Describing occupational medicine practice to establish a basis for ethical guidance

Ethical guidance to doctors usually assumes a normal doctor–patient relationship. However, in occupational medicine, such a relationship may not always exist. Occupational physicians in the UK appear to be polarized in their views as to what that relationship exactly is. On the one hand, there are those who view the advice they give to workers as being akin to a therapeutic intervention; on the other, there are those who see their interactions with workers as being more remote, objective and impartial. An alternative approach suggests that both sets of circumstances exist, and indeed there may be a ‘middle ground’ between these two extreme positions. This situation may partly explain the ‘significant current variation between occupational physicians and uncertainty regarding best practice with regard to consent and confidentiality’ [1]. If ethical guidance does not reflect the day-to-day reality of occupational medicine practice, then it is not surprising that there is confusion and uncertainty. However, rather than be critical of the ethical guidance, it may be better to consider the difficulty in producing such guidance when UK occupational medicine practice can involve so very different types of interactions with ‘patients’, workers or applicants (to pension funds). Therefore, it may be helpful to characterize these different interactions in a systematic way.

In order to do this, three models [2] can be proposed to characterize occupational medicine as practised in the UK: (i) a ‘quasi-therapeutic’ model, where the occupational physician–worker interaction would be close to the normal doctor–patient relationship; (ii) an ‘independent expert’ model, where the occupational physician could be for example, advising a pension fund; and (iii) an ‘impartial doctor’ model, which should reflect most of the work that occupational physicians do, such as advice to managers on sickness absence and health surveillance. In order to highlight the differences in the ethical basis of models 1 and 2, model 3 will not be described any further here.

At one end of the spectrum, model 1 (quasi-therapeutic) is similar to the normal doctor–patient relationship, which is characterized by trust and a power imbalance between the two parties (for example, due to the doctor’s greater medical knowledge and the patient’s distress and lack of knowledge). The doctor–patient relationship based on trust and the power imbalance in turn places fiduciary obligations [3] on the doctor, which can be summarized as a duty of ‘no conflict of interests’, a duty not to profit from his or her position, a duty of ‘undivided loyalty’ to the patient and a duty of confidentiality. Such obligations sit more comfortably in the therapeutic setting, especially for those doctors who see themselves as the ‘patient’s advocate’. Although model 1 occupational physician–worker interactions do not go as far as needing workers to trust the doctor ‘with their health and lives’ [4], there are probably many similarities with the normal doctor–patient relationship, so that ethical guidance produced for treating doctors also makes reasonable sense when applied to occupational physicians working in this type of context. Model 1 may arise more often where the occupational physician is working within an ‘in-house’ service and when workers have the ability to self-refer and do come to the occupational physician for health advice of their own accord. The only fiduciary obligation that cannot fully apply is that of ‘undivided loyalty’ to the patient or worker as the occupational physician should remain impartial even in this model.

Model 2 (independent expert) is at the other end of the relationship spectrum, and this relationship is at best an ‘arm’s length’ one. Many large pension schemes in the UK have a medical assessment process that is carried out remotely for the majority of applications as it is an assessment of the submitted medical evidence in relation to the scheme criteria rather than an assessment of the individual. Even when such pension assessments are carried out face-to-face, the independence of the doctor remains essential. (Indeed, the term ‘independent’ is used in the title ‘Independent Registered Medical Practitioner’ [IRMP] in the Local Government Pension Scheme [Benefits, Membership and Contributions Regulations 2007.] The need for trust in model 2 is less evident than in a normal doctor–patient relationship or model 1 and may be limited, for example, to trusting that the doctor has the correct qualifications and will be unbiased in applying the appropriate criteria for ill-health retirement. The power imbalance noted in the normal doctor–patient relationship may exist here as well although not necessarily for the same reasons. It is that the occupational physician’s opinion and advice is important to the employer’s or pension fund trustees’ decision to award an ill-health retirement. However, arguably this power imbalance can be reduced or even reversed if the applicant or his representative threatens the occupational physician that they will complain to the General Medical Council if the application is not successful. More importantly, the fiduciary obligation of ‘undivided loyalty’ (to the applicant) is totally incompatible with the role of an occupational physician advising a pension fund in this way. Independence and undivided loyalty are mutually exclusive, and without independence, an occupational physician in a model...
2 role would be legally and ethically in breach of their terms of engagement. (For example, the IRMP has to sign a certificate that includes the following, or similar, statement: ‘I have not previously advised, or given an opinion on, or otherwise been involved in this case, nor am I acting or have ever acted as the representative of the member, the scheme employer or any other party in relation to it’).

These differences are summarized in the table shown above.

It can be argued that the ‘dual obligation’ [5] or ‘two master ethics’ [6] position of occupational physicians is ethically difficult enough, and ethical guidance should aim to reduce any confusion rather than increase it. For example, the requirement to offer the report to the worker (which currently applies even to an applicant in model 2) before the commissioning party arises from the overriding principle of ‘no surprises’ [7] (a principle with which most bioethicists will be unfamiliar). This justification may be understandable and laudable in a therapeutic context, where trust and fiduciary obligations matter greatly. It may even make sense in model 1. However, in the context of a model 2 independent assessment, it is difficult to see any coherent reason why there should necessarily be ‘no surprises’. In any case, if the pension scheme or assessing physician or other practitioner advises the applicant of the possible outcomes (accept or decline), then there should not be any surprises. The outcome may not be to the applicant’s liking or wishes, but an independent opinion formed in good faith on the evidence presented should not require prior scrutiny by the applicant before the commissioning party receives it. A copy at the same time would be good practice and should suffice.

Stern and Serber call for ‘more specific guidance, to ensure uniformity and quality of practice’ and suggest that ‘the background ethical reasoning should be stated so that the parameters of the guidance are delineated’ [1]. This would seem to be an eminently sensible approach. Just as we have progressed to an evidence-based approach for the scientific basis of occupational medicine, in developing ethical guidelines, we should review the underlying overt or implied assumptions and justifications and be prepared to challenge those that are erroneous or incorrectly applied.

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References