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# Dual Loyalties and the Ethical and Human Rights Obligations of Occupational Health Professionals

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**Background** *Underlying most ethical dilemmas in occupational health practice is the problem of Dual Loyalties where health professionals have simultaneous obligations, explicit or implicit, to a third party, usually a private employer.*
**Methods** *A literature review was undertaken of case studies of workplace occupational health conflicts, international human rights and ethical codes and strategies for managing dual loyalties, complemented by iterative discussions in an international working group convened to address the problem of Dual Loyalties.*
**Results** *Violations of the worker-patient's human rights may arise from: (1) the incompatibility of simultaneous obligations; (2) pressure on the professional from the third party; and (3) separation of the health professional's clinical role from that of a social agent. The practitioner's contractual relationship with the third party is often the underlying problem, being far more explicit than their moral obligation to patients, and encouraging a social identification at the expense of a practitioner's professional identity.*
**Conclusions** *Because existing ethical guidelines lack specificity on managing Dual Loyalties in occupational health, guidelines that draw on human rights standards have been developed by the working group. These guidelines propose standards for individual professional conduct and complementary institutional mechanisms to address the problem.*
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***KEY WORDS: human rights; ethics; bioethics; conflict; professional practice; guidelines***

## INTRODUCTION

The traditional bioethical literature has, until fairly recently, largely neglected consideration of the particular dilemmas facing occupational health professionals [Emanuel, 2002]. This has arisen largely because of a limited ability to extend bioethical approaches beyond the individual doctor–client relationship to consider contextual issues such as the distribution of health care resources [Emanuel, 2002], or societal factors driving institutionalized discrimination [Rubenstein and London, 1998]. Occupational health practice also has a greater focus on preventive health and on groups than occurs in the typical clinical encounter. Moreover, when viewed in the light of universal human rights in the occupational setting [Howard and Gereluk, 2001; International Labour Office, 2003], use of ethical codes and bioethical reasoning alone may be insufficient to protect workers from violations of their rights [Rubenstein et al., 2002]. Indeed, bioethical approaches may relegate rights to represent only one of many competing ethical concepts, such as obligations and duties, character virtues, standards of values, goodness of outcomes, justice in the allocation of resource, and respect for morally acceptable laws [Gillon,

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1994; World Health Organization, 2002] rather than recognizing their unique primacy in protecting vulnerable groups.

Yet, despite the existence of numerous ethical codes in medicine, violations of the rights of vulnerable patients occur all too frequently. For example, one of the lessons to emerge from the findings of the South African Truth and Reconciliation Commission (TRC) was that the failure of health professionals to prioritize their ethical obligations to their patients in the face of dual loyalties led to some of the most egregious cases of human rights violations under apartheid [Truth and Reconciliation Commission, 1998; Baldwin-Ragaven et al., 1999]. The TRC recommendations identified the critical importance of viewing the protection and promotion of human rights as a core obligation for health professionals [Baldwin-Ragaven et al., 2000], rather than as one of a number of optional competencies for professional practice. Indeed, such a perspective has been increasingly echoed over the past two decades by authors around the world [Younge and Stover, 1990; Pagaduan-Lopez, 1991; De Gruchy et al., 1998; Iacopino, 2000] including medical associations in the UK [BMA, 2000], Canada [Williams, 1997], and the Commonwealth [CMA, 1994].

Whereas health professionals' concern for human rights has historically emerged in the context of environments of severe political repression, occupational health professionals are often faced with conflicts of interests in routine practice that may be similar, where loyalty to a third party may interfere with the doctor–patient relationship and with the obligations of fidelity imposed by professional ethics [Walsh, 1986; Rosenstock and Hagopian, 1987; McCrary, 1992; Lurie, 1994; Berlinguer et al., 1996; Higgins and Orris, 2002]. The failure to identify these conflicts and respond appropriately may have wide-ranging consequences to the point of infringing on a worker's fundamental human rights. For example, medical professionals in Mexico have facilitated post-hire pregnancy-based sex discrimination by implementing pregnancy testing to exclude women from work in maquiladoras [Human Rights Watch, 1998]. Pre-employment examinations of black miners under apartheid involved naked men being examined in groups under demeaning conditions that violated human dignity [White, 1997]. Medical doctors have conducted HIV testing on domestic workers in South Africa without adequate informed consent [Anonymous, 1996; AIDS Law Project, 2003], similar to experiences of work-related HIV discrimination reported elsewhere [Maletsky, 2000; Macan-Markar, 2003].

