Respecting patient autonomy in occupational medicine practice

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ABSTRACT
The discipline of occupational medicine, especially occupational health ethics and specifically the varying and often ambiguous tenor of the doctor-patient relationship, characterised by ethical dilemmas, is in many aspects unique within the field of healthcare. Respect for patient autonomy, privacy and medical confidentiality feature prominently in contemporary healthcare. Occupational medicine, though, is practiced wholly within the ambit of the labour setting; subject to labour related legislation and labour relations and invariably organised and exclusively funded by the employer. Within the occupational environment the employer/employee relationship, by its very nature an unequal, power-biased one, impacts all activities. Management has a vested interest in production, profitability, occupational safety and controlling employees. Unless the professionals responsible for delivering occupational medicine services to workers take due care, respect for the autonomy of their patients is in peril. Patient autonomy in occupational medicine is relative rather than absolute but ought to be afforded due respect.

The aim of this article is to raise awareness of occupational health ethics amongst professionals and stakeholders in the occupational health and safety arena by offering a glimpse of occupational physicians’ concern for respecting their patients’ autonomy, dignity and justified right to privacy in the healthcare environment.

Key words: occupational medicine ethics; patient autonomy; ethical principles; workplace healthcare

INTRODUCTION
Occupational medicine has come a long way since the times of Paracelsus (1493 – 1541) and Ramazzini (1633 – 1714). Although gaining recognition as a legitimate and valued field of medical endeavour, especially through the endeavours of the likes of Sir Thomas Legge (1863 – 1932), Alice Hamilton (1869 – 1970) and Donald Hunter (1898 – 1978), occupational medicine remains for many an obscure, even scorned, niche within the vast field of medicine and healthcare. The discipline of occupational medicine is concerned with the relationship between work and health, promoting the health of workers and the workforce collectively, mitigating potential work-related health hazards and promoting sustainable employee wellness. Clearly practising medicine in the ambit of labour relations, often on the employer’s premises, invariably at the employer’s sole expense (in compliance with occupational health and safety legislation) and subject to entrenched industrial labour relation practices, creates a unique doctor-patient context. Add to this an almost unavoidable restriction on the choice of healthcare provider, the employer’s vested interest in productivity and profitability and the fact that power and authority are inherently skewed in favour of management, and the playing-field presents a health management challenge second to none. No wonder occupational medicine is prone to ethical dilemmas and caveats to the extent that various national professional societies representing occupational physicians have issued ethics guidelines specifically for occupational health professionals. That of the Canadian Medical Association dates back to 1960, a time when general biomedical ethics was not yet afforded much prominence. Although a code of ethics provides a compass, everyday ethical practice demands that the astute occupational medical practitioner has insight, practical wisdom, sound discretion and virtue.

Around the 1970s, contemporary philosophers began focusing on bioethical issues. A philosophically grounded bioethical framework involving four ethical principles emanated from Georgetown University in the USA in particular. This framework soon gained immense popularity, being disseminated through a landmark 1979 book by its most ardent disciples, Tom Beauchamp and James Childress. Principism occupies a dominant position in current biomedical theory. Beneficence, nonmaleficence, justice and respect for autonomy have become the four widely recognised principles guiding ethical conduct in contemporary biomedical circles and endeavour. Beneficence, nonmaleficence, and especially justice, seem easily understandable and acceptable to non-medical managers in business enterprises. Only the most callous or intolerant supervisor/manager would begrudge workers fair and sound occupational healthcare.
To healthcare workers, respect for autonomy means to support and encourage the patient to act in accordance with his or her own beliefs and values, taking responsibility for informed decision-making – these principles are known as “liberty” and “agency” (capacity for intentional action). To managers respecting a worker’s autonomy in many ways spells relinquishing control – the very substance of the supervision and management of subordinates. Control is traditionally considered a key element of management. On most shop floors the foreman gives orders and expects obedience; he asks questions and does not tolerate hesitant answers – much less the withholding of information. Dodging questions about your illness, the reason for your absenteeism or the detailed nature of your injury might see you labelled a shirker or trouble-maker. Hinting that the production process is harming your health may well be frowned upon. Conflict has always existed between the need to ensure workers’ health and safety and business’s drive to achieve maximum production at minimum cost. Thus, since the occupational health doctor’s patient and the manager’s worker is generally the very same individual, it often leads to suspicion, controversy and conflict, brought about by clashing interests and strongly held values. Due to the tripartite nature of relationships in occupational medicine (doctor vs. patient/employee/union vs. employer/manager/government), respect for autonomy features high on the scale of medico-ethical principles to be heeded. Such respect encompasses privacy, confidentiality, consent and voluntariness, and goes hand in hand with veracity and trustworthiness. Key to understanding the profession’s ethical landscape is grasping the ambiguous tenor of the various doctor-patient relationship situations and the tripartite nature of some of these.

