To serve two masters? A moral analysis of an apparent conflict of interest in the profession of occupational physicians

by

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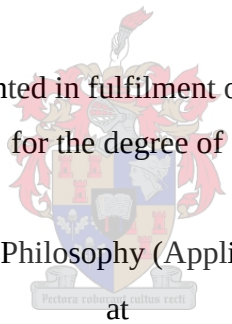

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Declaration

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Date: December 2019

Throughout this dissertation, gender-specific terms (such as his and her) are used in order to ease the text flow and make it easier to read. Whenever a gender-specific term is used, it should be understood as implying either gender; unless explicitly stated or when referring to a specific individual such as a historic figure or the author of literature being referenced.

I dedicate this dissertation to all Southern African occupational medicine practitioners who are committed to the improvement of worker health and wellness in our country.

“The bourgeoisie has stripped of its halo every occupation hitherto honored and looked up to with reverent awe. It has converted the physician, the lawyer, the priest, the poet, the man of science, into its paid wage laborers.” (Marx & Engels, 1848).

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Abstract

Occupational medicine is the branch of the medical profession concerned with the health and safety of people at work. A nation's labour force is a valuable asset and justifies legislation to preserve its productivity and well-being. Along with safety specialists, occupational hygienists, nursing professionals and human resources managers, physicians with specialised expertise in the field endeavour to keep workers safe and safeguard the public against accidents that might result from impaired workers performing safety-sensitive work. While these occupational physicians have a duty towards workers who become their de facto patients, the ultimate social good of occupational medicine and the discipline's mission is occupational health and safety.

An employer is legally responsible for the occupational safety and health of its workforce and has to carry all reasonable expenses. The occupational physician is thus employed by or contracted to the employer and remunerated to deliver an occupational medical service to the workforce. The question then arises whether the appointed physicians should primarily serve the interests of their patient, like doctors have been urged to do since time immemorial, or should serve the masters who pay their fee. Dual loyalty, or at least the suspicion that loyalty to either party would colour the occupational physician's judgement, has vexed the discipline in recent times and creates ethical ambiguity. Consequently, codes of ethical conduct for occupational medicine have been developed. Occupational health and safety has many stakeholders and participants, rendering it an inclusive discipline. Allowing loyalty to influence decisions is incompatible with professionalism. Part of the answer lies in the unique context of the doctor–patient relationship in occupational medicine. When healthcare is practised in the labour milieu – with its hierarchical structures, employment contracts, disciplinary procedures and legislation – ethical controversy can be expected.

This dissertation entails a description of the ethical field of occupational medicine in South Africa as experienced in a career of forty years and analyses various problematic aspects of the discipline. It is not possible to avoid all ethical qualms and suspicion in this discipline of medicine. However, there is some opportunity to raise the discipline's ethical reputation with stakeholders.

This includes acceptance that occupational medicine is not primarily patient centred, raising awareness of ethical codes, and exemplary professionalism of its practitioners. The prominent role of virtue ethics in the equation, emerges. Ethical practice in the field of occupational medicine calls for impartiality, veracity, tact when interacting with stakeholders and trustworthiness in clinical relationships.

Opsomming

Bedryfsgeneeskunde (of beroepsgeneeskunde) is die vertakking van die mediese beroep wat by die bedryfsgesondheid en -veiligheid van werkers betrokke is. ’n Land se werksmag is ’n waardevolle bate en regverdig wette en stelsels om werkers se produktiwiteit en welsyn te bevorder. In samewerking met veiligheidspesialiste, beroepshigiëniste, professionele verpleegkundiges en personeelbestuurders sien bedryfsgeneeskundiges nie net na die gesondheid van werknemers om nie, maar verseker hulle dat die publiek nie aan risiko’s blootgestel word omdat werkers nie hul werk veilig kan doen nie. Alhoewel bedryfsgeneeshere ’n plig het teenoor werkers wat ook in effek hul pasiënte is, is beroepsgesondheid en -veiligheid die uiteindelike doel van bedryfsgeneeskunde.

Werkgewers is wetlik verplig en aanspreeklik om na die beroepsveiligheid en -gesondheid van hul werknemers om te sien en al die redelike kostes daarvan te dra. Die bedryfsgeneesheer word dus deur die werkgewer aangestel en vergoed om die diens aan die werksmag te lewer. Die vraag is dan of sodanig aangestelde dokters steeds in die eerste plek die belange van hul pasiënte op die hart moet dra, soos dokters nog altyd veronderstel is om te doen, of eerder die belange van die maatskappy wat hulle vergoeding betaal? Dit lei tot gedeelde lojaliteit – of ten minste agterdog dat die bedryfsgeneesheer meer lojaal sal wees aan óf sy werkgewer óf sy pasiënte en dat dit dan sy oordeel sal beïnvloed. Sulke vermoedens voed die etiese twyfel en morele onsekerheid waaraan bedrysgeneeshere nog altyd onderworpe is. As gevolg daarvan is verskeie etiese riglyne vir bedryfsgesondheid ontwikkel. In die veld van bedrysfgesondheid en -veiligheid is daar heelwat deelnemers en belangegroepe, wat dit ’n inklusiewe dissipline maak. Om toe te laat dat lojaliteit besluite beïnvloed sou onprofessioneel wees.

Die oplossing vir die etiese problematiek in die veld van bedryfgesondheid lê deels in die uniekheid van die dokter-pasiënt-verhoudings in die dissipline. Wanneer gesondheidsorg in die arbeidsomgewing plaasvind – ’n omgewing wat deur hiërargiese strukture, arbeidskontrakte, dissiplinêre prosedures en arbeidswetgewing oorheers word – kan verskillende etiese opvattings verwag word.

Hierdie proefskrif behels ŉ bespreking van die etiese problematiek in die bedryfsgeneeskunde in Suid-Afrika soos ervaar in ŉ loopbaan van veertig jaar en probeer die oorsprong en konteks daarvan navors. Dit is ŉ gebied van geneeskunde waar bedenklike etiek, twyfel en agterdog nooit heeltemal uitgeskakel kan word nie. Nogtans is daar geleentheid om dit aan bande te lê en om die professie in ŉ beter lig te stel. Daar moet aanvaar word dat die individuele pasiënt nie die middelpunt van bedryfgeneeskunde is nie, etiese kodes moet beter bekendgestel word en die dissipline se praktisyns moet onberispelike professionaliteit aan die dag lê. Deugsaamheid het ook ‘n belangrike rol in etiese optrede. Bedryfsgeneeshere moet onpartydig, geloofwaardig en eervol wees en takt aan die dag lê in onderhandeling met regmatige rolspelers in bedryfgesondheid.

Chapter 1: Introduction

Work is an integral part of life. Working class people spend a large part of their adult life at work. Americans spend approximately 50% of their waking hours devoted to work (Robert Wood Johnson Foundation, 2013). Protestantism's two key religious leaders preached that people can serve God through their work (Hill, 1992). Martin Luther equated a person's vocation to his calling. From a spiritual viewpoint, all vocational callings were considered to be equally dignified – irrespective of the status of someone's occupation. John Calvin taught that all men must work, because to work was the will of God. "But most important, the Lord knew that from the crucible of work emerges the hard core of character" (Clarke, 1982:1). Similarly, "Islam lays a lot of emphasis on work and the need for man to work in earning his livelihood so as to be independent, self-sufficient and in order to uphold his dignity among his peers and in his community/society" (Ahmad & Owoyemi, 2012:117). "More often than not, work defines a man's worth to himself and to the world" (Rosenthal, 2002:1). On a more secular note, Waddell and Burton (2006:1) asks: "Is work good for your health and well-being?" In spite of several concerns and prerequisites, the predominant sentiment is that "in modern society, work provides the material wherewithal for life and well-being" (Waddell & Burton, 2006:1). According to the British Medical Association (BMA, 2011) labour and its rewards contribute to the personal well-being of workers and that of their families and society. Involuntary unemployment is demoralising. There is therefore strong evidence that work is generally conducive to physical and mental health and wellness (Waddell & Burton, 2006). 'Worklessness', a recently coined term, hints at the despondency that characterises long-term unemployment (Waddell & Burton, 2006:4). This is true at family level as well as community level. Ample employment leads to increased economic activity, which allows a society to thrive. Work and a well-organised labour dispensation are fundamental to human endeavour and sustainable societal success.

Hence, in most contemporary societies, the labour environment and labour-related relationships are thoroughly arranged and closely regulated. Spector (2006:1119) points out that "labour law is an offspring of the social and political action of the working class movement". "Governments conceded both democratic and labor law reforms under the pressure of uprisings, and toward the end of the [nineteenth] century, when working class parties and trade unions consolidated their

power, labor and industrial legislation was an essential feature of European law" (Spector, 2006:1119). Basically, labour law is "a complex bundle of restraints on freedom of contract in the labour markets" (Spector, 2006:1120).

Nowadays, statutes and case law regulate employee and employer rights and obligations. Protective labour legislation is important to keep workers from harm. In the labour law arena, employee health and safety are afforded priority. The right to health and safety at work is a recognised basic human right (WHO, 1995). Until relatively recently, this was generally not the case. In fact, the narrative of the working class prior to the twentieth century features exploitation rather than opportunity, suffering more than contentment, and unbearable workplaces instead of gratifying ones. Miners of antiquity were usually slaves, recruited from the ranks of condemned criminals or prisoners of war; and, if miners were in short supply, innocent individuals were exiled to the mines. Manual labour conditions were mostly harsh and work was gruelling. This description probably typifies conditions that prevailed: "The lash of the overseer drove them to their arduous labour" (Raffle, Lee, McCallum & Murray, 1987:10). Social stigma and prejudice against those who plied a mechanical trade can be traced to ancient Greece. The social division between labourer and aristocrat reputedly created "a cleavage which when complete made it impossible for the same man to be both worker and citizen" (Raffle et al., 1987:13).

The thirteenth century ushered in an era of skilled craftsmen, sculptors, stonemasons, woodcarvers, silversmiths and decorative ironsmiths with unusual creative ability. Their labour contributed to the construction of, among others, cathedrals of unsurpassed beauty. Craft fraternities were formed to control their activities and manual skills were in demand. Craftsmanship was cherished, took long training and apprenticeship to master and was often handed down from generation to generation. The years 1760 to 1850 (the period in which Britain's Industrial Revolution took place) were characterised by great inventions, which played a decisive role in creating a new kind of society – a society where labour was relegated to people of subordinate status. The industrial revolution was marked by the introduction of machinery into the process of production, with far-reaching implications – such as the division of labour. But more than that, over time it drastically changed how society was organised. Changes first occurred in the textile industry. Before, a rural handicraft economy saw textiles being spun in homes and clothing was hand-made by seamstresses and tailors whose skills were in demand. The advent of steam driven machinery and a series of inventions rendered many time-honoured human crafts obsolete. Skilled work was replaced by unskilled jobs, tending machinery in

factories. This inevitably saw the means of production shifting from small-scale or home-based operations to the new industrialists. Efficient production came to rely on the large-scale application of capital, rather than merely on labour. Workers were progressively divorced from the ownership of the means of competitive production.

However, as growing demand saw mining, the textile industry and foundries expanding uncontrolled, everything was engulfed in coal-dust and smog – town life became hideous and squalid (Raffle et al., 1987). This was the society which Marx and Engels (1848) laid bare in their epoch-making *Communist Manifesto*. Machines destroyed all individual character and charm that work once held for the proletariat. Labour became monotonous and workers mere appendages of machinery. Such labour requires little skill. Consequently, labour came to be in oversupply and worker wages barely rose to the means of subsistence. Industry replaced many little workshops of patriarchal master craftsmen with masses of labourers crowded into great factories. Workers resembled soldiers. "As privates of the industrial army they are placed under the command of a perfect hierarchy of officers and sergeants" (Marx & Engels, 1848:10). Words such as 'petty', 'hateful' and 'embittering', used by Marx and Engels in mid-nineteenth-century Europe to describe the feelings of the proletariat, may well reverberate in some present-day workplaces.

It is not incidental that modern occupational medicine took root in the same era. The discipline of industrial health developed side by side with British public health (Raffle et al., 1987). Living conditions were terrible and public hygiene poor. Uncontrolled rodent populations raised the risk of typhus and polluted water caused cholera. Sanitation could not keep up with rapid urbanisation. Around 1883, a public hygiene campaign was initiated after a census and bills of mortality revealed the strong link between mortality and poor hygiene. During that period, pioneers in the field of industrial health also drew public attention to the poor health of artisans and postural deformities of children employed in cotton mills. In 1833, Britain's Factory Act was promulgated to regulate child labour in the mills and factories of the United Kingdom.

Britain's Towns Improvement Clauses Act of 1847 for the first time gave large towns the power to appoint full-time medical officers. Sir John Simon, a surgeon and pathologist, took up the position of medical officer of health of the City of London in 1848. A milestone was reached and industrial medicine (the precursor of occupational medicine) came of age (at least in Britain, at the time considered the 'workshop of the world') with the appointment in 1898 of His Majesty's

first medical inspector of factories, Sir Thomas Legge (1863–1932). Legge would later become disillusioned with his government and employer, whose refusal to ratify drastic measures proposed by the 1928 International Labour Conference in Geneva to curb lead poisoning was the proverbial last straw. Despite being knighted in 1925, Legge refused to compromise his principles and resigned from his prestigious position. Subsequently, he accepted an appointment as medical adviser to the Trades Union Congress (Raffle et al., 1987). Through integrity and not being awed or blinded even by knighthood, the first medical inspector of factories set a precedent worthy of emulation. These events, however, were a foreboding of the perennial conflict in the realm of ethics that doctors employed in industry would face.

As may be gleaned from the history of occupational medicine (initially referred to as industrial medicine), social reform and labour legislation are the main driving forces that determine progress in occupational health. Despite ongoing improvement in the field of health and safety, numerous workplaces and many occupations remain hazardous. Occupational health and safety acts tend to be extensive and prescriptive in respect of precautionary measures. Various regulations control mining operations, the handling of hazardous substances, the operation of machinery, exposure to physical hazards such as noise, etc. Typically, the assessment of fitness to work and the periodic monitoring of health require the input of healthcare professionals. Such medical surveillance is mandatory in mining, the chemical industry, aviation, and elsewhere where workers are potentially exposed to physical, chemical and biological health hazards. In major industrial enterprises, the duly appointed occupational medicine practitioner is the legal and moral custodian of job-related worker and workforce health.

It follows that the tone of the doctor's role in the workplace would often be very different from that which prevails in a clinic or conventional surgery. The occupational physician establishes a professional relationship with the 'patient' but has an overarching socio-legal governance role, aligned with the health and safety responsibility of the employer. That responsibility extends not only to the workforce, but also to protecting the public.

Effectively, patients in occupational medical practice are bona fide patients only inasmuch as they are current or prospective members of the workforce. The doctor–patient interaction is more often obligatory than voluntary. In occupational medicine, the patient seldom independently initiates the consultation. It is more likely to be compulsory. In addition, depending on the reason for the contact, the outcome of an occupational medical consultation generally needs to be

communicated to the employer. The employer is responsible for implementing the decision, such as whether the employee can safely return to work, needs to be redeployed or requires special accommodation in the workplace. Often assessment, rather than curative healthcare delivery, is the main reason for consultations in occupational medicine. Usually, given the worker's wish to continue earning a living with finite skills, an expedient outcome of a fitness evaluation is critical for the patient. On the other hand, the employer's tolerance for potential, even implausible, health and safety risks might be low. In some situations, any hint of impairment could potentially cause a worker to be taken off the job and perhaps even to be labelled a production or safety liability. Patently, the two main stakeholders will at times have different, even opposing, interests in the verdict. (See Chapter 8.1 for a detailed explication of the doctor–patient relationship in the occupational medicine environment).

When aspects of a case are unclear – the findings perhaps equivocal and test results inconclusive, like things in medicine often are – opinions tend to vary. In situations where the decision has critical consequences, disagreement is prone to escalate into conflict. As soon as the correct decision seems debatable, stakeholders may subtly, or even overtly, invoke loyalty. This is a common situation in occupational medicine – especially if the stakeholders do not have any medical expertise or have preconceptions. Because business managers generally lack an understanding of medical ethics, they seldom have insight into what guides the decisions doctors make and stand by. There is often a deeply ingrained sense that doctors' loyalty towards their patients would automatically be undivided and unfaltering. This probably stems from doctors' visible devotion to caring for their patients. However, in the arena of occupational medicine such commitment regularly conflicts with the occupational physician's very raison d'être – legal compliance and workforce health and safety for which the employer is by law (and morally) accountable. Decision-making in occupational medicine clearly calls for integrity, judicious assessment of risk, and assertiveness commensurate with the occupational physician's professional obligations. When different stakeholders expect geniality, complaisance and loyalty to influence the physician's conduct, such expectations could result in disenchantment or discontent. This would happen especially when employers and managers believe their appointed occupational physician's first priority ought to be the protection of the company's vested interests. That is after all what is expected of employees. Should the employed doctor be an exception and be exempted from putting the company's bottom-line first?