But, given the acknowledgment in international human rights, law of rights such as that of access to health care, to social security, and to benefit from scientific progress [UNICESCR (United Nations International Covenant on Economic, Social and Cultural Rights), 1966], the need for approaches in occupational health based on recognition of workers' rights also has institutional implications in the impact of occupational health practice on the fairness of social welfare polices [Van Damme and Casteleyn, 1998; London, 2003] and in the very operation of International agencies concerned with occupational health [Soskolne, 1989; Watterson, 2000]. These tensions are likely to be significantly accentuated by the impacts of globalization [London and Kisting, 2002; Smith, 2003]. Yet, much like bioethics, rights concepts have, until recently [London, 2003; Reeves and Schafer, 2003; Smith, 2003] received relatively little attention in the occupational health literature.

## OCCUPATIONAL HEALTH PRACTICE IN THE CONTEXT OF POWER

Human rights are internationally recognized standards that seek to protect the most vulnerable members of society from potential abuse by governments and powerful third party institutions [Rubenstein et al., 2002]. Unlike bioethics, which aims to facilitate a process of problem-solving, human rights standards seek to provide clear benchmarks against which duty-bearers, usually the state, can be held accountable. To some extent, the bioethical principle of Equity/Justice popularized in the Georgetown consensus [Gillon, 1994; Emanuel, 2002] represents the analogous ethical stand to human rights standards that combat discrimination. However, bioethical discourse in North America has tended to preference autonomy at the expense of other ethical principles such as social justice [Emanuel, 2002; Rubenstein et al., 2002]. Accordingly, the elaboration of the social justice principle in bioethics has been relatively weak, particularly in a context where these principles are subject to diverse interpretations and little guidance exists as to their prioritization in relation to competing principles [Emanuel, 2002; Rubenstein et al., 2002].

However, both rights and ethics are normative approaches that aim to maximize human well-being and alleviate discomfort and suffering. There are two senses in which power is critical to consideration of the ethical and human rights dimensions of occupational health practice.

Firstly, professional ethics speaks to questions of trust in the professional, both by workers [Plomp, 1992, 1999; Rudolph et al., 2002] and by employers [Higgins and Orris, 2002]. Professionalism implies a commitment to meeting socially acceptable standards and norms of practice in exchange for the power that society confers on the health professional. Trust is based on the perception that health professionals are able to meet these ethical standards in professional conduct, and will not abuse that power. Unequal relations of power severely compromise the extent to which any procedure requiring a worker's consent can adequately meet internationally recognized standards for informed consent [CIOMS, 2002].

Secondly, many workplace health problems only emerge as a result of power conflicts between management and employees, in which the health care provider is expected to

intervene [Nemery, 1998; Deubner and Sturm, 2002]. Negotiating such conflicts [Higgins and Orris, 2002] is rendered more complex as a result of failing to recognize the implications of such power imbalances as do exist. Sadly, workers, particularly in developing countries have, at times, been at the receiving end of a failure of occupational health professionals and scientists to protect their health [Butler, 1997; Sass, 2000; London and Kisting, 2002; Aguilar-Madrid et al., 2003; Braun et al., 2003] as a result of their inability to act independently as advocates for their patients (see quote).

> Thor Chemicals, South Africa: Failure to protect workers from mercury exposure [van der Linde, 1995; see also Butler, 1997].
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> In 1992, a news story broke exposing high levels of mercury exposure experienced by workers at the Thor Chemicals plant in Durban, South Africa. Two workers died from mercury poisoning and many others were poisoned, but were lost to follow-up because of being casually employed. The company had a biological monitoring program for mercury exposure. Investigation after the first fatality showed that in the year prior to the death, 50% of the workforce had levels of mercury in excess of 250 μg/l, a level five times higher than the World Health Organisation's recommended standard but the company failed to act on the results. The company doctor was reported as disagreeing that these levels were dangerous, claiming the WHO standard was ''perhaps overly punitive.'' He blamed the media for ''exaggerated'' reports ''as one can be exposed to mercury and can tolerate it well.''
>
> In response, a doctor from the Medical Research Council pointed to the problem: ''doctors employed by companies should also be held accountable for what happens to workers. Only then will they be able to avoid the ethical dilemma of dancing to the piper's tune.''...

