Group 2012

*Provision of life preserving services: Guidelines for SMOs during strikes by other health care employees*  
Health Sector Relationship Agreement Steering Group 2012