Moral conflict is by no means rare in the practice of medicine in general. However, many may feel that it is almost inherent to occupational medicine. The first reason for this is that many case decisions in occupational medicine extend beyond health and healthcare. In essence, occupational health–related rulings might curtail the individual's freedom to work and earn a living in his line of work. This is more likely to happen to the most vulnerable workers – artisans and those performing hazardous work and manual labour. When a miner's fitness certificate is revoked in terms of the Mine Health and Safety Act (Republic of South Africa, 1996a), he and his family are likely to suffer deprivation, although he may be adamant that he is able to do the work. A worker could well obtain a different opinion from another doctor – usually one that is not legally appointed to the position of occupational medicine practitioner (and is neither versed in occupational health and safety nor legally accountable for it). The employer or management is likely (and rightly so) to maintain that it must abide by the decision of the occupational physician and has to terminate the worker's labour contract. To the worker it could appear that a biased company doctor is jeopardising his livelihood under the pretext of preventive healthcare and punitive compliance with health and safety regulations carried to excess. It is this suspicion of bias and the unique paucity of implicit loyalty towards their patients under which occupational medicine professionals practise that make their discipline a vexing one.

Ongoing controversy and unresolved discord concerning ethics have the potential to impede sound, dependable occupational medicine practice. These matters can cast an indelible shadow of doubt over the integrity of the profession. Employers, workers, health and safety authorities, and the community all need to be willing to give credence to the apt recommendations or conclusions of the responsible occupational physician. Decisions that affect business performance, the livelihood of workers, and workforce health and safety are critical, allowing no space for opportunism. This does not mean that the doctor's opinion is incontestable. Ideally though, it should be inarguably unbiased, measured, factually accurate and appropriate. Legal compliance is essential. The problem is convincing all stakeholders that the occupational medicine practitioner with whom they are dealing is competent, trustworthy and impartial.

In this study, the focus is on the latter aspect. Employers understandably suspect that their occupational physician is, as all doctors presumably are, dedicated to the interests of patients. Workers, on the other hand, quite comprehensibly expect the occupational physician, employed and paid by the company, to serve the employer's business interests. That is, after all, expected of all employees, including themselves, and all their managers. Loyalty is said to be the glue that

holds together effective teams. The result is that both parties are likely to feel that the doctor owes them loyalty but might have the interests of others at heart. Patients may suspect that the occupational physician collaborates with the employer while the employer may believe that doctors naturally lean towards promoting the best interest of their patients – patients that happen to be employees. The embattled occupational physician, whose presumed loyalty is consequently suspect from both sides, or at least prone to be divided, has not only guidelines on ethical conduct in medicine to heed, but also extensive health and safety legislation to consider. All this is set in the labour environment with its unique relationships, negotiated agreements, disciplinary codes, productivity targets and potential health hazards. What results, is the ethical conundrum of occupational medicine.

Dual (or divided) loyalty is the subject of much of the literature on occupational health ethics. Different service delivery models in different constituencies occasion more or less perceptible ethical caveats. It appears that occupational physicians' independence and tenure would be a decisive factor regarding whose interests they identify with. However, a greater degree of professional autonomy is no guarantee of impartiality. Neither does it automatically neutralise perceptions of favour. Loyalty is after all a sentiment that over time inconspicuously enters a valued relationship rather than results from a contractual stipulation or conscious decision. In fact, loyalty that developed in spite of autonomy would likely be more authentic than loyalty in a relationship characterised by subordination. In the latter variety, the prospect of reciprocity might entice opportunistic loyalty. It is not a given that a good, contracted occupational medicine practitioner or a good one appointed by some regulating authority would be less committed either to the workforce or to the company – or would guarantee freedom of bias. Indeed, there is no simplistic answer to this thorny ethical problem of the profession.

In Chapter 2, the author briefly considers the origin and history of occupational medicine. What were the conditions that drew attention to the health risks of work? What prompted pioneers in occupational medicine to challenge paltry working conditions and workplace misery? History explains the purpose of occupational medicine and the locus of the discipline – the ambit of labour. This short account of the profession's beginnings is indispensable for the uninitiated to understand its sentiments. Chapter 3 deals with the purpose, scope and ethics milieu of occupational medicine as it is typically practised in a large South African industrial setting. It provides insight into the medical doctor's role in occupational health and safety management. Several professional bodies have compiled codes of conduct in an attempt to guide their members

through the intricacies of occupational health ethics. The various relationships that characterise occupational medicine and the roles that occupational physicians must adopt are the key to understanding occupational health ethics. These roles vary in accordance with specific situations and different scenarios. Professional versatility is called for. One cannot practise equitable occupational medicine without referring not only to patient rights but also to worker rights and ultimately to human rights.

Chapter 4 deals with the all-important legislative landscape that guides and governs occupational health and safety. Owing to far-reaching legislation, no account of current occupational medicine practice and ethics would be complete without due reference to relevant labour legislation. The focus falls on labour-related legislation rather than on healthcare statutes and common law. This does not mean that the latter does not equally apply to occupational health professionals. Chapter 5 focuses on the physician's allegiances. Occupational medicine is an inclusive discipline where several stakeholders need to cooperate to realise the goal of sustainable worker health, wellness and even at times welfare. Nevertheless, professionalism calls for observing the obligations all doctors have toward their patients. Society endorses physicians with a moral mandate. In occupational medicine it is the social mandate that carries much weight. Approving the periodic flight medical of the pilot of a Boeing 747 is a weighty matter. Imagine the potential consequences if the diagnosis of major depression or angina is kept from the employer to afford the pilot confidentiality. Such responsibility demands unwavering commitment to social responsibility.

In order to delve into the apparent conflict of interest that plagues occupational physicians in the ethically responsible practice of their profession, the virtuous physician must be defined. In Chapter 6, loyalty as a virtue is dissected down to its substance and implications. No scholar of the virtues can consider loyalty without referring to the writings of Josiah Royce, who declared loyalty "a central principle of moral life" (Royce, 1908:13). The question that arises in the context of an occupation that entails a governance role and requires ample autonomy, is whether professionalism leaves room for loyalty to parties. Yet, the loyalty of employees towards their employers is often legendary. Add to that the high esteem society traditionally has for doctors who are loyal to their patients, and the vexing situation of occupational medicine practitioners becomes clear. 'Dual loyalty', a term used so often that it seemingly typifies occupational medicine professionals, implies a sentimental inclination to simultaneously please two parties. If stakeholders in the occupational health environment sense that a physician heeds loyalties, it might appear to represent an unspoken willingness to allow bias to compromise the integrity of

judgements. The author will argue that the context of occupational medicine calls for a nuanced exposition of loyalty.

Chapter 7 focuses on employee loyalty in the business environment – especially where employees who are professionals in their own right are concerned. The author touches on that enigma of frustrated, flouted or exploited loyalty: whistle-blowing. This topic is included because the occasional negative outcome of loyalty in the workplace throws light on its fragility and the potential for abuse. The uniqueness of the relationship between physician and employer, specifically in industry rather than in the ambit of generic healthcare, is addressed in Chapter 8. That relationship is placed in juxtaposition to that of the doctor–patient relationship in occupational medicine. The latter relationship varies significantly with different settings and scenarios in the practice of occupational medicine. The author thus considers it desirable to paint some practical situations that occupational physicians regularly deal with. Ethical guidelines for the profession cannot tell what ought to be done in every case. Pragmatism requires going beyond generic occupational medicine to the level of daily ethical matters confronting the discipline's practitioners. The occupational physician is for instance entrusted with a decisive role in pre-employment selection. Should the doctor decide which candidate employees will not be hired and how should that decision be made? Furthermore, is he obliged to apply management's recruitment/employment policy?

The dual loyalty issue is especially prone to arise in injury-on-duty cases. An assessment of the injuries/wounds sustained by a worker often reveals much about the probable mechanism of injury. While privacy prevails when a worker is injured at home, procedure calls for a thorough and detailed investigation of all occupational injuries. At times the clinical observation is incompatible with the evidence given by the victim or witnesses at the time of an incident investigation. This could put the occupational physician in a precarious position. The doctor has information which implies that the facts about what happened is likely being manipulated. What confidentiality status should the clinical data related to the injuries be afforded? Could it be that someone is attempting to shift blame and that the doctor's observations would reveal the truth? Invoking patient confidentiality could be seen as protecting the injured employee from due disciplinary process; or the wrong person might face sanction. Confidentiality of occupational health records is a notoriously thorny ethical issue. It extends to most aspects of occupational health – such as disability management, medical surveillance (the statutory monitoring of health in the face of exposure to health hazards) and fitness for work.

Virtue ethics is the subject of chapter 9. Codes of ethics provide guidelines for responsible, principled occupational medicine practice. However, it cannot tell what would be the best and a morally defensible option in each case. In occupational medicine, context is often crucial and so is the occupational physician's moral consciousness. Apart from the virtues generally associated with the healthcare professionals, occupational medicine's context calls for impartiality, veracity, trustworthiness and commitment to its cause. In their role as champion of work-related health, occupational physicians need the faculty and finesse to muster support from all stakeholders. In that context, I argue that tact is a virtue.

Chapter 10, a conclusion, reflects on the context of occupational medicine and how some of its ethical woes might be untangled. A profession that is vital to the health and safety of all workers who perform jobs that expose them to potential risks should be beyond moral reproach. It is a profession guided not only by health legislation, but also by labour laws. The ethical environment is consequently particularly complex with several legitimate stakeholders, unusual to the medical arena, that cannot be disallowed their valid interest in worker health and well-being. All parties ought to acknowledge how critical worker health and employee fitness are to sustainable business and society. They all have to contribute to establish a milieu of mutual trust that is conducive to efficacious occupational health risk management. Occupational medicine is an inclusive discipline in that sustainable worker health is the concern of not only the healthcare team, individual patient and his close family. It also concerns the employer, occupational health and safety authorities, co-workers and labour unions. The ethics of occupational physicians are sufficiently different from that of the conventional personal doctor to warrant the issuing of comprehensive ethical guidelines specific to occupational medicine for its practitioners. However, more than ethical codes is needed to ameliorate moral qualms in occupational medicine. Employers and employees alike could be educated about the invidious position of occupational physicians. Similarly, occupational health and safety authorities have to realise their pivotal role in supporting occupational medicine practitioners active in industry.

This study analyses conflict of interest in the ambit of occupational medicine. Legitimate and spurious expectations of stakeholders will be explored. The doctor's legal responsibilities, and where they potentially curb professional discretion, must be considered. One needs to contemplate what degree of professional independence is commensurate with the occupational medicine practitioner's employee profile. If this is stipulated in the doctor's employment contract, it provides a foundation that pre-empts future misapprehension about autonomy. The

various situations and doctor–patient scenarios that commonly confront the occupational physician need to be gauged. Circumstances and the purpose that dictate the tone of doctor–patient contact will be entertained. This is necessary to go beyond codes of ethics in order to flesh out the disposition, virtue and conduct most appropriate to various practical situations in occupational medicine. Prima facie obligations, which all medical doctors have, need to be identified and interpreted in the context of occupational medicine. These can never be neglected, lest respect and trust, which are critical for successfully practising any discipline in medicine, are forfeited. Would a loyal occupational physician be held in high regard; or might loyalty detract from the respect the medical doctor in industry generally commands? Loyalty is an intimate sentiment. In the context of professionalism, if it is not acknowledged or goes unperceived, loyalty could compromise transparency. To summarily deny that it potentially jeopardises equitable decision-making would be injudicious. Doubtlessly, the occupational medicine practitioner's ethical conduct should withstand scrutiny. How to achieve this, specifically in relation to the occupational physician often being confronted with profoundly conflicting interests, is the problem the author sets out to address.

Chapter 2: A short history of occupational medicine

A detailed history of occupational medicine is beyond the scope of this dissertation. However, a condensed narrative of the discipline's beginnings, growth, victories, turbulences and mainspring is necessary to introduce the uninitiated to what in effect is a little appreciated and (to most scholars) an obscure branch of medicine. The history of the discipline also holds lessons for contemporary occupational health professionals.

Heroes in the field of occupational health have established some timeless, inspiring truisms. Donald Hunter, in his 1955 seminal work, *Hunter's Diseases of occupations* (Raffle et al., 1987), often lauded as the bible of occupational medicine, tracks anecdotes about work-related illnesses to the ancient Egyptians melting copper 5 000 years ago and mediaeval guilds. German mythology attributed health hazards of mining to demons. Mining was so hazardous that the miner of antiquity was usually a slave, recruited from condemned criminals and prisoners of war. If miners were in short supply, innocent individuals would be exiled to the mines. Ancient Egyptian records on wall paintings show workers labouring under the whip as they build the pyramids and temples (Abrams, 2001). Social stigma and prejudice against those who plied a mechanical trade can be traced to ancient Greece. Hunter (Raffle et al., 1987) maintains that Hippocratic medicine was undoubtedly limited in its application to a section of the population and to the ambit of the aristocracy.

The possibility that occupational factors could be of importance in explaining a given illness was ignored throughout the Dark Ages. This was to change only with the Revival of Learning and a man called Ramazzini (1633–1714), immortalised as the father of occupational medicine by current day exponents. Like most of his peers in the field, he studied philosophy and medicine. What to us seems like a logical, almost common-sense remark, namely "ask the patient to describe his occupation" when taking a medical history, was at the time a striking addition to the art of diagnosis in that it brought to attention the risk of occupational exposure in the aetiology of many illnesses. Ramazzini also recognised ergonomic risks when he became convinced of the importance of "faulty posture" in producing ill health in many trades and advised exercise and regular change of posture. Practising medicine in Modena, his famous book, *De Morbis Artificum Diatriba (The diseases of workers)* was published in Latin in 1713. Only two years later the English translation appeared under the title *A treatise of the diseases of tradesmen, showing the*

various influence of particular trades upon the state of health; with the best methods to avoid or correct it, and useful hints proper to be minded in regulating the cure of all diseases incident to tradesmen (Abrams, 2001:39). Not shying away from less enticing workplaces, Ramazzini devoted a whole chapter to "Diseases of cleaners of privies and cesspits". A twentieth-century comparison of this can be found in a remark by Henry Sigerist (1960), a Swiss medical historian:

> Medical students are recruited from among the upper middle class and have no idea of what living and working conditions are in other social strata. Most of them have never seen what work is like in a coal mine, in a steel mill, in an office where 50 people work on the same room. In other words, they do not know the social environment from which their patients come.

2.1 The birth of modern occupational medicine

Britain was very much the birthplace of modern occupational medicine. The period 1760 to 1830 was distinguished by great inventions, which played a decisive role in creating a new kind of society. The industrial revolution saw the introduction of machinery into the process of production, with far-reaching implications. Commerce, the exchange of commodities, was stimulated as never before and the division of labour was inevitable. Efficient production came to rely on the large-scale application of capital, rather than merely on labour. The means of production shifted from small-scale or home-based operations to the new industrialists. Workers were progressively divorced from ownership of the means of competitive production. Arkwright's spinning machine and Cartwright's power loom set off this irreversible process. The advent of steam power and successively more efficient steam engines changed the face of industry forever. Mining, the textile industry and foundries grew unchecked, engulfing everything in coal dust and smog. With it, town life became hideous and squalid. By 1838, a campaign for public hygiene was initiated after Sir Edwin Chadwick (1800–1890), a lawyer and sanitarian, showed how the census and bills of mortality reflect public ailments related to squalor (Raffle et al., 1987).

Industrial health developed side by side with British public health. Charles Turner Thackrah (1795–1833) can be considered the first modern occupational physician. Having developed a keen interest in industrial medicine, he drew public attention to the health and wellness of

artisans. He specifically addressed postural deformities in children aged seven to fifteen working twelve hours a day in cotton mills. He died of tuberculosis at the age of 37. In that same year, 1833, Britain's Factory Act was promulgated to regulate the labour of children in the mills and factories of the United Kingdom. Our generation has difficulty assimilating some of the regulations contained in this Act: to forbid night work for those under 18; to restrict their work hours to 69 hours a week or 12 hours a day; to mandate at least two hours of schooling per day in a "factory school" for children under 13; and to set the minimum age to work in a factory at nine. Furthermore, a "medical man" had to certify that the child was of the "ordinary strength and appearance" of a child of nine (Raffle et al., 1987:130). On the positive side, this Act established a Factory Inspectorate to administer its implementation, which previously was voluntary. Furthermore, the cleaning of machines while in motion was prohibited. The mines, though, remained unaffected. Children of six were commonly used as labour in many pits. In spite of bitter opposition from the large coalmine owners, the Mine Act of 1842 abolished underground work by women and girls and only allowed boys to work underground from the age of ten!

A milestone was reached and industrial medicine came of age (in Britain at least) with the appointment in 1898 of His Majesty's first Medical Inspector of Factories, Sir Thomas Legge (1863–1932). Born in Hong Kong to a missionary father, he completed his medical studies at St. Bartholomew's Hospital, wishing to study preventive medicine. Legge was engaged in studying and dealing with the prevention of lead poisoning, the very malady that largely contributed to the position being created. In 1928, Legge represented the British government at the International Labour Conference in Geneva, helping to draft the original White Lead Paint Convention proposing the prohibition of the use of white lead paint for painting the interior of buildings. In 1926, his government (and employer) refused to ratify the Geneva Lead Paint Convention, claiming it to be a too drastic and untested. Because he considered drastic measures indispensable and was unwilling to administer half-hearted preventive measures, Legge resigned his position – this is spite of having been appointed CBE in 1924 and knighted in 1925. Three years after resigning from his prestigious government post because of his principles, Sir Thomas Legge accepted an appointment to the position of Medical Adviser to the Trades Union Congress. Having spearheaded the moral battle against led poisoning, Legge formulated his famous five aphorisms, which, if heeded, would have abolished paint-related inorganic lead poisoning in his time. His first aphorism repudiated the belief that workers must in the first place protect themselves from occupational hazards.