In the same way that unethical behavior by South African doctors under apartheid has left a legacy of distrust to reverse [Baldwin-Ragaven et al., 2000], occupational health practitioners (OHPs) need to be mindful of the impact of failing to adhere to ethical standards that place the worker or collective of workers as the primary focus of preventive, promotive, and curative professional practice.

These dilemmas are perhaps best illustrated by considering the problems of confidentiality and disclosure of information at the workplace. Evident in the summary of best occupational health practice contained in International codes of ethics (Table I) is the recognition of the primacy of the interests of the worker-patient or the collectivity of patients, and the importance of the protection of confidential information as a professional responsibility. Information should only be divulged of direct relevance to the stated need for information—usually met by an overall assessment by the practitioner of the patient's fitness for work, and not by release of detailed personal medical information. Further, informed consent remains a critical pre-requisite for release of any information, even to co-professionals. This implies an obligation to discuss the need for disclosure with the patient first in sufficient detail for informed consent to take place.

## DUAL LOYALTIES AND CONFLICTS OF INTERESTS

Underlying the contentious issues related to confidentiality (and, indeed, many of the ethical complexities in occupational health practice) is the question of dual loyalties [Rubenstein et al., 2002]. Dual loyalties is used here to capture that phenomenon where a health professional has simultaneous obligations, either explicit or implicit, to a third party, the consequences of which may lead to adverse impacts on a patient, client, or client community. In the occupational health setting, the third party is usually, but not always, a private employer. Health professionals providing occupational health services are often in a contractual or employment relationship with industry yet have professional relationships with workers as patients or users of preventive services. While the consequences of poor ethical judgment in the setting of medical treatment of a detainee may be more likely to result in an extreme violation of the patient's rights [Baldwin-Ragaven et al., 1999; British Medical Association, 2000], it is important to recognize that the same dynamic underlies the context in which the OHP is called on to work. For example, the violation of an individual's personal right to privacy in relation to their HIV status may affect not only their job security and ability to support their family, but also contribute to other forms of discrimination.

Where does conflict arise? On the one hand, the health professional, bound by obligations of fidelity to the patient, must seek at all times to maximize the well-being of his or her patient [Deubner and Sturm, 2002; Emanuel, 2002; Higgins and Orris, 2002]. On the other hand, the health professional usually does not see the patient as a free agent, nor is the patient in the workplace setting generally free to choose which OHP they consult. In most cases, a contractual relationship will exist in the form of an appointment, in terms of which the health professional is expected to provide a range of occupational medicine services. Almost always, the employer of the doctor is also the employer of the worker-patient [Higgins and Orris, 2002] but other relationships may also exist—doctors employed by various arms of the state in