RESPECT FOR AUTONOMY IN THE OCCUPATIONAL CONTEXT

Respect for autonomous choices of individuals runs deep in common morality; without necessarily implying an excessively individualistic approach whereby the social impact of a person’s choices on others is scorned. Respect for autonomy means acknowledging and accommodating the individual’s right to hold views, make choices and act on the basis of personal values, beliefs, reason and rational emotions (the latter meant to refer to understandable feelings). Autonomy implies liberty and agency – the relative freedom from control and independence to act with intent. Kant laid the foundation for recognising the unconditional worth of every person – not to be treated merely as a means to some end. That worth manifests in at least qualified autonomy. People have intrinsic moral worth.

The solemn concepts of informed consent in healthcare (in the presence of capacity for autonomous choice) and medical confidentiality flow from the principle of respect for autonomy. This biomedical principle attains enhanced significance in the occupational health environment – a healthcare setting characterised by measures to control employees, govern their actions and contractually sanction noncompliance and insubordination. Workers have to relinquish some autonomy for the benefits of employment; such as freedom of speech and of unrestricted movement. Being subjected to a negotiated disciplinary code is the price paid for the opportunity to earn a livelihood. But rights such as freedom of association, not to be discriminated against unfairly and reasonable privacy ought not to be curtailed. Consequently, beyond personally respecting the autonomy of their patients, the occupational physician and nursing professional are called on to defend patients’ autonomy from being trampled by the employer – to provide advocacy. Workers also have personal views, values and beliefs and should be afforded relative freedom to make personal choices. Employers do not own their employees.

The medico-legal rules related to respect for autonomy, such as medical confidentiality, effective communication and informed, voluntary consent equally apply in the occupational environment. Consent to invasive procedures such as blood sampling or to reveal confidential data or health related information must not be neglected. Whether the role of the occupational physician at the time is that of clinical expert,
Information imparted to management is usually limited to temporary work restrictions, sick leave and possible occupational relatedness. In the occupational health setup this is little different from the traditional private doctor’s role. It is also the scenario where free choice of doctor does not necessarily have to be compromised. It ought to be possible for the occupational medicine practitioner to refer an injured or sick worker to his personal doctor if so requested. Privacy should basically match that which would be found in family practice and communication to the employer that is deemed necessary would be discussed with and generally benefit the patient.

However, often the occupational physician adopts a role better described as mediator or expert counsellor to support occupational health decision-making and facilitate interventions necessitated by an employee’s health and fitness to work. A situation may call for mere advice and reassurance or it might require far-reaching job restrictions, redeployment or even medical boarding. Uncertainty, apprehension and a measure of anxiety are usually present in such situations and the occupational physician’s affective behaviour becomes critical to a satisfying encounter for the patient/employee. Dual loyalty, the ethical dilemma considered by many the bane of occupational medicine, comes into play when the occupational physician, appointed, remunerated and appraised by the employer, is morally bound to patient advocacy rather than committed to protect the employer’s interests. In the occupational health environment employees become patients; patients, who are often vulnerable, may suffer work insecurity and are subjected to the slanted employer–employee power relationship. Workers as well as the employer must be able to sense that the medical practitioner in the workplace has the aptitude, skill, finesse and professional independence to transact health-related cases in the labour environment in a fair and unbiased way. Such interventions also require that the enterprise’s medicine man/woman enjoys the trust and respect of the employer/management, is afforded the necessary influence, possesses a working knowledge of labour law and health and safety legislation and has a sound reputation for practical wisdom.

The latter means acknowledging that privacy bordering on secrecy could render efficient occupational health interventions almost impossible. The level of privacy usually afforded patients in the private healthcare environment might jeopardize occupational health and safety if enforced in the work environment. Occupational health and safety legislation mandates certain actions related to risk work such as mining and the production of hazardous chemicals. Obviously the employer has a right to know if a heavy vehicle driver is found to be an accident risk or occupational noise exposure is causing progressive loss of hearing. Employment equity legislation (Act 55 of 1998) requires an employer to afford employees living with a disability reasonable accommodation.
That can hardly be implemented if the employee fails to reveal his impairment to at least his supervisor and second line management. When a worker is restricted from working at heights it is logical that there is a risk of falling. Not revealing the small possibility of an epileptic attack at work precludes awareness training for co-workers who might provide valuable first-aid in case of an unexpected seizure. Releasing some privacy in the occupational environment when it benefits the worker and allows for preempting illness and injury, is logical. If this is not done voluntarily, legislation might at times have to be invoked. Valid interests of stakeholders such as management, the public, co-workers and state authorities feature in the labour environment and moderate employees’ right to privacy. Nevertheless privacy in the workplace is not nullified and ought not to be disparaged.