> Unless and until the employer has done everything – and everything means a good deal – the workman can do next to nothing to protect himself, although he is naturally willing enough to do his share (London, 2000:5).

Legge's fourth aphorism similarly still rings true in today's chemical industry.

> All workmen should be told something of the danger of the material which they come into contact with and not be left to find it out for themselves – sometimes at the cost of their lives (London, 2000:5).

The scene was set for occupational health to develop into a discipline that would demand commitment, perseverance and at times courage from its proponents to transform horrible workplaces and lethal mining operations. A succession of eminent twentieth-century physicians would emulate Legge, honour his legacy and through their endeavours shape the profession of occupational medicine to accede to the leadership role in worker health.

Just like the improvement of living conditions preceded advances in public health, so better working conditions and workplace hazard control were preconditions for the improved health of the workforce. Sound occupational hygiene proved to be a prerequisite for the improvement of occupational health. Though occupational medicine provides the impetus, occupational hygiene is at the foundation of worker health promotion.

2.2 Occupational medicine in South Africa

Prior to the discovery of precious minerals and diamonds in South Africa, it had an agricultural and pastoral farming economy. The discovery of gold in 1886, in what would become known as the Witwatersrand, provided the impetus for the first developments on the industrial health front. Mining, with its inevitable dust-related respiratory health risks, set the stage for developments in the ambit of labour that would become inextricably linked to the country's political and socio-economic climate (Acutt, 2003:6). Mining-related safety and health risks necessitated attention to occupational health – or what was then referred to as industrial health. The history of South Africa, inclusive of its healthcare, legislation, policies and practices, is steeped in racism (Myers

& Macun, 1989:216). It meant that statutes related to labour, health and compensation for work-related injuries and illnesses invariably discriminated on racial grounds. The same discriminatory policies, under the banner of apartheid, usually meant that in addition to the hazardous gold mining tunnels, the living conditions of the labour force was also detrimental to health (Kistnasamy, 1987).

The first commission of enquiry into phthisis (mineworker's pneumoconiosis and concomitant tuberculosis) was appointed in 1902 (Myers & Macun, 1989). This led to the Miner's Phthisis Act of 1911, which arranged compensation for those severely afflicted. Preventive measures were addressed by the Union's first Mines and Works Act 12 of 1911, which consolidated pre-existing colonial laws. A pioneer of occupational medicine in South Africa, Dr A. J. Orenstein, was appointed by the Rand Mines Group; he was also acting South African Surgeon-General in the First World War. Lagging mining by decades, the first comprehensive legislative control of conditions in other industries was only established with the Factories, Machinery and Building Works Act in 1941. Outside of the mining industry, the first Workmen's Compensation Act dates from 1914. This was superseded by the Workmen's Compensation Act of 1941. Various changes and additions to legislation governing the mining environment culminated in the Occupational Diseases in Mines and Works Act of 1973. Similarly, the Occupational Health and Safety Act, applicable to general industry, was implemented in 1993. The same year saw the promulgation of a new Compensation for Occupational Injuries and Diseases Act.

The Erasmus Commission of Enquiry, commissioned by the South African government in 1975 to assess the prevalence, prevention and management of occupational illness and the effectiveness of facilities and structures to that effect, promised to be a turning point in South Africa's occupational health landscape (Acutt, 2003:8). While reporting comprehensively on shortcomings such as fragmentation and duplication and making credible recommendations, almost nothing came of the Commission. Lack of political will, no sense of urgency and the protection of vested interests by the Departments of Labour, Health and Mineral Affairs sunk the initiative. Shortly afterwards, in 1977, the government appointed the Wiehahn Commission to examine the problematic issue of labour relations in a South Africa increasingly facing political turmoil and labour unrest. Unlike two years earlier, government now realised change was inevitable; recommendations and guidelines formulated by this commission were implemented and South African labour relations changed for the better. These changes led to the legalisation of the burgeoning black labour unions, which had been banned and were operating underground

at that time. In retrospect, legalised labour unions were to prove pivotal in the fight to dismantle the apartheid system that effectively had shackled labour (and society) in South Africa for decades.

Although real and sustained advancement in the ambit of occupational health and safety is historically linked to progressive legislation rather than the initiatives of healthcare professionals, physicians, nursing professionals and occupational hygienists with a passion for occupational health are vital to sound care. Occupational medicine remains an oft unrecognised niche within the vast field of medicine. In 1947, during a medical congress in East London, South Africa, twelve doctors expressed an interest in "industrial health". On 20 July 1948, the inaugural meeting of the Society of Industrial Health was held in Pretoria (Botha, 2008). Its name was later changed to the South African Society of Occupational Health and in 1985 to the South African Society of Occupational Medicine (SASOM). Under the chairmanship of eminent people such as Prof. Albert Coetzee, Prof. Johan Mets, Des Whitaker, Mike Baker, Ferdi Smith and recently Prof. Daan Kocks, the Society promoted the discipline of occupational medicine and the occupational health of workforces. SASOM has influenced legislation, written practice guidelines, organised conferences, initiated a journal and successfully lobbied to have occupational medicine recognised by the Health Professions Council of South Africa as a specialist discipline separate from public health (Botha, 2008).

Large mining operations, major industrial enterprises, the automotive industry, utilities and universities in Southern Africa employ full-time occupational physicians. Smaller plants, especially those that pose health and safety risks, contract with occupational healthcare providers or individual practitioners. Occupational health nursing practitioners form the backbone of occupational medicine practice in South Africa. Whereas the doctor advises on managing health risks, develops policies, evaluates fitness for work, assesses occupational disability and leads the clinical team, the professional nurse is the hands-on healthcare provider and unofficial counsellor in the workplace. It means the employee/worker has access to an approachable professional who, by virtue of that professionalism, has a different vantage point from that of supervisors and management. The occupational health nurse is an invaluable resource and an indispensable mediator between employer and an unwell or unhappy employee.

Chapter 3: The purpose and scope of occupational medicine

Occupational health has a scientific as well as a social (economic and ethical) dimension. In the words of Eddington (2006:2), "[occupational health and safety] is thus a complex animal". The discipline is fortified by its "scientific armour" – comprising its standards, procedures, collective body of knowledge and professional expertise. Its principal modus operandi is economic – to enable the sustainable health and productivity of human resources. Yet its "raison d'etre and final cause are ethical" and "its seed was sown out of a sense of injustice" (Eddington, 2006:2). The latter refers to the appallingly dangerous and unhealthy conditions that existed in mid-nineteenth-century factories, mines and other workplaces in Britain and elsewhere. A society that keeps on looking the other way when a few (industrialists) reap profit while causing many others injury, sickness, trauma and death would be thoroughly immoral. Conversely, safe and decent work is a cause as well as an outcome of a safe and civil society (Eddington, 2006). Through their labour, people can profitably deploy their own human capital and collectively thrive.

3.1 Occupational health and safety

Current-day occupational safety focuses on preventing work-related injuries and accidents causing damage to equipment. Occupational health (comprising occupational hygiene and occupational medicine) is concerned with the human factor. Hygienists identify, measure and mitigate potential health risks in the labour environment. Noise, harmful dust, extreme temperatures, poor ergonomics and hazardous chemicals are a few examples of occupational health risks. Doctors and professional nurses promote the health of the workforce, render preventive healthcare services, monitor biological markers of harmful exposure and provide primary care for work-related injuries. Much of the occupational healthcare delivered to a labour force performing work that entails risk (such as mining, chemical manufacturing, public transport and construction) is mandatory. Health is a prerequisite for sustainable labour productivity. Injury, illness and disability erode productivity. Customarily and understandably, the legally and contractually appointed occupational physician is accountable for all activities undertaken in the name of worker and workforce health in the workplace. At major industrial enterprises, the duly registered occupational health doctor(s) generally practise onsite and are the custodians of all healthcare records generated in the workplace. Traditionally referred to as the "company doctor"

(found in the older literature on "industrial medicine"), various other titles are common nowadays. Occupational medicine practitioner (OMP) is the generic designation found in the Occupational Health and Safety Act (Republic of South Africa, 1993a).

3.2 Understanding occupational medicine

The discipline of occupational medicine is concerned with the relationship between work and health, promoting the health of workers and the workforce collectively and shaping sustainable employee wellness (Acutt, 2003:14). Practising medicine in the ambit of labour relations, often on the employer's premises and invariably at the employer's sole expense (in compliance with occupational health and safety legislation) creates a unique doctor–patient relationship context. At times, the economic and ethical dimensions of occupational health alluded to above are in conflict. Stakeholder interest often threatens to dominate doctor–patient encounters – for instance, when fitness for work is the issue that triggers a consultation. The employee/patient may be either anxious to return to gainful employment or hoping to be granted extended sick leave. Similarly, the employer could push for prompt return to work of a key employee or refuse to allow a manual labourer, who has allegedly not regained adequate fitness and endurance, to resume demanding work.

The occupational physician, depending on acumen gained through training and experience, needs to arbitrate. In order to make an informed decision he would collate and verify the medical facts related to the case, arrange a personal consultation, avail him/her of the job requirements and seek expert opinion. The latter often will involve assessment by an occupational therapist. Obviously, individual cases can become complex, and occupational health conundrums involving several demanding stakeholders are common. Especially when job security is precarious, illness, absenteeism, convalescence and impairment easily become shrouded in sentiment that is difficult to fathom. The emotive aspect of having been injured at work often dominates the physical symptoms. Blame, subtle victimisation, disciplinary proceedings and a sense of having disappointed the team complicates rehabilitation. Labour legislation and health and safety practices assign the duly appointed occupational physician the authority and responsibility to rule on various workplace health matters that directly impact both employer and employee interests. Decisions can be far-reaching – inclusive of financial and operational implications. The former could extend to jeopardising a worker's livelihood. The latter can

interfere with business targets, imply a claim for work-related disease or even spur allegations of unfair labour practice.

Safety and the interest of third parties, such as the public and various civil authorities, are at times of paramount importance. Assessing whether a worker is, medically spoken, suitable to drive a fuel tanker carrying 20 tons of flammable product on public roads calls for unencumbered prudence. Murray (1986) draws attention to the "social control" role of physicians. Certifying employees fit for high-risk occupations reveals starkly the gravity of that aspect of the occupational medicine practitioner's role in society. It is a role best not entrusted to the driver's private family health practitioner. That is because it entails civil responsibility that leaves no room for heeding sentiments such as amity and patient loyalty. Revoking a driver's permit to transport hazardous cargo may well translate into retrenchment. Almost inevitably, such a decision is likely to erode any established doctor–patient relationship. When his livelihood and that of his family is at stake, the safety risk, to the mind of the affected employee, seems low. Self-interest colours perception. It can cause a measured decision, based on a real safety risk, to seem unwarranted. To complicate matters, assessing and quantifying the safety risk associated with gradually declining driver health or incremental impairment is not an exact science. It calls for keen judgement, professional discretion and integrity.

It is feasible that two eminently responsible doctors can reach different conclusions as to whether to still allow an obese diabetic with moderately well-controlled hypertension to continue driving. At least, neither the doctor–patient relationship nor the tenor of the doctor's association with the employer should influence the outcome of the medical evaluation. Some decisions in occupational medicine have such dire consequences for those affected that the responsible physician's verdict at times resembles that of a judge. Impartiality is thus critical. In occupational medicine, whether inadvertently or consciously, the tone of relationships stands to introduce inept bias to decisions that ought to be equitable.

3.3 The spectrum of workplace healthcare

The essence of occupational medicine differs from that of curative medicine as it is daily practised in doctors' consultation rooms everywhere. The existence of ethical codes specifically for occupational physicians hints at the distinct character of occupational medicine; so does the fact that it was long referred to as "industrial medicine" and its practitioners called "factory

doctors". Healing is not at the heart of occupational medicine. It is rather oriented towards promoting society's access to and the opportunity of individuals to benefit from healthy, safe and rewarding work (FOM, 2017). Work practices should also not create unreasonable risk for others or the public. This must be achieved while recognising that the exponents of occupational health are confronted with entirely different motivations in their daily routine, namely productivity and profitability. The occupational physician is usually responsible for a fair amount of clinical healthcare delivery to individual workers in the workplace clinic. However, the accountability for the health of the workforce, which lies with the occupational medicine practitioner because of his legal appointment by the employer/organisation, eclipses that related to individual doctor–patient relationships. It comprises accountability as the appointed custodian of workforce occupational health matters. Should the doctor neglect his duties, the employer could run afoul of its legal responsibilities, incur penalties and be held responsible for the consequences. Such duties are not limited to traditional patient care. The substance of occupational medicine lies in its social and economic role within the labour environment to promote worker health by minimising and managing work-related risks. Communities depend for their livelihood on the capacity of their gainfully employed or entrepreneurial members to work productively for most of their adult lifetime.

The Faculty of Occupational Medicine of the Royal College of Physicians in the United Kingdom compiled a list of the duties usually associated with occupational physicians (FOM, 2017:4):

The precise duties of an occupational physician may include:

- visiting the workplace regularly and advising on the provision of safe and healthy conditions by informed scientific assessment of the physical and psychological aspects of the working environment
- promoting compliance with relevant health and safety legislation
- helping to develop policies, practices and cultures that promote and maintain the physical, mental and social wellbeing of all workers
- assessing the fitness of individual job applicants and workers for specific tasks, ensuring a good fit between applicants and job, recommending suitable adjustments to enable a person to undertake the work they have been selected to perform safely and effectively, considering any health issues or disabilities they may have

- monitoring the health of workers who are potentially exposed to hazards at work through health surveillance programmes
- analysing data from surveillance programmes using sound epidemiological methods to identify trends in worker health and recommend any remedial measures necessary to improve worker health
- advising employees and employers regarding work-related health issues
- assessing potential cases of occupational injuries and illness; investigating, managing and reporting individual cases appropriately and establishing if this is a single case or if there is wider incidence
- managing immunisation programmes for workplace biological hazards and for business travellers
- case-managing workers who are on sick leave, working with other health professionals to ensure the earliest return of functional capacity and return to work
- recommending suitable alternate work in circumstances where a worker cannot perform their normal job, either temporarily or on a permanent basis
- determining whether employees satisfy the medical criteria for ill-health retirement under the terms of the relevant pension fund rules
- ensuring that people have the necessary health information to undertake their work safely and to improve their own health

From this exposition of customary duties, it is evident that the occupational medicine practitioner is as much manager in his domain as he is doctor in the more classical sense. It is likely that the Faculty consciously listed those duties that characterise occupational medicine, without emphasising the generic commitments shared with healthcare clinicians in other fields of medicine. Among such general duties are professional conduct, patient advocacy, maintaining adequate clinical acumen and being approachable. This implies heeding the principles of biomedical ethics, respect for autonomy, beneficence, non-maleficence and justice. Occupational medicine's association with the workplace, rather than the hospital, does not exempt it from observing any of these principles. In fact, reverence for the principles of respect for autonomy and justice weigh heavily on the shoulders of the occupational physician. The labour domain by nature restricts worker autonomy. Employers generally regard the observance of workplace rules and procedures and following instructions as far more important than amity and fairness.

One consequence of occupational physicians' participation in management is that their involvement is not strictly limited to medical or healthcare matters. The occupational doctor's faculty, insight and experience means that he is often party to establishing procedures, guidelines and practices beyond the narrow field of health and safety. This would include the wider field of human resources management such as recruitment, employee relations, disciplinary procedures, disability management, medical boarding, healthcare insurance, etc. The occupational physician that carries his ethical principles, rooted in the world of medicine, into the business domain brings biomedical ethics up against business ethics – as practised by the particular management team. The doctor can attempt to divorce his management role from his professional role. However, it would not be easy to do so conspicuously without sacrificing moral credibility.

The main dilemma is that once the doctor supports a policy or practice that he considers ethically questionable but legally acceptable, he cannot baulk at condoning its application down the line. For example: if consensus was reached that it makes good business sense for the company to avoid employing anyone with a history of epilepsy for any position, the occupational physician cannot logically resort to the principles of biomedical ethics when next it transpires that the finest applicant for a sedentary position is an epileptic who is fully controlled on medication. He cannot then invoke medical confidentiality, justice or beneficence. It would unmask moral pliancy. Covertly removing the candidate from the shortlist would be even worse. Management might consider it expedience but in terms of occupational health ethics, it represents moral bankruptcy.

Professional conduct that lacks transparency and veracity cannot be justified. A physician who participates in health-related management and holds a position for which registration as medical practitioner is a prerequisite is bound not only by business ethics but also inextricably by the ethics of medicine. In situations where an enterprise employs several occupational physicians, these roles would probably be split between primary clinicians and those who are predominantly responsible for occupational health management. However, straddling business and medicine and balancing the management and clinical roles are likely to elicit ethical conflict and demand compromise. If the latter is not feasible, ethical dissent will fester and intermittently surface.

3.4 The occupational health ethics milieu

How can morally suspect conduct in occupational medicine be identified and untangled? To answer this and other ethical questions, the context and style in which occupational medicine is practised (principally in South Africa) necessarily must be considered in some detail. Beyond first aid, healthcare delivery in the workplace would sound like an unnatural situation to most people. Sick employees stay at home and provide their employer with a sick certificate from their doctor. The sole discretion rests with patient and doctor. However, in mainline industry compliance with occupational health and safety regulations is mandatory. For industries performing controlled work, the appointment of an occupational medicine practitioner is a legal requirement. Occupational medicine activities include pre-employment, periodic and exit medical surveillance. Such clinical assessments aim to confirm fitness to work safely and without jeopardising the worker's health. It is performed with the health-risk assessment data for the specific job and work environment in mind. Recording base-line health data is important in order to enable future comparison to evaluate deviations possibly caused by occupational exposure. Numerous other issues require the occupational physician's input – such as disability management, primary care for work-related injuries, illness absenteeism assessment and expert evidence related to disciplinary proceedings.