**TABLE I.** Confidentiality of Medical Information: Comparisons of Best Ethical Occupational Health Practice

| Ethical area | Am. Occ. Med. Assoc. [1976] | Amer. Coll. Occ. Env. Med. [1993] | Inter. Comm. Occ. Health [2002] | Am. Ind. Hyg. Assoc. [1995] | Royal College of Physicians [1999] | So. Afr. Soc. Occ. Med. [2000] |
|---|---|---|---|---|---|---|
| Divulging to (non-medical) employer | Employers entitled to advice of fitness for work; no diagnosis or specifics | Employers entitled to advice of fitness for work and accommodation required; no diagnosis or specifics, except in compliance with law; otherwise possible with informed consent | Employers must receive only a statement of fitness for envisaged work; general information on work fitness or in relation to health requires informed consent | Keep personal and business information confidential; initiate measures to communicate health risks to management | No release of full medical details; can report in broad conclusions on employment implications—abilities and limitations of function; share report with worker first; different ethical obligations depending on the purpose of the examination Audit results must be free of identifiers | No clinical information without informed consent |
| Divulging to employer's medical advisor | At the request of the patient and according to traditional medical practice | According to accepted medical practice | | | Only with informed consent | |
| Divulging to other doctors | At the request of the patient and according to traditional medical practice | According to accepted medical practice | With the agreement of the worker | | | With worker's consent |
| Applicability of confidentiality | | Doctors must make reasonable efforts to ensure those under their supervision respect confidentiality | Code applies to all disciplines in occupational health; at workplace nurse and doctor responsible for record confidentiality | | To all health personnel; also to clerical staff who must handle such information = doctor responsible. All staff to sign policy | |
| Circumstances where confidentiality may be broken | At patient's request<br>Required by law<br>Overriding public health concerns | At patient's request<br>Required by law<br>Overriding public health concerns | Particularly hazardous situation where safety of other endangered<br>Legal requirement | With express authorization of owner of information<br>When required by law<br>Overriding health and safety considerations | With informed consent<br>In the patient's interest<br>Required by law<br>Unequivocally in the public interest<br>To safeguard security/prevent crime<br>Prevent serious public health risk<br>Research (conditional) | Medical condition that poses hazard to worker, co-workers or public; and only after attempting consent<br>Required by the law |
| Circumstances where confidentiality does not apply | | | No possibility of identifying individual in collective data | | Use of data for audit of quality control | |
| Patient access to records | | Doctors should notify workers of rights to access their medical records | | | Policy needed to accommodate; may be advisable if company closing and no storage | |
| Whistle-blowing | Actively oppose and strive to correct unethical conduct | | Doctor must respect secrecy of commercial information; but cannot conceal information necessary to protect health and safety of workers and community | If professional judgement overruled and health of people is endangered, should notify employer, client or authorities | If evidence emerges of a hazard, doctor's responsibility to workers must take precedence over proprietary restrictions; constrained by law | If evidence emerges of a hazard, doctor's responsibility to workers must take precedence over proprietary restrictions; must inform if colleague unethical |
| Hazard communication | Communicate information about health hazards in timely and effective fashion to individuals and groups potentially affected and make appropriate reports to the scientific community; communicate to patients significant findings and recommendations | Strive to expand and disseminate medical knowledge and participate in ethical research efforts as appropriate; communicate to individuals and groups significant observations and recommendations | Results of surveillance must be explained to worker; doctor must inform workers of hazards in objective and prudent manner; no concealment of fact; emphasise prevention; Assist employer to provide information and training; encourage health promotion | Should factually inform affected parties; communicate information needed to protect health and safety of workers and community; Initiate measures to communicate health risks to management, clients, employees, contractors, or relevant others | If evidence emerges of a hazard, doctor's responsibility to workers must take precedence over proprietary restrictions; communicate medical findings to patients | |

the public service [Rubenstein et al., 2002], by Trade Unions [Mahomed and London, 1991; Felton, 1997; Johansson and Partanen, 2002], by Industry Sick Funds or non-profit organizations [London, 1993], by Medical Insurance as Managed Care Initiatives [Lax, 1996], or by private consultancies [Guidotti and Cowell, 1997], or colleagues. The common thread is that the health professional experiences a simultaneous obligation, through his or her contract *to their employer*, and through his or her professional identity *to* the worker or collective of workers relying on their services.

Having simultaneous obligations does not necessarily lead the health professional into conflict [Emanuel, 2002; Rubenstein et al., 2002]. For example, where the obligation to an employer is equally supported by the patient, no conflict arises. An employer's request to a doctor to complete a report for compensation purposes will usually be consonant with the employee's desire to have such a report completed so that he or she may receive compensation benefits. Placing of medical information on a non-confidential document does not raise ethical concerns if the patient provides informed consent.

