Strike and the Medical Profession

The recent strike by non-consultant hospital doctors raises many issues that need to be deliberated upon lest the profession should ever contemplate embarking on such a course again. First, any form of industrial action in the medical profession carries the potential for causing considerable hardship and harm to those very people that doctors are there to serve, namely the patients, and the deleterious affects of such action must be carefully balanced against potential gains. However justifiable a sense of grievance may have been among the non-consultant hospital doctors, and they were by no means alone in the profession in experiencing the effects of the recent financial cutbacks, the issues on which their strike action was based were far from clear and certainly did not justify the ultimate weapon of withdrawal of service when forceful negotiation backed up if necessary by other forms of industrial action might have achieved the same result.

The consequences of the strike were felt by patients (though the effects were minimised by the participation of consultants in maintaining the hospital services), general practitioners, who had to contend with the increased work-load consequent upon the closure of out-patients and accident and emergency departments, consultants, nurses, para-medical workers and the administrative staffs in the hospitals, all of whom had to contribute in differing proportions to maintaining a limited hospital service for the public.

The effect of the strike on many non-consultant hospital doctors was also none too pleasant. Some of the few who chose to ignore the call to strike, because their principles dictated otherwise, were subject to considerable personal conflict and on occasion to pressure that was not far removed from the intimidatory practices associated with the more militant fringe of trade unionism. The personal anguish caused to many of those who went on strike against their better principles was also considerable. The Medical Council had to deliberate long and hard on the consequences of the strike for provisionally registered doctors and had the strike been protracted, the Medical Council might have had no alternative but to withhold registration for many doctors.

Then there was the effect on the medical profession as a whole. The public image of the profession is dependent upon the behaviour of its members, and strike which is regarded by many as anathema to doctors, demeans the profession as a whole and blurs the distinction between a profession and a trade; words the very meaning of which derive from a code of practice rather than being, as some would have it, a mere semantic quibble. Though many of the more militant non-consultant hospital doctors would place little value on such sentiments, even they would have to agree that the recent strike was a failure, and whatever meagre gains might be attributed to it did not justify the terrible risk inherent in such action.

The strike has highlighted differing attitudes in the profession, namely that on the one hand there are doctors who are prepared to strike, some for relatively paltry gain and others only if provoked beyond what they consider to be endurance, and then there are those who will never strike because they consider it morally indefensible for a doctor to withhold his service from a sick person. The former subscribe to the belief that strike action is justifiable if it sustains a secure profession which will ultimately be beneficial to society. Doctors opposed to strike believe that regardless of the difficulties they may encounter with government departments, they can never jeopardise their patient's welfare by withholding their services. They evaluate their position, moreover, not merely in terms of finance, but see themselves as privileged in having been afforded a period of intellectual development in training for a profession which commands a position of esteem in society, in return for which, standards, often difficult to sustain, are demanded. Comparisons with, for example, the hourly rate paid to other workers are not seen by doctors holding this view as valid because all such analogies fail to measure the considerable satisfaction that is the reward, often the only one, for simply being a good doctor, nor do such comparisons take account of the many varied opportunities that a career in medicine offers. In the face of the assertive form of collective action that characterised the recent strike, doctors morally opposed to such a course were denied an opportunity to express an opinion and they remained, for the greater part, silent. Their presence must now be recognised, not so much by way of a catharsis, nor merely to assess their numerical presence (which is unknown but may be considerable), nor indeed as a means of tempering opposing views (which being antithetical are irreconcilable though one may in the course of time influence the other), but in recognition of the fundamental ethic of the medical profession that puts the patient before all other considerations.

There are lessons, therefore, to be learned from this strike. First, in Ireland, as in other countries where strike in the medical profession has also

failed, strike action should not be a stratagem in industrial negotiation. It should be clear to all but the most politically myopic that government will no longer permit privileged groups to dictate policy and that to do so is effectively a denigration of the democratic process. This being so, the profession should give careful consideration to foregoing the right to strike in return for which it would obtain a guarantee of responsible and prompt negotiation with efficient arbitration procedures. If the profession ever considers resorting to strike again it must not do so without a mandate from the *entire* profession. It is unacceptable for a group such as the non-consultant hospital doctors, to inflict chaos in other sectors of the profession without obtaining the support of those groups. In future all doctors, the recently qualified and provisionally registered, the non-consultant hospital doctors, the consultants, the general practitioners, and all other groupings of doctors within the profession must be balloted on the advisability or otherwise of strike action. Had such a course been taken prior to the last strike it is probable that the unhappy event would not have occurred.

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Gestational assessment

The normal menstruation-labour interval is traditionally taken to be 280 days, or 40 weeks, or 10 lunar months. Franz Karl Naegele of Heidelberg (1778-1851)[1] first proposed a rule for calculating the expected date of delivery (EDD). The rule was to add seven days to the first day of the last menstrual period (LMP) count backwards three months, and count forward one year from that date. However a re-assessment of that rule showed that only 4% of all babies were delivered on the expected date, with 60% being born within two weeks of it.[2] In a series of 11,367 pregnant women the median interval from menstruation to labour was 282.53 days with the mode being on the 284th day. On the basis of these findings it was recommended that the most accurate way of determining the EDD is to add 10 days to the first day of the LMP, count back three months, and count a year ahead of that.[3] Alternatively if 280 days are added to the first day of the LMP, 61% of births will occur between the thirty-ninth and forty-first weeks of gestation.[4]

The EDD is always wanted by mothers for obvious reasons. For obstetricians, knowing the EDD indicates, on the one hand, the onset of post-maturity and the risk on intrauterine death, and on the other, prematurity and the risk of neonatal death. The importance of accurate gestational assessment is further emphasised by the large number of inductions of labour sometimes done for postmaturity.[5] Inability to detect the condition of the fetus *in utero* can lead to much haphazard and unnecessary intervention with the possibility of risk to the fetus. However, this risk must be balanced against the perinatal mortality (PNM) which at 43 weeks gestation was shown to be double that occurring at term in the British Perinatal Survey of 1964.[6]

Uncertainty as to how postmaturity should best be managed has only partially been resolved by two recent publications. In the first of these Steer concluded "that all the evidence suggests that vigilance for signs of growth retardation should continue throughout pregnancy, but in the absence of such signs, and in otherwise uncomplicated pregancies, the safest management of prolonged pregnancy is to await the spontaneous onset of labour".[7] In the second publication, Cardozo et al. using ultrasound to determine gestational age and to detect intra-uterine growth retardation, concluded that there was no evidence to support the view that women with normal prolonged pregnancy should undergo routine induction of labour at 42 weeks gestation.[8]

The use of ultrasound in gestational assessment has now become common practice,[9] and the problems associated with postmaturity have been reduced. Nevertheless in a recent survey of perinatal mortality in Ireland[10] there was a continuing excess of neonatal deaths in babies born after 42 weeks; and in a collaborative study in Dublin, postmaturity has been shown to be significantly related to the occurrence of seizures in neonates.[11]

So there are two approaches to the management of postmaturity: one is the routine induction of labour at 42 weeks gestation; the other is ultrasonic fetal monitoring in preference to routine induction, and effecting delivery only if monitoring reveals that the fetus is compromised.

So much for gestational assessment in the context of postmaturity. On the other side of the coin with neonatal intensive care capable of securing the healthy survival of small babies as never