An understanding of the expectations, legitimate or spurious, of patients and the employer/management in the arena of occupational medicine is needed to anticipate potential trepidation and pre-empt discontent. Firstly, it is befitting that the nature and purpose of every occupational health–related encounter between doctor and client or patient should be transparent and duly communicated. Secondly, there ought to be clarity as to the validity and extent of each party's stake in the intervention, be it clinical, statutory, mandatory or an assessment. The potential outcome, its likely consequences and the way in which the outcome needs to be communicated must be unambiguous. The somewhat extraordinary context of many consultations in occupational medicine has received much attention in the literature.

Some authors maintain that in much of occupational health consultation the traditional implied contract between doctor and patient is either not established or has a significantly different tenor. Plomp (1999) proposes a useful role differentiation model to explain the great variability of doctor–patient encounters in occupational medicine. He relates this variability to the more

complex professional role of the occupational physician – implying varied expectations and demanding a greater behavioural repertoire from the doctor. Plomp differentiates between three principle roles: that of the expert, the counsellor and the mediator. These roles are derived from patients' expectations of each type of "consultation". In occupational medicine, similar to insurance medicine, the context of the "patient" being examined for the sole benefit of the employer (like the insurer) is common (Rischitelli, 1995). However, it does not absolve the physician from the general obligation of reasonable care and respect. It qualifies the confidentiality privilege to allow disclosure to the extent reasonably necessary to protect some sufficiently substantial other interest. Certainly, it would be unwise and illegal to attempt denying the employer and the appropriate governmental occupational health and safety authority their reasonable stake in employee health and safety and appropriate access to information. In many situations, health and safety legislation, a myriad of regulations and collective interest take precedence over privacy and an individual patient's wishes. The yardstick of reasonable necessity and justification applies. Reckless, unnecessary or inappropriate disclosure is always ethically untenable.

Codes of ethics in occupational medicine attempt to provide a road map for doctors practising in the occupational environment. The most influential of such codes and the one least limited by local context is probably the *International Code of Ethics for Occupational Health Professionals* of the International Commission on Occupational Health (2014). In its preface, the Commission explains why a code of ethics distinct from those applicable to all medical practitioners is appropriate. "One [reason] is the increased recognition of the complex and sometimes competing responsibilities of occupational health and safety professionals towards the workers, the employers, the public, public health and labour authorities and other bodies such as social security and judicial authorities" (ICOH, 2014:5). It must be emphasised that "ethics in occupational health is by essence a field of interactions between many partners. Good occupational health is inclusive, not exclusive" (ICOH, 2014:9). The occupational physician leads the occupational health team but it is a multidisciplinary discipline; one where not all team members are necessarily registered healthcare workers. What this simply means is that in occupational health, the doctor–patient relationship is generically less snug. To a significant degree context dictates the level of confidentiality afforded their various interactions. To negotiate such ethical ambivalence amid divergent sentiments while considering conflicting stakes is not easy.

While job security and earning capacity are foremost in the mind of employees, the employer is likely driven by productivity and profit. Management is expected to deliver on stretch targets and is remunerated accordingly. Performance bonuses motivate them to excel at striving for short-term financial success. If individuals, especially those in a position of power, figure that the occupational physician poses an obstacle to reaching their goals, challenging his conduct or judgement is easy. If, in defence, the doctor invokes medical ethics, a nebulous entity to most non-professionals, it might well appear evasive or even pompous. In a formidable business environment the company doctor, isolated from medical colleagues, is likely to find neither comprehension of, nor sympathy with, his professional ethical principles. Management's business ethics anchor primarily in pragmatism and expediency. In an environment where senior employees ought to be wholly committed to the overriding goals of the enterprise, the doctor's seemingly aberrant ethical ideas, foreign to the hallways and boardrooms of industry, easily appears fatuous. Upholding patient rights such as respect for autonomy, confidentiality and procedural justice when it is not highly regarded by those wielding power is challenging.

The practice of medicine in the paternalistic labour arena, where every patient is someone's employee and subordinate, requires inspired commitment to ethical occupational health principles. No matter how much one refers to the roadmap provided by ethical codes of conduct, ultimately virtue provides the moral compass. Good intentions and general guidelines alone are unlikely to suffice. Experience teaches one to approach delicate situations with circumspection and to carefully consider the context of each situation. Astute occupational physicians must learn to anticipate complex equations and pre-empt ethical caveats. They must be able to negotiate the intricacies of dealing with their own and their patients' employers as somewhat unwelcome but authorised participants in occupational health matters. The practice of medicine is characterised by confidentiality. At most, a close family member might be privy to a healthcare consultation. But when healthcare is practised in the workplace, parties such as the safety officer, supervisor, manager and human resources consultant want to know the findings and outcome. Setting and respecting conditions and boundaries in accordance with the context and tenor of every medical engagement is the key to the ethical practice of occupational medicine. However, no code of ethics or professional guidelines can intercept every single situation and cater for the variant nuances characterising day-to-day medical practice. Character inescapably guides conduct. Sound character is a prerequisite for ethical conduct in the context of occupational health, and virtue is its fulcrum.

Worker health and safety is occupational medicine's banner. Indubitably, this concern extends beyond the well-being of individual employees to the collective workforce. Inevitably, depending on the nature of an employer's business, internal health and safety decisions might affect the community and the public at large. Consider the potential consequences of a medically unfit pilot in the cockpit of a commercial aircraft coming in to land over a metropolitan area. The occupational physician performing the pilot's annual flight medical has a serious responsibility to do the right thing. Doubtlessly, consideration for the pilot's license to keep on flying does not rival the prime aviation safety concern. On a different scale, similar sentiments apply to the factory forklift operator. In the domain of occupational medicine, social liability ranks high. The patient – the role into which occupational health casts the worker/employee by virtue of being the subject of medical attention – is supposedly the doctor's first allegiance. Every occupational physician takes up the mantle of weighing loyalty towards patients against being bound to occupational health and safety. Appropriately, Leslie London (2000:4) warns, "there can be no doubt that the workplace is a setting where health care is fraught with the potential [for] conflict". He adds that it "stems not only from the conflictual nature of employer–employee relations, but because of the particular position in which health professionals are placed" (London, 2000:4).

3.5 Codes of ethics for occupational medicine

The International Commission on Occupational Health (2014) introduced a code of ethics distinct from general ethical codes for healthcare because of the complex, often competing responsibilities characterising the field. They highlight the multidisciplinary approach, involving various professions, followed in occupational health. The Commission considers occupational health inclusive, not exclusive. Ethical dilemmas and moral challenges are part of everyday life in occupational health (Westerholm, 2009:492). Rodham (1999:307) even likens occupational medicine to "medics standing on a seesaw whilst trying to keep it balanced", but "in practice often shuffling uncomfortably from one side to the other". Other authors refer to professional ethical codes as representing the "crystallized conceptions of what is to be seen as good professional practice at a particular point in time" (Harling, Westerholm & Nilstun, 2004:328). A code can contribute to defining what considerations need to be brought into play in situations marked by complexity and ethical dilemmas. Peter Westerholm (2009:492), emeritus professor in occupational and environmental medicine in Sweden, reminds his readers that "ethics is not a science, nor an institutionalised system of regulations". He considers that philosophers have

"engaged the difficulties of teaching ethics" since the days of Socrates, and views ethical codes as "powerful bearers of traditional value sets of occupational health professionals" (Westerholm, 2009:492). Knowing what one ought to do in every situation or ethical dilemma can never be easy; guidelines can merely point the physician who is committed to ethical conduct in the right direction. However, there seems to be some consensus that a code of ethics for occupational health, and certainly for occupational medicine, is salutary.

Several professional bodies have developed and adopted a code of ethics in occupational health or medicine. London (2000:9) lists six from four continents. Of these, the International Code of Ethics for Occupational Health Professionals, adopted by the Board of the International Commission on Occupational Health (ICOH, 2014), is most authoritative. Three short paragraphs, which succinctly state the premises underpinning their code, are worth quoting (ICOH, 2014:16):

> The purpose of occupational health is to serve the protection and promotion of the physical and mental health and social wellbeing of the workers individually and collectively. Occupational health practice must be performed according to the highest professional standards and ethical principles. Occupational health professionals must contribute to environmental and community health.
>
> The duties of occupational health professionals include protecting the life and the health of the worker, respecting human dignity and promoting the highest ethical principles in occupational health policies and programmes. Integrity in professional conduct, impartiality and the protection of the confidentiality of health data and of the privacy of workers are part of these duties.
>
> Occupational health professionals are experts who must enjoy full professional independence in the execution of their functions. They must acquire and maintain the competence necessary for their duties and require conditions which allow them to carry out their tasks according to good practice and professional ethics.

The Commission avoids the terms "occupational physician" and "occupational medicine" in their code of ethics, in favour of "occupational health professional". This signifies their conviction that professional exclusivity ought to be avoided in favour of a multidisciplinary approach. For

the purpose of its code, the International Commission on Occupational Health defines the term "occupational health professionals" as a broad "target group whose common vocation is a professional commitment in pursuing an occupational health agenda" (ICOH, 2014:5). The Commission acknowledges that many aspects of occupational health ethics are profession specific. They leave it to specific professions such as engineering, hygiene, nursing, psychology, medicine, epidemiology and their representative professional bodies to develop additional specific ethical guidance. Demonstrating the extent of the concern for ethical standards in the field, the International Commission on Occupational Health refers to no less than 30 codes, guidelines, charters, declarations and position papers on the subject of occupational health ethics published across professions and nationalities.

Chapter 4: The statutory status of occupational medicine

Occupational health and safety is a social good that aims to protect all workers from the risks and potential harm related to performing their jobs. Worldwide governments employ statutory law to set minimum standards that must be complied with in order to prevent or minimise work-related injuries, diseases and fatalities. Obligations of employers and employees are set to attain this in diverse work environments varying from transport and construction to mining and chemical production. Risks inherent to different occupations and environments are identified and mitigated. Some dangers workers might be exposed to, are hazardous chemicals, silica dust, radiation, excessive noise and biohazardous agents such as viruses. High-risk work is consequently controlled by way of comprehensive regulations and penalties set for non-conformance. A healthy, safe and secure workforce is a prerequisite to productivity and a nation's sustainable economic growth.

4.1 Relevant South African occupational health and safety legislation

The Mine Health and Safety Act (Republic of South Africa, 1996a) and several regulations of the Occupational Health and Safety Act (Republic of South Africa, 1993a) compel mines and industrial sites at which certified risk work is performed or hazardous material is handled to appoint an occupational medicine practitioner to oversee worker health. Legal requirements and the governance role of various authorities have an impact on the confidentiality of some medical records. Obviously, one cannot succeed with a compensation claim for impairment or loss of income without consenting to have the clinical details of your injury or occupational illness revealed to the relevant authority. The level of compensation is determined by the actual degree of impairment, persisting symptoms, the nature of any ongoing treatment required, etc. Likewise, section 36 of the Occupational Health and Safety Act (Republic of South Africa, 1993a) rather sweepingly mandates the disclosure of "information concerning the affairs of any other person" where it is necessary for the proper administration of a provision of the Act, or even just at the request of a health and safety representative or health and safety committee "entitled thereto".

Legislation thus clearly has an impact on both employee and employer privacy and creates a context different from that prevalent in the usual healthcare environment. No occupational

physician would want to obstruct the law, but needs to guard against the abuse of health-related information to infringe on the privacy of employees. Four acts form the core of occupational health and safety legislation and thus merit discussion. Only sections and regulations that are most relevant to occupational health ethics are discussed.

4.1.1 The Occupational Health and Safety Act 85 of 1993

The purpose of the Occupational Health and Safety Act (Republic of South Africa, 1993a) can be summarised simply as to provide for the health and safety of people at work, people using plant and machinery and people indirectly exposed to hazards related to these activities. The occupational medicine practitioner is defined as a medical practitioner duly registered as such with the Health Professions Council of South Africa and holding an additional qualification in occupational medicine recognised as such by the South African Medical and Dental Council. The Act lists general duties to be observed by employers and employees. An employer must provide and maintain, "as far as is reasonably practicable", a work environment that is safe and free of health risk, enforcing the necessary measures and informing employees appropriately. The minister can declare certain work "listed", meaning it will forthwith be closely controlled. The latter entails formal health risk assessment, prescribed preventive measures and subjecting employees to periodic medical surveillance. Employees have a duty to take reasonable care, cooperate with management's health and safety efforts and obey safety rules. Workers are urged to report unsafe situations, incidents and injuries. The Act specifically prohibits the employer from recovering any expenses related to meeting its health and safety responsibilities from an employee. Section 43 of the Act endows the minister with extensive authority to make regulations.

Twenty-four sets of regulations have taken effect to date. These endeavour to enforce the safe operation of everything from electrical installations to civil construction, from lifts and escalators to pressure vessels, and from driven machinery to explosives and major hazard installations such as jet-fuel storage facilities. More relevant here are the regulations that require the input of occupational medicine professionals because, over and above safety risks, some work pertinently poses health risks. Professional diving, work involving hazardous biological agents, exposure to asbestos and work with the potential for lead poisoning are the subjects of specific regulations. Included in these regulations are requirements for medical surveillance, defined in the Act as a planned programme of periodic clinical examination, medical tests and biological monitoring of

potentially exposed employees by either an occupational health practitioner (referring also to an occupational health nurse) or, when prescribed, an occupational medicine practitioner.

The Regulations for Hazardous Chemical Substances that form part of the Occupational Health and Safety Act (Republic of South Africa, 1993) serve as the classical model of regulations applicable to a class of health and safety hazards. The requirement to initially and at intervals inform workers on the existence and nature of workplace hazards and train them in protective measures, precautions and safe working procedures features prominently. Potentially exposed employees equally have duties to obey lawful instructions, comply with the use of personal protective equipment and subject themselves to health surveillance and prescribed biological monitoring. The responsibilities of the occupational medicine fraternity are mostly contained in regulation 7, which deals with medical surveillance. Such surveillance is mandatory if workers are potentially exposed to a substance listed in an annexure to regulation 7. Twenty-eight so-called Table 3 substances are listed and the legislator specifies what biological samples should be collected, and when, and gives a biological exposure index for each. Notoriously toxic substances such as benzene, mercury, arsenic and parathion feature in the list. In addition, an employer must implement recommendations for monitoring exposure to other substances when such recommendations have been ratified by an occupational medicine practitioner. Compliance with the above pre-employment and periodic medical assessments of workers in the chemical industry is compulsory. No employer may allow an employee who has been certified medically unfit for work by an occupational medicine practitioner to work where further exposure is possible.

Occupational health recordkeeping is addressed rather briefly. Cautioning employers that personal medical records shall only be made available to an occupational medicine practitioner, can be interpreted to mean that the employer has these records to make them available. In what many would believe an ill-considered way, the legislator rules that an employer shall allow any person, subject to formal written consent of an employee, to peruse the records with respect to that particular employee. Again, the discretion to reveal personal health records seemingly vests with the employer. Anyone familiar with common practices in many workplaces will realise that employees could expose themselves to being labelled uncooperative if they insist on privacy by withholding consent. Many employees cannot say no to their employer and are subservient rather than risk being suspected of hiding something. Juridically, medical records must be stored for 30 years. While occupational health and safety legislation protects the worker, compels the

employer to take good care and regulates workplaces, it undoubtedly has an impact on employee autonomy and privacy; an impact that can be seen as unfortunate but inevitable.

4.1.2 The Mine Health and Safety Act 29 of 1996

The historical prominence of gold mining in the South African economy is responsible for occupational health legislation following two parallel tracks – mining versus other industry, commerce and services (Myers & Macun, 1989:216). It also relates to the prevalence and partial uniqueness of mine dust–related lung disease (miner's phthisis, also called pneumoconiosis). Nevertheless, it was only the current Mine Health and Safety Act (Republic of South Africa, 1996a) that really addressed the issue adequately – by finally abolishing racial discrimination and relinquishing much of the centralised control previously seated in the Mineworker's Bureau. The current Act (as amended) is comprehensive. Its objectives include employee participation, enforcement, training, cooperation, consultation and promoting a health and safety culture in mining. As is to be expected, the clause "as far as reasonably practicable" appears in several pivotal sections of the Act. This can be construed as representing a legislative weakness, in spite of an attempt to define the term. "Having regard to" the severity of a hazard, the availability of means to mitigate and the cost and benefits of removing a hazard do not quite bring across the level of priority intended by the Minister of Mineral Resources.

One aspect that stands out is the detailed attention afforded the qualifications and competence of the mining managers appointed in different functional areas. Apart from a Mine Health and Safety Council to advise the Minister, a Mine Qualifications Authority, another tripartite institution, was established in terms of the Act. It sets standards of competency, arranges assessments and examinations and performs accreditation. In the interest of occupational health, every mine owner must engage an occupational hygienist and employ an occupational medicine practitioner to perform and/or direct medical surveillance. Wisely, section 15 of the Act explicitly determines that confidential medical surveillance records will be kept in accordance with "ethics of medical practice". Such records must be maintained for 40 years from the last encounter. A Code of Good Practice must be established if required by the inspectorate to guide practices related to certificates of medical fitness issued in a decentralised fashion at the professional discretion of the occupational physician. An appeal procedure is provided for. After years of uncertainty and ambiguity, occupational medicine in the South African mining industry is now underpinned by trendsetting legislation.