However, there are situations where the obligations may not be mutually desired and their recognition is critically important. For example, employers may seek to use the medical examination to terminate the employment of a poorly performing worker. Trade Unions may seek access to confidential information to address concerns over hazardous exposures. Managed Care institutions may place constraints on the type of care that the professional can provide to his or her patients. Under all three circumstances, the demands of the worker-patient and the third party are not consonant, placing the health professional in the middle of a dual loyalty conflict. Moreover, attached to the obligation to the third party is usually some element of external pressure, for example, in the form of awareness that his or her contract may be contingent on meeting employer expectations. Similarly, the Managed Care program may use the threat of reduced payment to induce compliance by the medical practitioner. In contrast, the only ''pressure'' the worker brings is the moral standing of patienthood, which is even more attenuated in the non-clinical preventive or promotive context. He or she cannot control the payment to the doctor, and often cannot choose their doctor. Thus, unlike that to third parties, the ethical obligation to the worker is qualitatively different: rarely buttressed by direct material pressures, and usually less powerful in its consequences, particularly in non-litigious societies where civil claims are beyond the reach of most health care users, or where professional licensing authorities are reluctant to act on allegations of professional misconduct.

Third party pressures are often pressures ''to use clinical methods and judgment for social purposes. . .'' [Bloche, 1999]. Typical examples would include examinations for assessment of disability grant applicants where the doctor's clinical skills are used on behalf of the State or private pension fund to decide on eligibility for welfare benefits [Cullen and Rosenstock, 1994; Lewis and Kleper, 2002], or the use of medical skills to assist management with the control of absenteeism [Strasser, 1981] often misapplied in OH practice [Forst and Levenstein, 2002].

Thus the potential for a situation of Dual Loyalty rests upon four elements:

1. The existence of simultaneous obligations to the worker-patient and one or more third parties.
2. The incompatibility of these simultaneous obligations.
3. The existence of some measure of pressure on the health professional from the third party that is qualitatively different to the power the worker holds.
4. The separation of the health professional's clinical role from that of a social agent.

Myser [2000] has argued further that exacerbating factors in the context of dual loyalties may elevate the likelihood of human rights violations consequent to an inappropriate clinical or management decision. Such exacerbating factors include risky employment relationships, role conflicts for health workers, personal bias, institutional discrimination and stigmatization of patients, the presence of a repressive political environment, and professional power and self-interest.

Employment relationships involving the OHP may disadvantage the patient in two ways. Contracts with employers may be explicit about the legal obligation on the OHP, whereas the OHP ethical obligation to the worker remains at a moral and hortatory level, subject to differing interpretations and lacking in legal enforceability [Ladou et al., 2002]. Vagueness in the sense of obligation to the patient serves to undermine the strength of the worker's claim to the doctor's fidelity compared to the very explicit obligations the health-care professional has to the employer.

On the other hand, obligations to employers may also be implicit or internalized. Much as some district surgeons in South Africa felt an allegiance to the Apartheid State in their professional relationships with political detainees [Rubenstein and London, 1998; Truth and Reconciliation Commission, 1998; Baldwin-Ragaven et al., 1999] so some doctors in industry may feel allegiance to the company, even in the absence of any objective basis in a contract of employment [Rodham, 1998]. Rather, the allegiance operates at an emotive level, where the social identity (values and world-view) of the health professional is meshed with that of the company, as a result of which he or she makes decisions in the best interests of the company [Berlinguer et al., 1996]. In other words, where health care becomes bureaucratized, the health care provider's professional ethics lose relevance, and are subordinated to a set of non-

professional obligations, where professional skills are deployed but no countervailing sense of professional morals prevails.

Is it ever possible for a health care provider serving a non-medical function to operate in terms of different codes at different times? There are, of course, well-recognized instances where it may be justified to subjugate the interests of an individual to that of the public good, such as occurs typically, with an outbreak of infectious disease [Gostin et al., 2003] or, in the occupational setting, where a worker's impaired health status presents a risk to others (e.g., the basis of driver medical examinations). There are both ethical and human rights arguments that justify such actions, in that protection of the rights of the third party or the public outweigh the rights of the individual [Rubenstein et al., 2002], but such provisions to limit rights in the public interest are usually subject to very careful checks and balances [Gostin and Mann, 1999; Gruskin and Tarantola, 2002].

Nonetheless, legitimate third party objectives may justifiably intrude in the clinical setting. However, does this mean that a doctor can be at one moment a provider bound by professional ethics, obliged to put their patient's well-being above all else, and then at the next moment, to put all that aside because they now act as agent of an employer or another third party?