To comprehend medical confidentiality in the ambit of occupational medicine one needs to understand the variety of doctor-patient relationships and roles of the occupational physician in industry. The occupational health governance role, featuring prevention and health promotion, eclipses the traditional curative role characterising most doctor-patient relationships in general healthcare. Medical surveillance is the term used for periodic clinical assessment of the health of workers exposed to potential health risks, especially in hazardous occupations or work environments. The intention is to monitor for the early signs and symptoms of work-related illness or biological deviation. Few would argue against an annual audiogram to detect insidious high frequency noise-induced hearing loss in noisy workplaces or regularly testing the vision of ageing professional drivers. Similarly, fitness assessment on return to physically demanding work after serious injury is vital. Much of the medical surveillance performed in occupational medicine clinics is compulsory – in compliance with occupational health and safety regulations. Such regulations in many instances require the employer to take action should there be concerns and therefore would have to be informed – not told detailed test results but at least what is necessary to mitigate risks.

The purpose of pre-employment or pre-placement medical surveillance is to obtain baseline health data and to select candidates who are able to perform the required job reasonably unimpaired and without extraordinary health or safety risk. In this respect these assessments are valuable tools in managing occupational health and safety risk inherent to many occupations. Neglecting medical fitness assessment would in many instances constitute legal non-compliance. Though one can argue that such pre-emptive medical testing is also in the best interest of prospective employees, the perception is rather that it is a hurdle to employment – more so for those dependent on performing physically demanding work and facing unemployment. In practice the occupational health practitioner has the legal and moral responsibility to sanction placement of individuals in jobs either likely to be detrimental to their health or which they cannot safely and effectively perform. Naturally the doctor-patient relationship in this setting resembles an insurance medical rather than a healthcare encounter. It could be viewed as part of the job interview. In this context “patient” privacy ranks differently. Diagnosis and actual test results need not be revealed but the fact that a candidate does not meet justifiable medical fitness criteria for a job, has to be communicated to the proposed employer. This requirement must be understood by the prospective employee when he or she consents to a pre-employment medical. Such consent may not always be truly voluntary because withholding consent would usually mean the job offer is withdrawn; certainly for occupations justifiably subject to mandatory medical surveillance. A formal labour contract often requires the worker to relinquish some privacy. The employer in effect procures a vested interest in the employee’s ability to perform the work for the foreseeable future and takes on a legal responsibility not to jeopardise his health and safety.

It remains every astute occupational physician’s responsibility to carefully rank the employer’s legitimate interests against the right of employees to privacy and medical confidentiality. Confidentiality does not mean secrecy. The aim is not to hide pertinent personal information; health-care confidentiality rather seeks to protect from unjustified,
inappropriate and harmful disclosure. In occupational health cultivating a balanced, respectful and just approach to patient autonomy, always in proper context and against the applicable legislative background, eventually serves the best interest of workers and management alike. Attaining that ideal admittedly requires a combination of professional integrity and practical wisdom.

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CONCLUSION
Occupational medicine is prone to ethical conundrums. It indubitably relates to the discipline being practiced in the labour arena; an environment dominated by the employer and appointed managers pursuing objectives against which their success is measured and they are rewarded. The very term used to describe people in business – human resources – is indicative of workers being considered a means to a capitolistic end. Presiding over the long-term work-related health and wellbeing of workers in that competitive setting is the occupational medicine practitioner’s challenge. It calls for applying the principles of biomedical ethics in an often adversarial healthcare setup; of which respect for autonomy especially requires discreet commitment. When workers become patients they should be afforded due patient’s rights.

Awareness of and commitment to established medico-ethical principles empower occupational health doctors and nurses to negotiate the ethical caveats characterising their profession. But if physicians employed in industry are the only ones calling for sound occupational health ethics, their voices are easily drowned in the noise of production targets – or may even to some managers sound like misplaced medical antics. Therefore they need stakeholders, especially their non-medical peers in the health and safety arena, to grasp and support their quest for adhering to sound ethical practices.

DECLARATION
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LESSONS LEARNED
1. Occupational medicine, practiced in the ambit of labour relations and often on the employer’s premises and at the employer’s sole expense, creates a unique doctor-patient context.
2. Established principles of biomedical ethics also apply to occupational medicine and the discipline’s astute practitioners ought to respect the autonomy of their patients.
3. Labour law and occupational health and safety legislation moderate the extent to which patient privacy and confidentiality can be realised in the workplace.
4. Scenarios such as pre-employment medical assessment differ significantly from traditional doctor-patient encounters and logically call for a different approach to patient autonomy.
5. Occupational physicians ought not to allow the employer’s business objectives to bias their professional judgement.

REFERENCES