4.1.3 The Compensation for Occupational Injuries and Diseases Act 130 of 1993

The principle of worker compensation is institutionalised in most countries. The concept of no-fault reparation, established in the Compensation for Occupational Injuries and Diseases Act (Republic of South Africa, 1993b), is an example of utilitarianism being applied – with good consequences. The no-fault principle entails that the right to compensation for damages suffered does not rest on fault or culpability by either employer or employee. Utility matters more than presumed justice. The worker who was injured while acting contrary to any law applicable to his employment, or acting without or contrary to any order given by or on behalf of the employer, retains his right to worker's compensation as long as his action was in connection to the employer's business (Republic of South Africa, 1993b: section 22[4]). In effect, this means that an injury resulting from common negligence or from not heeding safety rules does not invalidate the right to compensation. The legislator goes even further by ruling that, in the case of serious disability or death resulting from "serious and wilful misconduct" (Republic of South Africa, 1993b: section 22[3]), the worker or his dependents can still be compensated. In the same vein, when a worker employed in any scheduled work contracts a work-related occupational illness, a causal relationship is presumed and need not be proven.

The Compensation Fund is funded solely by employers through annual assessments by the Commissioner, based on payroll, industry risk and enterprise risk. The other side of the no-fault coin resides in section 35 of the Act. In all cases of work-related injuries where an employee–employer relationship exists, statutory compensation benefits substitute all other legal remedies. This section of the Act relates to employers funding no-fault compensation in exchange for indemnity. It is controversial, as it abolishes the right of employees to sue their employer for total damages rather than settle for the statutory compensation and its inherent limits.

> No action shall lie by an employee or any dependent of an employee for the recovery of damages in respect of any occupational injury or disease resulting in the disablement or death of such employee against such employee's employer, and no liability for compensation on the part of such employer shall arise save under the provisions of this Act in respect of such disability or death (Republic of South Africa, 1993b: section 35).

No employee injured on duty thus needs to pay attorneys money he does not have or surrender half his compensation to secure legal aid to prove his employer's liability and claim compensation. Also, no small employer will be rendered bankrupt by a successful major claim for damages – potentially causing all his employees to lose their work. Even if one party in a particular occupational injury situation justifiably might have been more at fault, win-win (although admittedly compromised) compensation collectively has greater utility than legal tussle. Appeal to the highest court on whether section 35 of the Compensation for Occupational Injuries and Diseases Act is unconstitutional is imminent. It stems from disillusionment with the meagre compensation afforded mineworkers suffering from silicosis (see Chapter 4.5).

However, no-fault compensation is not faultless. Apart from popular anecdotal evidence of workers intentionally cutting off fingers to claim compensation, the prospect of compensation undoubtedly, and more than occasionally, modifies the behaviour of injured workers in the occupational medicine clinic. Canadian researchers (Cole, Mondloch & Hogg-Johnson, 2002) who consider recovery from work-related soft-tissue injuries a "complex process", hint at the intricacies of injury-on-duty management. Facilitating recovery requires "intervention on psychosocial factors" (Cole et al., 2002:749). Beyond guaranteed compensation for medical expenses, loss of earnings and significant permanent impairment, the perception that the employer is responsible easily creates an attitude of entitlement – especially if labour relations at shop-floor level are already less than congenial. Add lack of privacy and the scene is set for psycho-socio-medical complexity. The usual in-depth injury investigation directed by management to find the "root cause" of the incident is aimed at uncovering all the details of the incident and conduct or behaviour that could have contributed to the incident. If the occupational physician does not take the lead in insisting on a semblance of privacy, the injured worker might feel stripped bare and eventually attempt to hide behind his injuries.

4.1.4 The Occupational Diseases in Mines and Works Act 78 of 1973

Mine work has historically enjoyed a special position in the South African socio-political scene because of the importance of gold mining to the country's economy for more than a century, the prevalence of silica dust–related respiratory disease in mines and the collective political influence white mineworkers once commanded. Consequently, legislation (initially termed the Phthisis Act) written early in the twentieth century favoured white miners. For decades, compensation was based on the presence of radiological evidence of silicosis on a chest X-ray

or post mortem, regardless of whether functional impairment was present. Compensation was consequently paid to many thousands of miners quite able to continue working – creating a sort of entitlement and privilege not afforded workers beyond the mining industry. This was coupled with a now outdated system of centralised annual medical assessment at what was known as the Mineworker's Bureau. On analysing the sociological context of occupational health in South Africa, Myers and Macun (1989:216) describe the country's history as "steeped in racism" – this was especially true of the mining labour dispensation. Until its amendment in 1993, the Occupational Diseases in Mines and Works Act was a stark example of legalised racial discrimination. For decades, compensation for black mineworkers was a mere fraction of what their white counterparts received for the very same degree of impairment due to work-related lung disease.

The Act (as amended) allows the Minister of Health to declare any work in connection with a mine or works "risk work" if it entails exposure to potentially harmful dust, gas, fumes, chemicals or working conditions. A "works" is defined to include the handling of rock and ore such as crushing or loading, mineral extraction, refining, subterranean tunnelling and reworking mine dumps. A controlled works or mine pays a fixed levy per "risk shift" worked to fund administration and compensation. No one without a valid certificate of medical fitness is allowed to perform risk work at a workplace controlled by the Act. Pneumoconiosis (phthisis) in a worker who performed risk work is automatically compensable. Two degrees of severity are recognised when determining the compensation amount. Pulmonary tuberculosis qualifies for compensation if the mineworker has worked at least 200 shifts. Suffering from pneumoconiosis as well as tuberculosis attracts the augmented compensation attached to second-degree illness. Chronic obstructive airway disease, a common affliction characterised by the triad of asthma, chronic bronchitis and, in the later stages, emphysema, is compensable. Compensation for this disorder, which is especially prevalent among smokers, is unique to the "mines and works" environment. Progressive systemic sclerosis, a disorder of connective tissue that could be triggered by individual immune response, is also included in the Act's definition of "compensatable disease". So is any other irreversible cardio-respiratory disease considered by the certification committee to be related to performing "risk work". Importantly, the legislator indubitably makes the mine owner responsible for all expenses related to medical examinations and observation in accordance with the provisions of the Act and, from the date of diagnosis, for all legitimate medical expenses related to a compensable disease.

The appointed occupational medicine practitioner at the mine is the one who has to inform a mineworker that his medical fitness certificate is being revoked, which means that he can legally no longer work in the industry. His employer then has a legitimate reason to terminate his employment contract. Mineworkers generally have little understanding of the intricacies of the Mine Health and Safety Act and the related Code of Good Practice that each mine has to adhere to on the issue of fitness certificates and the continued dust exposure of workers already diagnosed with pneumoconiosis. Having to inform a staunch mineworker with a family to support that, due to anticipated future ill health, he will never again be allowed to enter a mine is tantamount to sentencing him to poverty. He may have been employed in mining for 20 years or more – the only job where his skills count for anything. ,

In a recent landmark court case, *Mankayi v AngloGold Ashanti Ltd*, the South African Constitutional Court delivered judgment allowing Thembekile Mankayi, a former gold miner at AngloGold Ashanti, to sue his former employer for damages suffered due to chronic obstructive airway disease and tuberculosis contracted while performing risk work at a controlled mine. The case revolved around section 35(1) of the Compensation for Occupational Injuries and Diseases Act (Republic of South Africa, 1973), which the defendant claimed applied to all "employees", although the claim related to work in a mine and that the Occupational Diseases in Mines and Works Act consequently applied. The said section rules that statutory compensation substitutes all other legal remedies. The Constitutional Court judges held that section 35(1) applies only to employees entitled to compensation under the Compensation for Occupational Injuries and Diseases Act and that the two acts (respectively applicable to mineworkers and other workers) do not constitute a single system of compensation as was held by the Supreme Court of Appeal. In effect, this ruling opens the gate to "mines and works" employees to institute action against mine owners for delictual damages on the basis that the mine owed them a duty of care arising under common law and statute to provide a safe and healthy working environment. Given that an employee would have to prove and quantify not only damages but also negligence, the more likely consequence of this ruling is a test case of class action to be brought on behalf of numerous affected employees – similar to what happened in the case of large numbers of former asbestos miners suffering from debilitating asbestos-related respiratory diseases.

As with many other socio-legal events, one can expect a ground-breaking constitutional ruling like this, which has implications for future liability, to focus attention on mining hygiene and health. Legal shelter for mining companies against the financial implications of illness related to

poor dust abatement practices in mines could well be something of the past. Positive consequences can be anticipated as a result of better occupational health diligence, ongoing research and sharper surveillance.

Chapter 5: The physician's allegiances

Traditional wisdom in biomedical ethics ordains that a trustworthy physician's unwavering commitment to his patients' best healthcare interests is a paramount moral obligation. In ancient times, Hippocrates developed this solemn duty into an altruistic pledge, which the public to this day continues to believe doctors should all live by. In a similar vein, there is an inscription at the temple of Asclepius (Greek god of medicine, healing and physicians) in the Acropolis that reads "These are the duties of a physician … he would be like god, savior equally of slaves, of paupers, of rich men, of princes, and to all a brother, such help would he give" (Barondess, 2000:308).

Szasz (1977) refers to the dual ancestry of the moral foundations of modern medicine: From the Greeks, medicine inherited the idea that the physician's primary duty is to his patient and from the Romans that it is firstly to do no harm (*Primum non nocere*). The former signifies that the good of the patient is the first principle of medical ethics and the goal, purpose and end of medicine. Pellegrino (2001) distinguishes four components of "the good of the patient". Firstly, the medical good relates directly to the art of medicine – based on knowledge, science and expertise. Its aim is to reduce pain and suffering and the return of physiological function of body and mind. Secondly, the patient's perception of the good, how it is perceived in context of personal preferences, choices, values and the patient's life situation, is a distinct component. Each patient's circumstances, station in life and beliefs are unique and cannot be defined by the physician or caregiver. Personal convictions colour perceptions of what is good. To disregard it could mean, for instance, that a patient views therapy assumed to be beneficial as inappropriate or intolerable.

Thirdly, Pellegrino (2001:569) distinguishes "the good for humans". This aspect of healthcare morality relates to the preservation of human dignity – persons having inherent value that is not determined by wealth, education, position in life, etc. This is the tier of duty that provides the philosophical roots of familiar principles of medical ethics such as autonomy, beneficence, non-maleficence and justice. It precludes the devaluation of the lives of the poor or handicapped through the violation of their dignity and value as human beings by denying healthcare. Lastly, the author considers spiritual good (Pellegrino, 2001). Whether expressed in religious terms or not, the realm of spirit gives meaning to human life. Patients' beliefs and the doctrines they live by ultimately carry weight in their decisions. The three lower levels of good must accommodate

the spiritual good in order to be gratifying. Therapeutic options that are generally sound but are considered morally repulsive in terms of a patient's specific and strong religious beliefs cannot be sensible.

Had it been possible for the Hippocratic patient to remain the physician's singular devotion, the practice of medicine would not have become fraught with moral contradictions. Loyal and undivided commitment to only one beneficiary, the patient, once claimed to characterise the ideal doctor–patient relationship, has been rendered untenable. Though private and confidential consultation behind a closed door remains an essential institution in healthcare, medicine has long ago become a vast enterprise. Whether it is socialised, institutionalised or profitable business, current-day healthcare delivery has numerous stakeholders – not all of whom's first interest is patients' welfare. Hence, along with all healthcare professionals, physicians' clinical decisions and discretion are subjected to review, audit and sanction. This might relate to consensus, enforced clinical protocols (based on what is called evidence-based medicine) or, very often, financial considerations. It deliberately and systematically attempts to control clinical practices and modify doctors' behaviour to realise targets usually set by the funding stakeholder.

Given that physicians generally are privy to clinical protocols, can access the underlying rationale and have been increasingly exposed to redistributive justice realities, they mostly tend to accept it as unavoidable. However, compromised professional independence, leading to ethical dilemmas such as dual loyalty, can and does arise. Patients, often anxious about their illness and with less insight in the intricacies of modern healthcare provision and funding models, are more likely to be concerned whether they can still count on their doctor's steadfast devotion. Surely the medical profession is, or ought to be, bound by immutable moral principles. After all, is it not common knowledge that every physician solemnly took an oath that was formulated many centuries ago? If patients can no longer hold their doctors to the ideals preached by Hippocrates, what virtue, ethical principles and professional behaviour can they reasonably expect and demand? Willingness to act in accordance with the constraints of duty is considered the single most important feature of the moral life (Schumaker, 1979). Doctors certainly have prima facie obligations towards their patients – but which of those hold true in our time?

5.1 Prima facie moral obligations of doctors

Medicine (along with law and ministry) lays claim to professional status. “That special claim lies less in their expertise than in their dedication to something other than self-interest. That something else is a certain degree of altruism, or suppression of self-interest when the welfare of those they serve requires it” (Pellegrino, 2002:378). “The image of the physician at the bedside, dedicated to the present patient, has been consecrated in art and literature” (Wendler, 2010:66). Ethical guidelines translate this image into the core principle that physicians are obligated to act in the best interest of the patient. Wendler (2010) gleaned from such guidelines the terms “complete loyalty”, “primary commitment”, “sole obligation and “paramount interest”. Whether the concept of doctors’ unwavering loyalty to exclusively serve the interest of their patients is sensible and hallowed or nostalgic and impracticable is not pertinent here. What matters more is the perception of total dedication to the patient’s welfare and the trust which that perception engenders.

Illingworth (2002:31) views trust as “a public good and a scarce medical resource” and the doctor–patient relationship “as a vessel of trust”. As such there is a moral duty to protect trust within that relationship. Trust and fidelity form the fulcrum of fiduciary relationships – of which the doctor–patient communion is in many ways the paradigm. Where there is trust, there must be trustworthiness. Being trusted by a patient calls for an honour-bound duty to value and cherish that trust. It is likely that trust within the doctor–patient relationship has potential therapeutic benefit. In order for doctors to make accurate and timely diagnoses, they must have adequate and reliable information from their patients – information that would not be forthcoming in the absence of trust (Illingworth, 2002). Customarily, when people trust their doctor, they confide in them to the extent of revealing “secrets” they would not tell their closest family members.

The benefits of trust in physicians go beyond the trust patients have in their personal medical practitioner. When society has a high level of trust in the medical profession, it creates social capital. The earliest ethical codes encouraged physicians to carry themselves in ways that would cultivate trust (Wikipedia, s.a.). “Historically, medicine emerged to its role as a true profession in the Middle Ages as a relationship between the profession and society” (Veatch, 1979:15). While society bestowed certain privileges on medical professionals, including a virtual monopoly to practise the art of medicine, it imposed vital responsibilities on members of the

profession. Jansen (2013) discusses stewardship in medicine at length, showing that it has an important and distinctive place in medical ethics. She equates it with "taking good care of that with which they have been entrusted" (Jansen, 2013:51).

The idea that physicians are or should be fiduciaries for their patients is a dominant metaphor in medical ethics (Rodwin, 1995). The concept of a fiduciary relationship is grounded in the canon of trust, fidelity and agency. A fiduciary is a person entrusted with power and property to be exerted solely for the benefit of someone else while being held to the highest standard of conduct. It generally implies specialised knowledge or expertise and requires sound judgement and discretion. The relationship hinges on dependence, reliance and trust on the part of the party whose interests are being served, but who often does not possess the means to effectively monitor the fiduciary's compliance or performance. Competent fiduciaries thus also must be scrupulously honest, must not violate confidentiality and must not promote their own interests or that of third parties to the detriment of their "client". Conflict of interest is at best avoided and, alternatively, timely declared.

The doctor–patient bond has many characteristics of a fiduciary relationship. Physicians have a duty to act primarily in the interest of their patients. Patients are at a disadvantage with regard to their physicians' medical knowledge and skill (Illingworth, 2002). Especially when they are ill and worried, patients often experience dependency, insecurity and vulnerability. Nevertheless, they have to reveal very personal information related to their symptoms, situation and feelings in order to be helped. A physician is required in effect to make decisions on behalf of and in the best interest of a patient, maintaining confidentiality and above all honouring the patient's trust. In traditional clinical doctor−patient situations, the patient is practically at the mercy of the doctor's discretion. There is even the notion that in some situations patients have little option but to trust a doctor. How else would they access the doctor's acumen to enable a cure for their ailments? It extends the good of a patient's trust in an individual doctor to the social good of the community's trust in the medical profession. "The doctor–patient relationship is a rare and valuable source of trust" (Illingworth, 2002:32). It ought to be protected and allowed to flourish on considerations of beneficence, utility and fairness. Trust ensures better clinical outcomes, facilitates more efficient healthcare and infuses the doctor–patient encounter with candour, reverence and mutual esteem.

