

# Codes of ethics in occupational health – are they important?

## Ethical dilemmas and moral challenges in occupational health.

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This article addresses the ethical competence of occupational health professionals (OHPs). Ethical dilemmas and moral challenges are part of everyday life in occupational health (OH), increasingly requiring that OH practitioners are competent in dealing with these issues. According to Susanne Rameix of the Sorbonne University of Paris, ethics is not a science,<sup>1</sup> nor is it an institutionalised system of regulations. It is a matter of knowing what to do. Since the days of Socrates, philosophers have engaged the difficulties of teaching ethics.

A fundamental question occupying the minds of philosophers is whether or not there is a universal set of values more or less shared by countries and different world cultures. It does seem possible to discern a set of basic values transcending most cultures with reference to the importance of 'anti-egotist' (in contrast to 'egotist') values emphasising social considerations and collective interests over the interests of individuals.

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### *Determinants of moral behaviour*

Whether conduct is considered moral or immoral relates to our systems of norms, which may be considered to be broadly determined by:

- law and regulations
- predominant values common to a community
- professional values
- our personal set of values.

When acting in consonance with these norms, the situation does not normally constitute a problem. When there are inconsistent signals, however, we have a moral dilemma as we cannot fulfil all our moral obligations, and our decision will perforce be less than optimal.

### *Moral theories*

Deontology and consequentialism are two currently predominant moral theories. See textbooks such as Holland (2007) for more detailed accounts.<sup>3</sup>

**Deontology:** The source of the moral value is the nature of the action taken, irrespective of consequences. Deontological considerations concern what is actually done and notions of principles and duty have prominent roles.

**Consequentialism:** The moral value of an action is never determined by the action itself but by reference to its consequences. Consequential moral theory is focused on results and the consequences of action.

The following case history (from France) illustrates the the type of ethical dilemma an occupational physician may have to confront.

*An occupational physician (OP) carries out a medical examination for new employment on JT, who is seeking employment as a lorry driver. JT declares no particular previous illnesses or ill-health. The OP certifies JT as fit for the job. A short time afterwards the OP hears by chance that JT has serious circulatory disease and a sleep apnoea syndrome which has not been medically treated. The OP calls JT for a repeat visit. After this visit, with heated exchanges, the OP withdraws certification and advises JT to seek medical advice for his sleep apnoea. JT adopts a hostile and threatening attitude, and informs the OP that he will go elsewhere to seek employment as a professional driver and will drive his own car.*

The ethical dilemma concerns the autonomy of JT and the prevention of serious risks arising from his health state to the health and life of a third party – the public. Can the demands of individual health, health at work and public health be reconciled in following guidance obtained from an ethical code?

### *Ethical codes*

Some well-known ethical codes are the ICOH International Code of Ethics for Occupational Health Professionals,<sup>4</sup> the Code of Medical Deontology issued by the National Order of Physicians of France<sup>5</sup> and the Guidance on Ethics for Occupational Physicians, adopted by the Faculty of Medicine of the Royal College of Physicians of the UK.<sup>6</sup> The ICOH code was first adopted in 1992. The introduction refers to the overriding duties of OH professionals in 'protecting the life and health of the worker, respecting human dignity, and promoting the highest ethical principles in occupational health (OH) policies and programmes. Integrity in personal conduct, impartiality and

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protecting the confidentiality of health data and the privacy of workers are part of these duties.' The substantial content of the code addresses the duties of OH professionals, their roles and their obligation to develop their own competencies. Full professional independence in the execution of tasks is emphasised, as related to concepts of integrity and impartiality addressed in the Code.

The Code de Déontologie Médicale, revised in 2006, was first issued by the National Order of Physicians of France in 1947.<sup>5</sup> Moral obligations and duties of physician members are addressed. The fundamental ethical principles of the code are condensed in its second article, stating: 'The physician in providing service to individuals and also in a public health context serves in the spirit of respecting human life, human beings and human dignity.' Detailed explanatory comments emphasising professional independence are attached to the 112 articles. The requirement is framed in stark terms: 'The physician is not in any form to dispense with professional independence'. One particular feature of the French Code of Medical Deontology is its integration into the legislative and regulative structure of France. It is drafted by the Order of Physicians, vetted by the civil administration, eventually approved after legal scrutiny and signed by the Prime Minister as an integral component of public health legislation in France.

The UK Faculty of Occupational Medicine has produced the 'Guidance on ethics for occupational physicians'<sup>6</sup> which is based on the ethical principles of (i) respect for autonomy and integrity, (ii) beneficence, (iii) non-maleficence and (iv) equality in rights and responsibilities (distributive justice). It is important to keep in mind that in distributive justice is also included the material principle of distribution according to need. The FOM Guidance provides practical advice for scenarios familiar to occupational health professionals (OHPs), in particular medical doctors. This concerns confidentiality of medical records, subject consent in disclosure of information to third parties, fitness for work assessments, health screening and surveillance, and relationships with colleagues, nurses, managers, trade union representatives and other stakeholders.

While these three examples of codes for ethical guidance in OH represent different approaches, all advise doctors and health professionals on what they should and should not do. They exert a regulatory role.

### Problems with codes

The number of legal and non-legal regulations has increased tremendously. Three types of problems with these codes are interpretation, multiplicity and legalisation – described by Eriksson, Höglund and Helgesson in 2008.<sup>7</sup>

The *interpretation problem* stems from the experience that there is, and will always be, a gap between rules and articles of a general and abstract code and real life. Ethical guidelines also contain internal contradictions, making interpretation difficult.