The Royal College of Occupational Medicine Code [Royal College of Physicians, Faculty of Occupational Medicine, 1999], for example, acknowledges in its introduction that doctors may at times act in different capacities (including: (a) traditional therapeutic doctor-patient relationship; (b) impartial medical examiner; (c) researcher, and (d) expert advisor either to management or unions). However, when in these different roles, the doctor must be aware of the capacity in which he or she acts, and be sure that others are also aware of the role the doctor is asked to fulfill, and are, therefore, able to respond appropriately.

Furthermore, regardless of role, normal professional ethics such as the need for informed consent still applies. Thus, for example, the worker-patient, when informed that the doctor is acting as an assessor for an insurance benefit, has the right to refuse examination, or refuse disclosure of certain information. Under such circumstances, the patient, being fully informed, carries the consequences of exercising his or her right. The worker may elect to see a different doctor for the assessment, or seek a second opinion, all actions which ethical practice should facilitate.

Similarly, holding a non-therapeutic role does not equate to divorcing oneself from ethical responsibilities. For example, the Royal College Code explicitly emphasizes doctors' ethical responsibilities in the role of expert advisor.

> The position of an occupational physician in an organisation must be that of impartial professional advisor, concerned with safeguarding and improving the health of employed persons. Demonstrable professional independence and integrity, as well as openness in matters of concern, are necessary for the confidence of management, employees, and their representatives [Royal College of Physicians, Faculty of Occupational Medicine, 1999].

Other ethical codes, for example, those of the International Commission on Occupational Health [ICOH, 2002], the South African Society of Occupational Medicine [SASOM, 2000], and the Association of Occupational and Environmental Clinics [Brodkin et al., 1996] similarly reflect the importance of ''impartiality,'' ''full professional independence,'' and avoidance of ''influence by conflict of interest'' in the execution of an OHP functions.''

## IMPLICATIONS FOR OCCUPATIONAL HEALTH PRACTICE

Health professionals must therefore be able to recognize a situation of dual loyalty, and respond in the most professional and ethical manner. For example, in considering pre-employment or pre-placement examinations, conducted for an employer, the medical practitioner is asked to use clinical skills to conduct an examination of the applicant as an impartial third party to inform the assessment of work fitness. Even in the absence of an established doctor-patient relationship with the applicant, the practitioner still has professional obligations towards the worker while simultaneously holding an obligation to the employer to provide a report. Were such a report to contain medical information, it would breach confidentiality, one of the central tenets of medical ethics. For example, if a job applicant were found to have a history of depression, revealing this information without consent would be a breach of medical ethics and may have significant adverse consequences for the worker's rights in terms of stigmatization and discrimination.

However, by conducting this examination within an ethical framework that maximizes beneficence and non-maleficence, promotes patient autonomy and is, as far as possible, able to promote fairness (through avoiding adding to existing inequities in the particular enterprise), it is possible to minimize ethical conflicts and avoid any potential infringement of the worker's rights [Higgins and Orris, 2002].

This implies that medical testing would not be ethical unless clearly relevant to the particular hazards faced by, or likely to be faced by that specific employee. In turn, this necessitates that the practitioner be adequately informed as to the hazards of the workplace. If not, it would be unethical for the practitioner to make such an assessment of fitness for work. Indeed, the ICOH Ethical Code [ICOH, 2002]

confirms that ''occupational health practitioners . . . must acquire and maintain the competence necessary . . . to carry out their tasks.'' Knowledge of the workplace, its hazards, and the job activities expected of the worker-patient are essential components of the required ethical competence of an OHP.

Of course, the converse of maintaining confidentiality may also arise, should an OHP encounter a known workplace hazard which management refuses to correct [Kern, 1998]. Here, the opportunity to whistle-blow, with workers' consent, presents both an ethical and human rights obligation for protecting workers' rights to a safe environment [Watterson, 1994; ICOH, 2002]. In that sense, the OHP is not entirely an 'impartial' player but must take sides in favor of workers' health. Similar concerns also arise in relation to genetic screening for susceptibility factors, which may be used to exclude workers from employment such as those with beryllium sensitivity [McCunney, 2002]. Policies based on the inappropriate use of screening in a predictive rather than preventive mode, and a failure to appreciate the impact of false positives and false negative tests [Van Damme and Casteleyn, 1998; Holtzman, 2003] are unjustified and are more likely to compromise workers' rights rather than contribute to the protection of health.