As with trust, it is unthinkable that good medicine can be practised in a milieu of disrespect. Respect for patient autonomy is an important, even indispensable, principle in the ethical practice of medicine (Beauchamp & Childress, 2009). The bioethical concept of respect for patient autonomy eclipses the more general truism that healthcare professionals should always treat patients with due respect – referring to courtesy, consideration and professionalism. In the context of bioethical principles, respect for patient autonomy refers to the "fundamental acknowledgement of the freedom [of individuals] to hold and to act upon judgements that are rooted in personal values and beliefs" (Cook, Mavroudis & Jacobs, 2015:1616). Although patient autonomy came to prominence only recently, in part to counter paternalism, it has since acquired the status of maxim in the healthcare ethics environment. It derives mainly from deontological ethics and Immanuel Kant's moral imperative of respectful and dignified treatment of persons as ends in themselves. The argument is that respect for autonomy flows from the recognition that all persons have unconditional worth, each having the capacity to determine his or her own moral destiny (Beauchamp & Childress, 2009). That principle places obligations on healthcare professionals when engaging with patients: to tell the truth when dealing with patients, to communicate effectively, to respect privacy and confidentiality, to obtain informed consent and to aid patients to make decisions (Moodley, 2011). Such respect "has both a cognitive dimension (believing that patients have value) and a behavioural dimension (acting in accordance with this belief)" (Beach, Duggan, Cassel & Geller, 2007:692). Physicians have a moral obligation and professional duty to act towards patients in a dignified way so that their conduct invariably warrants the respect that society has for the medical profession. They owe it not only to their patients but also to their colleagues, peers and community. Disrespectful conduct, unbecoming of the medical profession, breaks down the trust patients and society have in doctors; trust that is the essence of the doctor–patient relationship. But trust is fragile. Like fidelity, once disenchanted, trust is not easily restored.

Trustworthiness and respect for their patients constitute key moral obligations of physicians. It culminates in a precondition that lies at the very heart of the bond between doctor and patient – the ethos of confidentiality. Doctors are duty-bound not to divulge confidential information about their patients. Confidentiality characterises the doctor–patient relationship to the point of unspoken covenant. That confidentiality features prominently in the Hippocratic Oath emphasises its position as a timeless principle in medicine (Saunders, 2016). "And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding

such things to be holy secrets" (Wikipedia, s.a.). The expectation that physicians will not reveal what patients tell them in confidence is implied in every consultation. It is implicit in and fundamental to the doctor–patient relationship and every healthcare encounter.

Confidentiality derives from a doctrine of respect for people and a moral obligation to patients (Saunders, 2016). An assumption of trust lies at the very heart of the doctor–patient relationship. "Patients visit their doctors in the belief that the information they supply to the doctor, or which the doctor finds out about them in the course of examination or treatment, will be kept secret" (Sokalska, 2004:35). Reservations about telling one's doctor everything about symptoms experienced, what might have sparked it and one's habits and dispositions would compromise accurate and timely diagnoses. The trust people have in the medical fraternity to not divulge their confidential health issues, private thoughts or even indiscretions, is a social good. Were it not that patients can rely on confidentiality, the diagnosis of many illnesses might be missed or the origin of some injuries would remain obscure. Anamnesis, the process of meticulously establishing patients' medical case history by relying on their recollection and candour, is an indispensable part of successful diagnosis.

Patients who trust their doctors have the confidence to reveal all the information, rather than doing so selectively for fear of embarrassment or potential public ostracism. Not all patients are equally concerned about their privacy in terms of their ailments, operations or symptoms. Those who openly discuss their health history with family, friends and even casual acquaintances do so on their own account. However, it ill becomes healthcare professionals to lack respect for any patient's privacy or violate a person's right to confidentiality.

5.2 Medical professionalism

"Medical professionalism as a concept can be traced back at least to around 400 BC with the Hippocratic Oath" (DeAngelis, 2015:1837). Despite modern concepts differing from the original, somewhat quaint edicts, it is the earliest description of expected physician behaviour. Confidentiality, caring for the sick, respect for life, knowing one's limitations, steering clear from inappropriate relationships, building a sound reputation and reverence for one's tutors/mentors, all addressed in the antiquated Oath, reverberate to this day. Yet, unsurprisingly, given the social context of technologically advanced twenty-first-century healthcare, defining

medical professionalism in modern times has become a frustrating endeavour (DeAngelis, 2015). Nonetheless, professionalism is integral to the practice of medicine (Srinivasan, 1999). Traditionally, definitions of professionalism focus on desirable attributes, behaviours, commitments, obligations, principles, values, virtues and traits of professionals (Wynia, Papadakis, Sullivan & Hafferty, 2014). Certainly competency, keeping one's knowledge and technical skill updated, accepting accountability and managing conflicts of interest have to feature when professionalism comes to mind. Anthony-Pillai (2016) adds taking cognisance of one's limits, collaborative working and good record-keeping. Undoubtedly professionalism also requires the maintenance of good inter-collegial relationships. There are probably few scenarios that characterise unprofessional conduct better than doctors that disrespect or belittle nurses. Arrogance and haughtiness are the antithesis of professionalism. But is professionalism then merely a virtue such as integrity? Or is it a cluster of virtues that render an individual suitable for a vocation calling for propriety?

Defining professionalism in its entirety is elusive. However, professionalism belongs at the heart of medicine and healthcare. So much so that, in 2012, the American Board of Medical Specialties (ABMS), covering 24 disciplines, initiated a project to create an operational definition of medical professionalism to serve as a foundation for member boards certifying medical specialists (Wynia et al., 2014). Wynia and colleagues (2014) argue that professionalism transcends lists of desirable values and behaviour. At root level it is a motivational force and belief system. The ABMS is concerned with what medical professionalism entails, how it works and what its purpose is. In medicine, professionalism serves to ensure its practitioners are worthy of the trust patients and the public have in them. The definition that the ABMS adopted asserts that:

> Medical professionalism is a belief system about how best to organize and deliver health care, which calls on group members to jointly declare ("profess") what the public and individual patients can expect regarding shared competency standards and ethical values and to implement trustworthy means to ensure that all medical professionals live up to these promises. (Wynia et al., 2014:213)

Similarly, in 1999, the European Federation of Internal Medicine, the American Board of Internal Medicine and the American College of Physicians and Society of Internal Medicine combined efforts to launch the Medical Professionalism Project to develop a charter. The preamble to their charter reveals a social contract approach to medical professionalism.

> Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physicians, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession. (Medical Professionalism Project, 2002)

When professionals conduct themselves in ways befitting members of their profession, they are said to be professional. It is an encompassing attribute that embraces at least competence, integrity and sincerity to invariably act discretely, honourably and considerately. These virtues that culminate in professionalism form the ethical foundation of the medical profession. "Publicly in his oath and privately in his encounter with the patient, the physician professes two things – to be competent to help and to help with the patient's best interest in mind" (Pellegrino, 2002:381). Such commitment invites trust and promises trustworthiness. Implicitly in clinical encounters the doctor promises "curing when possible, caring always, relieving suffering, and cultivating health" (Pellegrino, 2002:381).

Professionalism is easier to observe than to unequivocally describe. Similarly, unprofessional conduct is quickly perceived while professionalism manifests with time. Therefore, it is pertinent to consider some of the most common challenges to medical professionalism in our time. Obviously, unethical behaviour by doctors, deficient patient care, the misuse of resources, weak self-regulation, arrogance and impropriety erode medical professionalism and society's respect for the medical fraternity. But beyond misconduct by individual healthcare practitioners, the medical profession at large is facing challenges threatening their professionalism. Of these, commercialism, consumerism and the bureaucratisation of healthcare delivery are the most pervasive (Williams, 2009b).

Traditionally, service to patients – not business success – was the first and foremost concern of doctors. The doctor–patient relationship was quite distinct from that of seller and buyer. Nowadays the tendency is often for medical professionals to see themselves as entrepreneurs. Free market principles are embraced and products/services developed and supplied in response to demand. Commercialism sees cost controls, time management and profitability imperatives outranking the importance of patient care and authentic professionalism. The flip side of

commercialism is consumerism. It manifests as a tendency to consider healthcare a consumer good. Consumers (erstwhile patients) access healthcare to satisfy their demand. "Many patients go 'physician shopping' until they find one who is perfectly satisfactory, and they demand treatments that in the professional judgment of the physician are unnecessary or sub-optimal" (Williams, 2009:49b). This behaviour resembles the demanding and buying of healthcare rather than establishing a doctor–patient relationship characterised by respect, trust and reciprocal trustworthiness, underpinned by medical professionalism.

Equally, the bureaucratisation of healthcare and the inevitable controls, regulations, treatment protocols and constraints it entails impedes professional discretion. Traditional clinical contacts in medical practice primarily entailed a one-to-one relationship between physician and patient – with confidentiality being implicit and almost sacred. Nowadays third parties, notably medical aids, health management firms and health insurance enterprises, have no qualms to insist on detailed information to consider eligibility for benefits. Beneficiaries have to consent to revealing their symptoms, its duration and severity, test results and the proposed treatment plan. Otherwise benefits are either withheld or hefty co-payments apply. Doctor–patient confidentiality is no longer respected or valued. That relationship has been invaded by stakeholders that have a vested interest in what goes on between doctor and patient in the privacy of the consulting room.

In the ambit of occupational health, the employer not only has a vested interest in the health of its employees but claims a contractual right to much information. The status of a person's health directly impacts on his functional capacity for work, and the prognosis for successful rehabilitation and soon regaining occupational productivity have financial implications for the employer. Adopting the role of occupational medicine practitioner demands practical wisdom and cautious navigation from physicians to preserve medical professionalism.

5.3 Shifting allegiances in healthcare and medicine's social mandate

In present-day communities, reverence for physicians has dwindled. Rather, their conduct and practices are scrutinised for appropriateness of care delivered and compliance with rigorous public policy and healthcare funding principles. Whereas doctor–patient interactions were once very private and the relationship almost sacred, medical aid funds, purveyors of managed healthcare and government officials now regularly intervene. Within professional healthcare

circles, peer review is considered indispensable and treatment protocols essential. Even those physicians contracting directly with their patients (in the South African healthcare environment referred to as independent private practice), experience encroachment upon their professional autonomy. This amounts to interference in patient management that most view as potentially harmful; meddling that increasingly challenges the singular loyalty of physicians to their patients. Decades ago already, Szasz (1977) asked whom the physician should serve and what the moral mandate of medicine is. Referring to Plato, he maintained that we had not "advanced one step beyond this [Plato's] naïve, hortatory answer to the question of whose agent the physician is" (Szasz, 1977:3).

Physicians are urged to consider the care of the patient their paramount or even sole obligation. Words such as "complete loyalty" and "primary commitment" abound in ethical guidelines (Wendler, 2010:66). The provision of compassionate care by physicians is a prima facie moral obligation at the very heart of medicine. Such prima facie duties "carry obligatory force on the face of it, while they may in specific cases be outweighed by other considerations" (Reid, 2011:466). In practice, doctors often have to decide if considerations for their patients should override other considerations such as the valid interest of society, a community or various legitimate role-players (Lynöe & Mattsson, 2004). The physician's medical knowledge and skill are ordinarily focused on the primacy of the good of the person he attends. But medical expertise is also needed to facilitate certain important societal goals (Pellegrino, 1993). The settings for these are manifold, varying from contemporary institutional and organisational medical practice to legislative bodies, the implementation of public health policy, the military, forensic medicine and the life insurance industry.

Whatever the type of their [medical] practice, physicians cannot escape moral accountability for the way their special knowledge is used in cooperation with extraneous influences inimical to their patient's well-being. In the use of medical knowledge, the physician is the 'final common pathway' – that is to say, if medical knowledge is to be used competently, at some point, it will have to be administered, supervised, approved or recommended by a physician. (Pellegrino, 1993:373)

Bloche (1999:268) groups the use of clinical skills for purposes other than the promotion of patients' individual interests into three categories: "(1) pursuit of public health aims, (2) furtherance of non-health-related social ends, and (3) ascription of rights, responsibility, and

opportunity based on health status". Involuntary vaccination, limiting the use of antibiotics to slow down the evolution of resistant bacterial strains and the reporting of contagious diseases to the relevant authority are examples of the first category. The second category, namely furthering non-medical ends, even when they are widely seen as legitimate, is prone to controversy. These include the facilitation of criminal justice and interventions to expedite the return of wounded troops to combat. The third category encompasses the life insurance industry, sick leave certification, civil law matters such as ruling on mental competence and the gatekeeping function that is indispensable to the health management industry and healthcare funding.

Beyond patient care, medical expertise is also needed to facilitate certain critically important social goals. "As agents of an institution or as citizens, they [physicians] are [also] required to fulfil certain legally or socially legitimated roles" (Pellegrino, 1993:371). Being bound to the ethics of care for the patient and simultaneously held responsible and accountable for the societal duties of the medical profession creates intriguing moral territory.

As far back as 1987, Prasad (1987:1125) reported "an implicit notion that physicians serve a dual purpose: (1) to remain ardent advocates of the patient and (2) to function efficiently as agents of society to contain health care costs". It created "moral tension at the bedside" with the "imposition of a high degree of responsibility but a diminishing latitude in the application of clinical judgement" (Prasad, 1987:1125). Physicians became beset by a myriad of "federal regulations, reimbursement mechanisms, bureaucratic red tape, legal liability, hospital rules and committees, and many other regulatory structures" (Prasad, 1987:1125). While all of the latter progressively permeated the ambit of medical practice and professionalism, physicians faced "growing pressure to serve ends that fit awkwardly with the ideal of fidelity to patients" (Bloche, 1999:268). Nevertheless, "medical judgement and skill have enormous moral import beyond the bedside. A medical ethos decoupled from public morality would be at best insensitive and at worst arrogant" (Bloche, 1999:270). Few of medicine's societal duties can be considered more deserving or lofty than occupational health and safety.

Labour is the livelihood of the working class. Reading about horrific working conditions and fatality rates at the time of the industrial revolution leaves no doubt that occupational health and safety justifies the concerted and sustained effort of all stakeholders. And undoubtedly, the occupational health physician is equipped and required to lead in the field of occupational medicine and play an indispensable role in occupational health and safety. Especially, because

occupational medicine is practised in the business and labour environment, the occupational health physician is irrefutably responsible for adhering to the principles of medical ethics. In that role, the physician in industry would often be the sole voice and custodian of heath care ethics in the workplace. Whereas in institutionalised general clinical medicine the stakeholders are mainly aligned to the healthcare industry, in occupational medicine the employer has a dominant position and productivity and profitability are generally the driving force. Equally important for the employer is rooting out occupational injuries and recording fewer cases of occupational illness in the workforce. In pursuit of improving the enterprise's safety record, the interests of individual workers are subordinate to that of management. Risk aversion then trumps justice, beneficence and certainly respect for autonomy. In practice it often comes down to laying off a worker with even a mild or temporary impairment rather than accepting the remote risk of a minor work-related injury occurring. For the doctor who has a duty to promote occupational health and safety and simultaneously fulfil the culturally shaped expectations of professional benevolence, empathy and trustworthiness towards all patients, there is inevitable conflict between medicine's social purposes and the ideal of clinical fidelity (Bloche, 1999).

A particularly disconcerting aspect of the physician fulfilling two roles – that of clinician/therapist and agent of institutional purpose – is the role confusion that is prone to develop in the relationship between doctor and the individual subject of healthcare. Whether that is effectively a doctor–patient relationship or more of a medical assessor–assessee relationship needs to be reflected upon. The latter, probably more pragmatic, approach has seen occupational health nurses (who, in the South African occupational health environment, play a prominent and indispensable role and outnumber occupational medicine practitioners probably twenty to one) referring to their patients as clients. This serves to distance the nurse – who, even more than the doctor, is traditionally associated with a caring and nurturing role – from the needs of the individual. Increasing that distance, nurses in the field of occupational health have in most settings abandoned the time-honoured idea of donning a white uniform. Office attire seems more appropriate. Without in any way degrading the nursing profession, in my experience, the workforce senses and accepts that nurses carry out orders and work to set protocols and company policies. Conversely, physicians in most quarters are considered to be professionals with a significant degree of professional independence to exercise discretion and act in accordance with personal conviction. In healthcare and medicine, the proverbial buck stops with the doctor. Even in occupational health, that is the perception – whether it is reality or not.

Chapter 6: Loyalty as a virtue

We cannot imagine an ethos devoid of virtue or morality independent of sound moral character. "What matters most in the moral life is not adherence to moral rules, but reliable character, good moral sense, and emotional responsiveness" (Beauchamp & Childress, 2009:30). Prominent twentieth-century ethicists such as Elizabeth Anscombe and Alasdair MacIntyre actively rekindled old-style Aristotelian virtue ethics (Van Niekerk, 2011:29). Aristotle's answer to the question "What is the good of man?" was "an activity of the soul in conformity with virtue" (Rachels & Rachels, 2010:158). Virtue, intention and sincerity – what is in "people's hearts" – surpass presumed Kantian duty and a concern for consequences as a sound moral base for ethical conduct (Van Niekerk, 2011:31).

The essence of the virtues needs some clarification. Aristotle, maintaining "a virtue is a trait of character manifested in habitual action" (Rachels & Rachels, 2010:160), identified that worthiness is only admirable if it actually and invariably results in worthy conduct. Philosophers refined the definition to discern between virtues and vices. Rachels and Rachels (2010:161) simply added that which "is good for anyone to have" to distinguish between a good and a bad trait of character. Beauchamp and Childress (2009:31) define a virtue as "a trait of character that is socially valuable". They point out that particular communities might not only approve of virtues for the social benefits they bestow but might also value certain vices that potentially make their community/group more competitive. Thus, "moral virtues" must be morally valuable – not only socially beneficial. In defining virtue, Van Niekerk (2011:30) refers to Aristotle's original idea that a virtuous character trait often occupies the middle ground between two extremes, both representing vices. Neither prodigality nor stinginess is admirable, but providence is commendable. Russell (1946:169) refers to it as the "famous doctrine of the golden mean". This raises the question of where along the scale virtue is located. Between the two extremes, the discreet man needs to consider securing capital assets, saving to provide for the future and living a frugal life while being generous, unselfish and charitable. It seems that quality, quantity and context determine virtuousness imparted by traits of character generally considered good. Such context hints at the different social roles post-modern man takes on.