The *multiplicity problem* has to do with the great number of ethical codes and guidelines being produced. They may sometimes pull in different and contradictory directions.

The *legalisation problem* is that the ethical code is often given a legal form. When ethical issues are interpreted as legal problems there is a moral risk. The question 'What needs to be done?' is trumped by a narrower question: 'What is legally required/permissible?' Ethical reflection is dominated by legal interpretation, since health professionals, researchers and laymen are usually not competent to interpret legal regulations. This may be to the detriment of the responsibility of health professionals.

One constantly recurring problem with ethical codes is that they do not give guidance on how to manage situations marked by ethical dilemmas where one is seemingly required to comply with one aspect of the code and not with another. When seeking to protect the autonomy of a person, and at the same time promote his or her health, how does one handle a situation where the person declines all health-related attempts to intervene in matters of lifestyle?

## Consequential moral theory is focused on results and the consequences of action.

### Conclusion

While some reservations have been expressed about professional codes of ethics, they are balanced by positive aspects to which Whitfield<sup>8</sup> drew attention in 2004.

They:

- define accepted/acceptable behaviours
- promote high standards of practice
- provide a benchmark for members to use for self-evaluation
- establish a framework for professional behaviour and responsibilities
- serve as a vehicle for occupational identity
- are a mark of professional and maturity.

## The number of legal and non-legal regulations has increased tremendously. Three types of problems with these codes are interpretation, multiplicity, and legalisation.

OH ethics has historical roots in the practice of medicine, implying an inherited individual doctor-patient relationship. Over time the employer/client company has entered this relationship as a third party and responsible agent for the working conditions causing and contributing to disease. So, the employer is not a stakeholder who can be ignored. This brings the OHP into the field of conflicting loyalties and tension between the productivity interests of the company and employee health. This is, however, not the full picture. The client/employer also carries the role of sponsor in paying for the services required of OHPs. This implies a pressure, or a force of attraction on OHPs to provide services demanded in order to secure their existence in the market. Following the logic of the marketplace, services may be provided even if they seem not to be necessary. One such example is the regular, annual health examinations of employed staff, which are provided in many countries of the world.

The key issue in discussing ethical codes is the extent to which they can be utilised to enhance moral awareness and thereby earn the trust of clients and the public. Employees in companies require their needs to be met by health professionals without outside interference. The client company has a productivity agenda and seeks the loyalty of health professionals and employees. The dealings between company, employee and

## Codes of ethics

OHPs may involve confidential health and other information.

OHPs might well reflect on the following four difficult ethical questions:

- Is it ethically defensible to market OH services that are not based on the needs of the client?
- Is it ethically defensible to market OH services of doubtful effectiveness?
- Is it ethically defensible to market OH services for which the service provider has no or insufficient competence?
- Is it ethically defensible to market OH services aiming at protection of the professionals' own survival in the market?

### **Ethical codes should be seen as powerful bearers of the traditional value sets of occupational health professionals.**

Addressing these four questions above, the dilemmas arising from the multiple loyalties while seeking to comply with requirements of evidence-based medicine is at times most challenging. For coping with these there is a need to include in the curricula of both medical undergraduates and postgraduates regular teaching of the principles of ethical analysis. These also need to be drilled.

Ethical codes should be seen as powerful bearers of the traditional value sets of occupational health professionals. As tools to be used in achieving moral excellence of OHPs, codes of ethics can be evaluated

with respect to their understanding, communication, implementation and impact. They can also be utilised in the training of new generations of OHPs. In these ways they can contribute to an ethical awareness and sensitivity to ethical reflection, which is the hallmark of a professional. To achieve these goals, and to give direction, they must be seen – just as a lighthouse is seen to provide direction to avoid catastrophic situations.

In these ways they can contribute to the ethical awareness, the sensitivity to ethical reflection and the professional accountability which all are hallmarks of an occupational health professional. To achieve these goals, and to give direction, they must be seen – just as a lighthouse is seen to provide direction to avoid catastrophic situations. They need to be made visible.

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### *In a nutshell*

- Determinants of moral conduct: law and regulations, civic values of community where we live, professional values and implicit knowledge, personal set of values.
- Professional codes of ethics generally aim at guidance and regulating professional conduct. General problems in using them are problems of interpretation, problems of multiplicity of codes, problems of their legalisation and the problems caused by their inability to resolve ethical dilemmas.
- In analyses of ethical dilemmas of occupational health professionals (OHPs) the vested interests of OHPs themselves as stakeholders should not be forgotten.
- The difficult ethical questions to be addressed by OHPs concern:
  - their professional competence
  - the importance of delivering only services which are needed
  - delivering effective services addressing service needs
  - prioritising clients' needs in planning service outputs – not professionals' own needs to stay in the market.

### *Single suture*

## ***Fats can switch off fat burning***

Healthy muscle cells exposed to fat can behave like cells taken from people with type 2 diabetes – with the genes that control fat burning permanently switched off. This is according to Roman Barrès of the Karolinska Institute in Stockholm.

This suggests that healthy people who eat fat-rich diets may land up with changes to their DNA, which could explain why adults develop type 2 diabetes. Barrès and colleagues found that cells from people who have diabetes already have these changes, particularly in *PGC-1*, a gene that orchestrates burning fat.

Research showed that the same effect could be triggered by exposing healthy muscle cells to the fat plamitate – which suggests that foods may reprogramme our DNA.

Barrès R, et al. *Cell Metabolism* 2009; 10: 189-198.



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