Moreover, dual loyalty applies as much in the context of a collectivity when asked to provide expert input to policy development as it does to seeing an individual worker in a pre-placement examination (Table II). Historical precedent in South Africa indicates how poorly professional ethics has coped with Dual Loyalty in the asbestos industry.

> Dual Loyalty: Asbestos companies and their medical advisors in South Africa [McCulloch and Tweedale, 2004].
>
> By the end of the 1950s, there was clear scientific evidence of the link between asbestos exposure and mesothelioma in the UK. A study in South Africa by the Pneumoconiosis Research Unit

**TABLE II.** Balancing Dual Loyalties in Two Typical Workplace Occupational Health Scenarios

| Pre-placement medical examination | Occupational health practitioner asked to advise on occupational health policy |
|---|---|
| (a) Identify for the patient the role that the doctor has been asked to play in assessing work fitness, emphasizing the practitioner's clinical independence and their responsibility to provide an unbiased assessment of work fitness | (a) Clarify to all parties involved in policy formulation his or her role as an impartial expert. This responsibility includes having the independence to provide an unbiased assessment of the occupational health implications of all policy options under consideration |
| (b) Discuss with the worker-patient the implications of this role. Along with this would be an explanation of any tests required, and what different results would imply for fitness assessment. The worker-patient once aware of the purpose and implications of the examination may elect to refuse examination or seek assessment elsewhere, understanding the consequences for their employability if they choose this action | (b) Clarify the implications of his or her role emphasizing the ethical requirement for impartiality as contained in occupational health codes. This would apply as much to an expert nominated by management as by an expert nominated by labor, if such a situation were to arise |
| (c) Once you have sufficient information to be able to exercise your clinical judgement and form an opinion, discuss your assessment and recommendation with the patient | (c) Identify that the health of worker-patients remains the primary consideration of the recommendations even though considerations related to management functions may be part of the brief of the advice. Thus, for example, concern for the costs of AZT prophylaxis in the event of needle-stick injuries amongst staff may be a management consideration in the elaboration of policy. However, the medical advice should help to formulate how best to reach an occupational health objective (protection of patient's health) rather than pronounce on whether the costs are or are not justified |
| (d) Having outlined your assessment, the practitioner is now in a position to obtain informed consent for release of any clinical information relevant to work fitness if necessary. In most cases, such clinical information would not be necessary, and a summary evaluation of 'fitness' or 'unfit' would suffice | (d) There may well be legitimate grounds for considering the rights of a collectivity of workers in relation to the rights of an individual patient, where risks to co-workers are real and significant |
| (e) If medical issues emerge that require further management, whether related to fitness for work or not, take appropriate steps (referral, counseling, treatment, etc.) as appropriate | (e) If the policy interaction raises medical issues distinct from the issue under consideration that require further intervention, the occupational health practitioner is obliged to take appropriate steps. For example, if it emerges that a serious health hazard exists at the workplace, and no remedial action is contemplated by management, the occupational health practitioner may be obliged to resort to one or more whistle-blowing strategies as part of his or her ethical responsibilities |

(PRU) into the incidence of mesothelioma and its relationship to asbestos dust exposure and asbestosis in the early 1960s was terminated in midstream by industry pressure, including the withdrawal of funding. The medical officer for Cape Asbestos was sent to South Africa where he visited the mines and saw first hand the high exposure to dust. Despite this, he did not recommend any interventions or further research to reduce dust levels but rather disparaged the PRU researchers and suggested relocating ten mesothelioma sufferers in Prieska out of the area to Johannesburg, thereby removing the problem from sight. Actions such as labeling of fiber bags with health warnings were dismissed as not only unnecessary and impractical, but undesirable.