Unambiguous virtues such as integrity, trustworthiness and conscientiousness probably qualify as universal moral virtues. In the vein of Beauchamp and Childress' (2009:31) distinction

between moral and social virtues, many well-recognised virtues better fit into the social virtue category. The desirability of various social virtues is situational – semi-dependent on context. In healthcare, we are more concerned with the social roles of physicians than with their interaction with family and friends – recognising that many patients become like friends. Felten (2011:73) quotes philosopher William James on the valid point that "man has as many different social selves as there are distinct groups of persons about whose opinion he cares". Though the exemplary professional is an ethical individual, being a virtuous father and husband differs vastly from being a virtuous physician. Some virtues promote loving personal relationships; others create a competitive advantage in armed conflict. Yet other character traits allow for a thriving professional career. Shklar (1993:186), who recognises this, groups loyalty, commitment, fidelity and allegiance together in a genus of virtues that "all invite conflict; trouble is their middle name". That is often the likely outcome when one allows loyalties to interfere with sound professional judgement. According to Beauchamp and Childress (2009:35), "morally unworthy and condemnable actions" could stem from "virtues such as loyalty, courage and kindness". They caution against respectfulness, generosity and patriotism being misdirected by obedience, zeal or excessive devotion. Undeniably, not all virtues valued in the social arena (notably among family and friends) unconditionally befit professionals entrusted to make vital decisions biased by neither patronage nor favour.

Considering the three classic professions (divinity, medicine and law) provides a sobering perspective on the appropriateness of loyalty in the moral armamentarium of professionals – in their professional roles. Writing on the central importance of Christians' unquestioned loyalty, Sorge (2004), a pastor, leaves no doubt that divine loyalty to their Creator and fellow believers is valued above all else. The judiciary represents the other pole. Demonstrating loyalty to any persons, groups, authority, government or political party on the bench disqualifies judges. Their verdicts would be suspect and their judgments treacherous. A judge's only loyalty ought to be to justice and the truth. In fact, judicial commissions go to great lengths to scrutinise applicants for the position of judge in order to confirm their independence. Loyalties often equal emotional baggage that may bias judgment and compromise objectivity. For instance, a judge whose religious convictions include the sacredness of antenatal life, might inadvertently be biased when a woman's right to abortion is the subject of a case. Juries are subject to similar scrutiny. Loyalty (except for Royce's genus of loyalty to causes) is no virtue in the judiciary. Should not doctors, who are regularly involved in what may be termed life-and-death decisions, in their professional practice deal with loyalty more like judges than like priests? The physician's ethic of care,

dedication and empathy does not need loyalty to supplement it. In the medical profession, circumspection should pre-empt loyalty. Where third parties have a valid stake in physicians' conduct and healthcare conclusions, sentiments of loyalty and decisions influenced by such loyalties, are best avoided.

6.1 Royce's philosophy of loyalty

Josiah Royce, by declaring loyalty "immeasurably precious" (1908:vii), "a central principle of moral life" (1908:13) and "the fulfilment of the whole moral law" (1908:15), earned the uncontested title of loyalty prophet. Royce refers to his lecturing on the subject as the furtherance of a doctrine. "Everybody has heard of loyalty; most prize it; but few perceive it to be what, in its inmost spirit, it really is − the heart of all the virtues, the central duty amongst all duties" (Royce, 1908:vii). Acknowledging that loyalty is "old world", Royce seems critical of "the tendency to revise tradition, to reconsider the foundation of old beliefs, and sometimes mercilessly to destroy what once seemed indispensable" (1908:3). Nevertheless he considered his own study of the foundations of moral life a timely undertaking − seeing that his age and that of his contemporaries was "a good deal perplexed" (Royce, 1908:8). For this Royce blames their moral leaders, reformers and prophets rather than "any peculiar waywardness of our time" (1908:8). Much like MacIntyre (1981) with virtue, Royce's intention was to clarify and simplify their moral situation. He identifies "the root of our modern moral confusion and distraction" as an inability to "see a fitting and central object of loyalty", a cause that is really worthy of one's devotion (Royce, 1908:46). "We all need to find causes which shall awaken our loyalty" (Royce, 1908:56). Having found causes that are appealing and worthy, a life task that awakens his heart, the loyal man shall "justify the sense of his own life" (Royce, 1908:58).

To correctly comprehend Royce's exposition of loyalty, it is vital to keep in mind his interpretation of loyalty − "If one is loyal, he has a cause which he indeed personally values" (1908:18). In our era Royce's version of loyalty, to causes, would rather be described as dedication, commitment and determination. Generally, the subject of loyalty is rather taken to be a person, a group, one's country, employer or friends. In healthcare, loyalty is a virtue associated with the doctor-patient relationship. Doctors are expected to be loyal to their individual patients. But are doctors then required to be loyal to all their patients? After all, loyalty (in its traditional sense as referring to devotion to persons), is a sentiment that is awakened over time and it is

never universal. Being equally loyal to everybody (such as all patients), to an extent undo's (or dilutes) the virtue of loyalty. It then merely refers to an exceptionally supportive individual − which is commendable. In that sense of the word "loyalty", such a doctor is not loyal to some individual patients but, reverting to Royce's brand of loyalty, committed to a cause. Worthy causes for loyalty in the ambit of healthcare are professionalism, clinical acumen, respect for autonomy and social justice. For occupational physicians their primary loyalty should not be to their patients or their employers but rather to occupational health and safety for all. Royce's version of loyalty is a far better ethical guide for occupational medicine practitioners than the kind which approves of loyalty to stakeholders in the workplace.

Critics of Royce's seminal work faulted his interpretation of loyalty. Ladd (1967:97) is quite adamant that in "common moral language, as well as historically", loyalty refers to interpersonal relationships. "The object of loyalty is ordinarily taken to be a person or group of persons" (Ladd, 1967:97). Oldenquist (1982:175) similarly rejects the notion of loyalty to a cause. Classic loyalty can also be "characterised as a practical disposition to persist in an intrinsically valued (though not necessarily valuable) associational attachment" (Kleinig, 2007:2). Allen (1989:286) considers Royce's famed dictum, "loyalty to loyalty", to be a "forced and artificial phrase". Royce's conception of loyalty introduces ambiguity to the classic loyalty debate. However, looking beyond that, his writings focus attention on whole-hearted dedication to one's principles and that which one stands for. Royce called "upon a man to renounce lukewarmness" (White, 1956:101). While the concept of loyalty to people are vexed with suspicion of egocentricity − advancing the interest of those with whom one personally associates − he who subscribes to a worthy cause "is not seeking his own private advantage" (Royce, 1908:19). Furthermore, Royce maintains that "loyalty is social" (1908:20). The cause to which a loyal person is devoted is never something wholly personal. There would be others who serve the same cause. That cause being worthy; it tends to unite many individuals who are then loyal to each other, but only through the cause that tie them together. Ideally then, a passion for the advancement of occupational health or for the furtherance of occupational medicine ethics could inspire the forming of a communion of occupational health and safety professionals with likewise principles and loyalty to their cause. It would counteract the professional isolation which occupational medicine practitioners tend to experience in business enterprises.

6.2 In defence of loyalty as moral good

According to Sorge (2004:15), "loyalty is a noble, unswerving allegiance, rooted in faith and love, that binds hearts together in common purpose". In addition, "God has placed a 'loyalty chip' in the 'hard drive' of the human psyche" (Sorge, 2004:15). Every human being consequently has a desire to and ought to rise to the nobility of loyalty, this devoted Christian author pronounces. On a more secular tone, Ewin (1992:419) concurs that loyalty is constructed from feelings of sympathy, compassion and love. Ironically, the same author, in a different article, holds that "loyalties, like religions, beget countless sins" (Ewin, 1993:36). This against the background of Josiah Royce (1908:vii) extolling loyalty as "immeasurably precious". Moreover, Oldenquist (1982:173) suggests that, if possible, loyalty has to be defended against the charge that whoever defends it defends immorality. Clearly, loyalty engenders controversy and clarification of its moral status is belated. Lamentably though, Ladd (1967) argues that loyalty has seemingly been banished from respectable ethical discussions due to its historical association with such odious political movements as Nazism. This despite, loyalty is an essential ingredient of "any civilized, humane system of morals" (Ladd, 1967:97). Devoid of loyalty, social life would be not only bleak but near impossible (Ladd, 1967:98).

Social life depends on durable and congenial relationships. Forming ties with other people is part of human nature (Ewin, 1993). Loyalty is near the top of the list of human qualities that enable friendship (Rachels & Rachels, 2010:165). We desire to be with other people and are inclined be part of a group – to an extent willing to bear some cost for the privilege of partnership (Ewin, 1992:419). Kleinig (2007:4) accurately points out that loyalty does not stem merely from general affiliational attachment. Only associations with which we strongly identify and to which we have become deeply committed, evoke loyalty. Sorge (2004:16) calls it "a bond of affection" that "cements us into relationships in a positive way".

It is not surprising that loyalty among kin and friends rates so highly on the moral scale. Loyalty, reciprocal caring and benevolence are cornerstones of family life. Extended to intimate social groups and permeating a community, it ultimately stands to form the glue that shapes a society. That is by implication what Royce preached. At least one laureate author, from quite a different age, ventures the "somewhat radical suggestion" that "all of social morality may depend on

loyalties" (Oldenquist, 1982:173). He implicates virtuous loyalty in a remedy for urban alienation. In other words, loyalty can create harmony; certainly not far-fetched if we confine context to community life. Loyalty indeed goes beyond relationships and social cohesion. It is a virtue that affects who one is and how one sees oneself (Ewin, 1993). Loyalty creates pride – even endorses hubris. Loyal people walk tall in the knowledge that they possess social identity. Being part of something that one can be proud of, an entity worth cherishing and defending – even voluntarily going out on a limb for – creates self-worth. Man has a multitude of duties, to the extent that dutifulness might at times prove gruelling. Conversely, loyalty embraces more than duty, but less toil – it implies affection and sentiment (Ladd, 1967:98), even wholehearted devotion. True loyalty is neither demanded nor obligatory. It simultaneously fulfils and enchants. Witness how loyal sports fans occasionally escape their daily toil to rally boisterously in support of their various teams, demonstrating their true-blue worship with unchecked elation. Loyalty is a very satisfying emotion – apart from any benefits of such loyal support reaped by the subject. It enriches an otherwise monotonous, very ordinary existence. To experience lasting loyalty is to feel good about being part of something worthwhile or of a select group that inspires. One is only loyal to that with which one positively identifies (Ewin, 1992:416).

Inevitably, proponents of loyalty as moral virtue are confronted with the reality of loyalty potentially deployed in the interest of evil motives. Baron (1984:12) uses simple language: "Loyalty seems so bad and yet so good". David Hume is quoted as saying that loyalty holds "less of reason than of bigotry and superstition" (Ladd, 1967:97). On a less scathing note, Kleinig (2007:10) indicates that loyalty need not endure the setting aside of good judgement. Ladd (1967) also draws attention to the difference between misdirected loyalty and, much worse, devotion to an evil purpose. But is it peculiar for character traits generally considered to bestow virtuousness to also have a negative side?

Ewin (1993) singles out the risk inherent to courage, one of the classic virtues. Courage, the readiness to take appropriate risks for worthwhile ends, can precipitate tragedy if things go wrong. Unfortunate consequences do not distract from the courage of intervening in a dangerous situation with the intention to safe life. In such cases, hindsight does not determine virtue – although sound judgement is expected. Perseverance, enterprise and leadership can all be deployed in the interest of unsavoury projects. So can loyalty. It does not render loyalty a vice. The fact that villains exhibit daring in successfully raiding a bank does not distract from the virtuousness of courageous men who risk being shot at when attempting to free hostages.

Indecent intentions nullify all virtuousness. There is no such thing as a caring rapist or a courteous murderer. It is a deception and would be spurious. Equally, nobody should mistake conniving, collusion, conspiracy and gangsterism for loyalty. A loyal malefactor is a misconception. Salutary courage or loyalty qualifies as a virtue. Malicious commitment and collaboration towards immoral objectives constitute chicanery and entrapment masquerading as, or mistaken for, loyalty. Thugs with genuine courage will attempt to turn their lives around to become loyal citizens. Their malice does not taint loyalty.

6.3 Decrying loyalty

Exclusion, injustice, conflict, egoism, bigotry and servility – these words abound in the literature dealing with loyalty extending beyond family life and friendship. Those who propound the universal virtue of loyalty are suspected of being naïve, single-minded, obsequious, morally biased and thus irresponsible (Allen, 1989; Baron, 1984; Ewin, 1993; Felten, 2011; Oldenquist, 1982). Doubtlessly loyalty is not an unalloyed virtue. Its moral value is questionable on several counts.

6.3.1 Loyalty spells egocentricity

Listen to anyone expounding personal loyalty and inevitably either the words “I, my and mine” or “we, us and our” will repeatedly be heard. Identifying with and fending for the own is the central theme of loyalty. It is shared ownership and the sentiment of belonging (being an insider) that makes loyalty possible. To root for “them and theirs” would be tantamount to disloyalty, even defection. “Loyalties involve an ineliminable first-person (possessive) pronoun: ‘my’ (or ‘our’)” (Baron, 1984:4). It simply means I can only be loyal to my x, y or z – my friend, my boss, my company or that in which I have a stake. Kleinig (2007:5) asks “What magic is there in the pronoun ‘my’ that should justify us in overturning the decisions of impartial truth?” Oldenquist (1982:175) points out that acting in the interest of “my so-and-so” is logically no different from doing it for my own benefit. While loyalty has the aura of subjugation, in reality it is a self-centred sentiment. Self-interest and even smugness may, under the banner of loyalty, masquerade as self-effacement, allegiance and faithfulness.

6.3.2 Autonomy trumps loyalty

When sacrificing autonomy out of loyalty extends to subordination, the result is servility. We often choose to subjugate ourselves to the material needs of family and close friends. It stems from affection, vows and devotion; it entails the cherished version of loyalty that humankind has celebrated since time immemorial. Even so, in one's functionary role, relegation of sentiments such as loyalty and attachments is required to responsibly execute one's duties. Baron (1984) leaves no doubt that the duty of justice overrides considerations of loyalty. In her words, "the autonomous person is no one's puppet" (Baron, 1984:18). Personal integrity approximates independent judgement. MacIntyre (1998:191) reminds us that none less than Kant "hated servility and valued independence of mind".

Indications that loyalty compromises the credentials of its most ardent devotees are a concern. Felten (2011:203) probably best appreciates the impact of status on loyalty (and vice versa) when he provocatively outlines the stance of leaders: "Leaders look for loyalty from their followers". But there is a good reason why they do not often reciprocate. "Leaders have duties and responsibilities that may override personal duties" (Felten, 2011:203). They cannot afford to let "sentimental attachments or conflicting obligations take primacy" (Felton, 2011:203). "Loyalty's for chumps" (Felten, 2011:267). This perspective is not unique to this witty columnist known for *Postmodern Times.* Allen (1989:292), writing in *The Review of Metaphysics,* calls Japanese-style employee loyalty "industrial feudalism". He finds the very idea of loyalty to a firm incomprehensible. Loyalty as anything beyond due fulfilment of a contract is odd. In Kleinig's (2007:10) opinion, loyalty requires complaisance. The measure of trust that forges loyalty easily entails credulity and gullibility. Loyalty can be classed with respectfulness, generosity and goodwill. Beauchamp and Childress (2009:35) caution that, in medicine, coupled with obedience, zeal and devotion, these dispositions can lead to misdirected loyalty. Felten (2011:13) relates that Isaiah Berlin once said of a brilliant acquaintance: "Freddie's unwavering loyalty to his friends is a childlike, pathetic, very endearing quality that always move me a great deal. The mixture of sophistication and simplicity is very odd and attractive". A "giant of logical positivism", exhibiting signs of loyalty was being "tagged as simpleminded" (Felten, 2011:13). Traditionally doctors were encouraged to be "upright", diligent and conscientious while nurses, the "handmaidens" of physicians, had to cultivate obedience, submission and, inevitably, loyalty (Beauchamp & Childress 2009:35).

The argument against loyalty as a virtue, barring in the arena of kinship and friendship, is strong. Felten (2011:273) concludes that loyalty is a "forlorn relic" but that he wants "to dust it off". I cannot agree. Loyalty may be the linchpin of social virtue but beyond one's social circle, it belongs in the ambit of camaraderie and bonhomie. Its social value resides in forging durable personal alliances based on amity and fraternity. A sentiment of loyalty satisfies the need for acceptance, belonging and hopefully reciprocal support from those of similar creed. Sharing a vantage point to a degree defines identity. Loyalty recognises that I have so much in common with you. Consequently, by being a buffer for you, I also fend for myself.