## THE INDIVIDUAL OHP AND THE INSTITUTIONAL RESPONSE

For many reasons, it is insufficient and probably ineffective to locate the problem in an individual practitioner's behavior [Emanuel, 2002]. Critical is the need to look more broadly at the institutional context in which ethical behaviors are facilitated or obstructed, and what steps can be taken to enable practitioners to make the best ethical choices when faced with conflicts of dual loyalties. This would include an examination of what professional organizations could do to support members through advisory and ombudsman functions to promote ethical professional practice, and, particularly, to support colleagues [Ladou et al., 2002] whose isolation facilitates their victimization for their ethical stances [Kern, 1998]. Precisely because the choice to follow an ethical course of action may lead to adverse consequences for the OHP [Frumkin, 1998; Kern, 1998], the role of professional collectivities is critical in addressing the problem of dual loyalty [Rubenstein et al., 2002].

Education and training is a key strategy to promote awareness and best practice, not only directed at the community of practitioners but also at key stakeholders in the occupational health setting—employers, employees, and their organizations. Raising the level of awareness amongst employer bodies of the need to respect practitioner independence and impartiality would be a first step in enabling individual practitioners to assert such ethical obligations.

Secondly, the nature of the occupational practitioner's contract with a third party should explicitly include the ethical obligations of the OHP, and be buttressed by regulations [Ladou et al., 2002; Rubenstein et al., 2002]. Provisions in a contract recognizing the independence and impartiality of the OHP open space for the practitioner to insist on keeping ethical obligations above third party considerations.

Largely in recognition of the need to address the problem of dual loyalties in the health professions, an International working group has proposed guidelines on dual loyalties for health professional practice [Rubenstein et al., 2002]. These guidelines propose standards for individual conduct and also identify institutional mechanisms to address the context for ethical behavior and protection of human rights, in a framework that integrates human rights standards with ethical practice principles. This integration of human rights and ethics is an evolving perspective that has much to offer ethical practice [British Medical Association, 2000] including that in the occupational and environmental health fields [Smith, 2003]. Besides generic guidelines, the working group included the workplace as one of its setting-specific guidelines (http://www.phrusa.org/healthrights/dual_loyalty.html/), specifically in recognition of the importance of dual loyalties in ethical dilemmas in occupational health practice. As these guidelines are increasingly considered by national medical associations and international professional associations, it would be helpful for the international occupational health community to engage with the proposed guidelines, in order to promote debate to expand and elaborate on the proposed actions and mechanisms. The opportunity to turn a legacy of human rights violations into guidance material for OHPs should not be ignored.

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## APPENDIX: Dual Loyalties: Guidelines for Health Professionals in the Workplace.

1. Health professionals should exercise independent judgment[1] in their clinical management and non-clinical assessment of the worker/patient.
2. Even when acting in a non-therapeutic role in relation to the patient, such as that of independent evaluator, a health professional cannot ignore the ethical obligations to the individual patient, to which he or she would be subject in a typical clinical encounter.[2]
3. Health professionals should maintain confidentiality of medical information, and not disclose clinical information not directly germane to the purpose of evaluation.[3]

[1] The requirement for independent judgment on the part of occupational health personnel is explicitly cited in ILO Recommendation 112 (Occupational Health Services in Places of Employment, 1959) and in ILO Convention 161 (Occupational Health Services, 1985).

[2] This guideline is consistent with similar approaches in forensic practice.

[3] The obligation to maintain medical confidentiality is contained in ILO Recommendations 112 (Occupational Health Services in Places of Employment, 1959) and 97 (Recommendation Concerning the Protection of the Health of Workers in Places of Employment, 1953).

4. Health professionals must release information regarding workplace hazards to affected workers or the appropriate authorities, where definable harm—either existing or threatened—to the worker-patient, other workers, or third parties outweighs the right of the company and of the patient to privacy.
5. Health professionals should ensure that any audit or regulatory monitoring undertaken to ascertain risks to workers, their families, or the neighboring community, is undertaken with the highest standard of scientific integrity.
6. Health professionals should support other occupational health professionals facing conflicts arising from dual loyalty conflicts.
7. Health professionals should identify and declare any conflicts of interests before helping disseminate research findings or formulate policy for the control of occupational health hazards.

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