Membership of a troop has benefits that the loner forfeits. Resorting to loyalty provides patronage; however, at a cost. The price of loyalty is sacrificing autonomy – the latitude to contemplate the good, right and just, unencumbered by sentiment or skewed by favour or prejudice. In business, loyalty inevitably risks introducing preference. The interests of one stakeholder will likely be afforded precedence based on nothing more than loyalty. If a loyal professional claims that this will never happen, he does not embrace loyalty. For loyalty, like all presumed virtues, does not merely entail ideological conviction, but actual conduct in accordance with that disposition. Aristotle pointed out that for a trait of character to be a virtue, it has to manifest in habitual action (Rachels & Rachels, 2010:160). How can anybody then claim that his established loyalties will not influence the soundness of his decision-making? True loyalty is exactly about conduct commensurate with deep-seated feelings of prized allegiance. Hence, loyalty ill becomes those whose professional discretion ought to be beyond contention. Aristotle's "great-souled man" speaks his mind "without fear or favor" (MacIntyre, 1998:75). Such men cherish their autonomy, independence of opinion and acting on personal convictions. Professional integrity precludes pliancy, sycophancy and servility.

6.3.3 Loyalty suspends judgement

The most significant moral objection against unbridled loyalty is that sound judgement might be suspended when staunch allegiance prevails. Ewin (1992:411) considers setting aside good judgement, at least to some extent, intrinsic to loyalty. The very notion that loyalty dictates conduct that would otherwise not have realised is morally deplorable. How can professionals compromise acumen and integrity, even discreetly, by allowing loyalties to blur their mind-set?

Baron (1984:7) believes loyalty narrows our vision; a constraint we are "supposed to escape through moral reasoning". Though Royce (1908) advocates single-minded pursuit of loyalty, Baron (1984:9) is adamant that it is hardly something to advocate for professionals such as engineers. Loyalties resist scrutiny. Stalwarts appear to be unmoved by considerations. Ladd (1967:97) quotes Hume as saying loyalty has "less of reason than of bigotry and superstition". Similarly, Ewin (1993:6) cautions that judgement cannot effectively curtail wayward loyalty because loyalty determines judgement.

Not only might loyalty relegate reason; such sentiments could actually cloud cognition. When loyalty, or even conflicting loyalties, contaminate reason, contemplation is no longer guaranteed to remain pure and principled. Though loyalty befits households, loyalty is immensely more controversial where one's extended social role and certainly professional roles are concerned. It is at loggerheads with justice, fairness and equity. Consider to what extent loyalty would be a flaw in law. Independence and neutrality of the judiciary is highly rated. No loyalties should sway or impede Supreme Court judges. Jury members are thoroughly interviewed to uncover allegiances and sentiments that introduce bias. Historically there is a strong belief that doctors owe loyalty to their patients. This sentiment verges on dogma. Present-day physicians are confronted with many laying claim to their commitment, if not loyalty. Coherent decision-making in healthcare calls for clear-headedness. There is no room for entangling loyalties in the moral armamentarium of the mentally agile professional. How else can one negotiate the potential minefield of conflicting stakes? Pharmaceutical companies, hospitals, medical aid schemes, employers and colleagues all compete with patients to render the doctor an ally. Westerholm (2007:23) warns against loyalty with a pun: "a handshake should not go beyond the elbow"! Reason, unblemished by subtle or overt loyalty, should ground judgement. Cognition as moral foundation for conduct eclipses loyalty, precedence and valuing personal alliances on all counts.

6.4 Loyalty, utilitarianism and Kantian deontology

Favouritism and particularism spark the most trenchant yet intelligible opposition to loyalty. Particularism "for many modern ethicists is a dirty word" (Felten, 2011:86). "Partiality and loyalty seem to run counter to the very notion of moral and just behaviour" (Fletcher, 1993:165). In the age of moral Enlightenment, Immanuel Kant and Jeremy Bentham respectively

championed rule morality (Kantian deontology) and utilitarianism. Critics of loyalty as credible moral virtue evaluate its compatibility with these popular moral theories of modernity. Similarly, loyalty detractors, referring to John Rawls' (1971) *A Theory of Justice,* maintain that sentiments of loyalty distort justice.

Kantians "insist that we should rest our moral judgments on reason that also applies to all other persons who are similarly situated" (Beauchamp & Childress, 2009:343). Kant crusaded for reason, born out of a rational capacity to align conduct with truth and duty, "independent of the passions and the inclinations of the body" (Fletcher, 1993:166). Sentiments of loyalty ought not to interfere with pure reason. Deontologists act out of duty and Kant's categorical imperative established a moral law that disallows conduct that cannot ethically be universalised. How can I justify resorting to a different moral yardstick for those I have a special relationship with? Is loyalty not exactly about more readily overlooking, pardoning or forgiving conduct of associates and subtly or overtly advancing the interests of confidants? Surely it is likely to be at least unfair and at worst to the detriment of someone else. It might not commonly be the case where family and friends are concerned, but in public and vocation it is more than just probable. If everyone allows their loyalties to colour their moral disposition and influence their behaviour, ethical woes will abound. Being committed to and demonstrating loyalty does not pass the test of Kant's "supreme moral rule".

Jeremy Bentham (1748–1832) advanced the then novel idea that "morality is about making the world as happy as possible" (Rachels & Rachels, 2010:97). It can be achieved by giving precedence to the anticipated consequences of moral decisions and aiming to maximise the happiness of as many people as possible while minimising pain. Rather than adhering to moral rules, the utility of moral decision-making matters most. "Actions are to be judged right or wrong solely by virtue of their consequences" (Rachels & Rachels, 2010:109). John Stuart Mill, while tweaking the theory to render it less uncompromising, became the leading advocate of what was labelled utilitarianism. The principle that each person's happiness or pain counts the same and adds up is central to utilitarianism. Unqualified utilitarianism bars loyalty from meddling in moral contemplation.

6.5 A verdict on loyalty

Loyalty is a sentiment. The word "sentiment" derives from the Latin for "to feel". In short, a sentiment is an idea coloured by emotion (Merriam-Webster). Interestingly, the Oxford Dictionary (oxforddictionaries.com/def) adds "self-indulgent feelings" and a thesaurus (Wikipedia) yields "bias", "leaning" and "slant". The most relevant definition of sentiment is "a combination of beliefs and emotions as a basis for action and judgment" (yourdictionary). In other words, loyalty determines conduct and certain actions, based on judgement – judgement merely underpinned by feelings and self-indulgent emotion. People have very many diverse feelings, emotions, ideas and thus sentiments. Those cannot be trusted to be rational. We observe that dogs also have feelings and experience emotions. Their bark, snarl, whimper or tail wagging demonstrate their disposition and intended action – based on instinct and strong feelings. Man's best friend, in spite of lacking reason, is renowned for an unmatched capacity for loyalty. Sentiment firmly anchors loyalty, founded on random feelings and emotions, at times subject to exploitation. Zealous loyalty is at best gratuitous, often irrational, and potentially pernicious. Under the prudish pretence of virtue, loyalty, by compromising discretion, sanctions ill-considered judgement. The loyal person's sentiment per se may seem innocuous; yet the resulting conduct, untested by reason, is disquieting. The test of loyalty is after all conduct, not intensity of feeling (Kleinig, 2007:3). Loyalty, in circumstances where responsibility and integrity are called for, is a menace.

One more lurking suspicion haunts loyalty. When Felten (2011:12) hints that dim-wittedness in general bolsters loyalty, is it only cynicism? He is after all referring to a brawny horse in George Orwell's *Animal farm.* He observes that "the best and the brightest are rarely the most loyal of staff". Baron (1984:15) touches on a sensitive issue of particular relevance in the occupational environment – that of loyalty in deference to authority. In hierarchical set-ups, loyalty is almost invariably directed upwards. Team members are loyal to leaders, a subordinate to his manager, employees to the company and a servant to his master. The common exception is obligatory loyalty – loyalty that clients of a lawyer or patients of a doctor presumably contractually gain a right to.

However, voluntary loyalty, of the variety legends are made of, is heavily slanted upwards. It matters which rung on the ladder one occupies. If loyalty happens to reap rewards, loyalty to an

entity with more power than oneself makes sense. According to Allen (1989:292), loyalty "is primarily a matter of status". Identifying with someone on the upper rungs who wield influence certainly eases the process of shaping self-image and nurturing self-confidence. Yearning for the snug sensation of belonging is understandable. Relative autonomy is gratifying but in the absence of a point of reference and firmly established self-identity, independence can become intimidating and lonely. Being suitably loyal to appropriate individuals or a group is conducive to recognition as an insider, approval and even a measure of esteem. Unreserved support of, admiration for and visible devotion to a superior, the substance of loyalty, involves a measure of voluntary submission – if not servility or sycophancy. Suspending one's own judgement because of loyalty signals to the object of that loyalty that his interests are afforded precedence over that of his staunch supporter. Loyalty in the vocational arena inextricably implies a significant degree of subordination. Walsh (1987:3) alludes to this potentially dispiriting impact of the work environment that at times "poisons the wells of identity, motivation and self-worth". Loyalty implies being prepared to habitually go out on a limb for someone; not out of respect, duty or in support of the truth, but categorically. Ardent loyalty undermines dignity and poise while fierce loyalty is frankly degrading. Professionalism does not discount appropriate loyalty, but candour is far more prized. Business leaders looking for and rewarding loyalists may be interested in lackeys. Unless one yearns to forever be nostalgically remembered as "good old loyal so-and-so", being frugal with loyalty, or altogether reserving such sentiments for kith and kin, is the best strategy. Allowing loyalty to guide professional conduct is not commendable.

Chapter 7: Employee loyalty

We are social creatures who need relationships to thrive. Rachels and Rachels (2010:165) ask "Why are virtues important?" Loyalty is a good example. It is all-important because "loyalty is essential to friendship" (Rachels and Rachels, 2010:166). Royce (1908:20) declares "loyalty is social" and "concerns other men". Fletcher (1993:3) opens his essay on the morality of relationships with these words: "We all live in networks of personal and economic relationships – of friends and acquaintances, of families and nations, of corporations, universities, and religious communities". Constancy and loyalty are the glue of relationships. Hence, loyalty is a natural human phenomenon (Schrag, 2001:52). Identifying with others, their interests and that which is important to them forges our ties. Whom we associate with and the objects of our loyalty help define who and what we are. Humankind not only has a capacity for loyalty; in a way, we hanker for enduring commitment and valued relationships. It provides social substance to our everyday existence. Considering how much of our waking life we spend in the workplace, that is where loyalty, beyond kinship, frequently manifests. Most employees are thus susceptible to sentiments of loyalty – and potentially vulnerable to exploitation of heartfelt, especially naïve, loyalty.

The power of determination in the traditional employer–employee relationship is by nature skewed in favour of the boss. Schwarz (2011:2) reminds us that "loyalty is the free person's virtue". Freedom of association is even a constitutional right (Republic of South Africa, 1996b). Loyalty is an associational matter. Also, freedom to either allow nascent loyalty to flourish or suppress such feelings (at times rationally) is very much personal choice. Employers can demand commitment and dedication from employees, but loyalty is the unfettered sentiment of a free agent. In the labour arena though, lack of tangible employee loyalty may well be frowned upon – or worse. How does an employee explain to his manager that loyalty is a spontaneous sentiment, triggered by reverence, affection and identifying with someone – but that is not what he experiences? Labour law and workplace practices significantly constrain employees – perhaps apart from those in the most senior echelons. The workplace and tenor of the labour contract eminently curtail the freedom of employees. Employers might not demand loyalty, but many expect it. Managers can fail to grasp the supererogatory nature of loyalty extending beyond adequate commitment and sound performance. Apparent lack of loyalty is easily construed as evidence of ingratitude, shirking or even disloyalty. Due to the formal and tacit labour contract,

the issue of remuneration and the likelihood of contrived or discreet additional reward, the context of employee loyalty differs from genuine loyalty characterising revered friendship. In the ambit of gainful employment, the individual is no free agent. The labour domain precludes ample employee liberty and free will that inescapably underpin authentic loyalty.

Misgivings about the moral and social virtue of employee loyalty are understandable. Baron (1984) is especially concerned about the position of professionals such as engineers. The question arises: "What is the moral significance of employee loyalty?", as asked by Schrag (2001). He considers whether ties of loyalty to the organisation are in fact a good thing for employees or the employer. It is inadequate to assume it is. Dogma does not suffice. It is imperative to identify the de facto object of employee loyalty in order to unpack the virtue of such loyalty.

Loyalty may develop towards individuals at various levels in the occupational environment. The object of an employee's loyalty determines the potential impact of such a tie. Identifying with an individual is the trigger towards eventual loyalty. Due to the relational nature of loyalty, the object of loyalty is more likely to be someone an employee develops a close relationship with – rather than a leader several ranks higher. It might be a supervisor or a more senior manager seemingly worthy of emulation. When the founder of a close-knit business or its chief executive is a charismatic and highly esteemed figure, it is not strange for that individual to attract loyalty across the echelons of the enterprise. Employee loyalty can also be directed at the collective management, at the relevant department or at immediate colleagues. At times the company's successful brand seems to inspire loyalty. This probably represents pride and workforce morale rather than true loyalty. Duska (1993:551) is adamant that loyalty towards the business entity or collective as such is improbable. Companies and corporations lack persona and thus moral status. Duska, like Ladd (1967), suggests that those who believe in loyalty towards a cause or some superlative entity that eclipses mere mortals are idealists. Loyalty ordinarily refers to relationships between persons (Ladd, 1967:97). A business enterprise is a vehicle or instrument deployed to achieve commercial objectives. Affording an enterprise the moral status that justifies loyalty debases the status of its individuals (Duska, 1993:552). Individuals do not derive their worthiness of loyalty from their membership or affiliation. Their personal qualities, demeanour and deportment spark loyalty.

If then, in the vocational arena, relationships remain the determining factor in loyalty, where does the utility of employee loyalty accrue? What proves advantageous for the object of someone's loyalty might prejudice others – or even the interests of the enterprise as a whole. Strong loyalties within a business enterprise are likely to introduce bias into business decisions. This could slant day-to-day operational calls and even potentially muster loyal support for ill-advised strategic decisions. While loyalty towards a supervisor or team leader is admirable, even if quaint, ardent loyalty in a professional or technical expert raises questions about independence, credibility and soundness of counsel. Contentious verdicts of loyal subjects will always be suspect and scrutinised for bias. This is especially so when it transpires that their findings had to be "cleared" with some general manager or business authority prior to announcing the outcome. This is even more so when external stakeholders have a legitimate and enforceable interest in findings. In addition, said professional, such as a registered engineer or physician, is in his personal capacity accountable to Council (and thus indirectly to the public). Where an employee is entrusted with a governance role, employee loyalty can prove especially awkward. Baron (1984) compiled a module for the Center for the Study of Ethics in the Professions at the Illinois Institute of Technology that aptly demonstrates this dilemma.

7.1 Professionals in employment

When Baron (1984:1) writes that engineers "are in a position of public trust", she implies that no labour contract dilutes or nullifies the statutory or moral obligations of professionals ultimately accountable for that which they designed, inspected and/or certified. Board certification and personally accepting legal responsibility for conduct in one's field of expertise differentiate professionals from other knowledge workers. With it comes onerous duty and moral obligations. Professionals such as structural engineers and occupational health doctors are ultimately responsible and accountable for the decisions they make in their professional capacity. Every ruling or judgement potentially has serious implications and thus requires circumspection. Professional negligence invites disciplinary steps and disgrace. In Baron's example, employee loyalty potentially has dire consequences for those who need to trust a company's engineers to inspect its products for critical flaws with implications for the safety of people. Employee loyalty extending to personal sacrifice is generally creditable. However, when loyal conduct of employees, whether ill-advised or well meant, endangers others, it is inequitable and inexcusable. Unfortunately, when loyalty triumphs, the risk of jeopardising others is easily underestimated.

Burning loyalty coupled with enthusiasm for business ventures blurs judgement. Baron (1984) relates how an aerospace engineer buckled under pressure exerted by his employer to approve a fraudulent report on a newly designed, but seriously flawed, brake system in the name of loyalty. Though loyalty is of one's own volition, such sentiments have the potential to become a compelling force. Hajdin (2005:259) concludes that "loyalty, by definition, overrides the criteria (norms, standards, values, etc.) that would otherwise govern one's choices". An example of the stark reality is William Vanderbilt, famous (or notorious) mid–nineteenth century American railroad executive, who allegedly declared, "The public be damned. I'm working for my stockholders." (*Weston County Gazette*, 1936).

Established professional values and popular business norms are distinct. At times, the difference probably relates to varied interpretation but, not infrequently, it is more akin to a moral chasm. Solomon (1993) aptly points out that, unlike in the classical professions, business ethics are concerned with an area of human enterprise where the currency is money. Pragmatic considerations about the fairness of capitalism until recently coloured business ethics (Solomon, 1993). Undoubtedly, business ethics alone cannot provide the moral framework for the conduct of professionals employed by industry. Professional doctrine guides conduct and practices. It generally determines proper professional behaviour in varying context. Formal professional codes of ethics exist. Conversely, corporate ethics usually revolve around value statements supporting the brand and ostensibly reflecting the business culture. Popular corporate "ethical values" are commerce oriented. The aim is sound business practices rather than adherence to moral principles. We strive for continuous improvement. We are customer oriented. Safety first. Reliable. Zero tolerance for fraud and bribes. The arena of business ethics hardly provides professionals in full-time employment with a moral compass. On the contrary, the ethical values of their company, which may suffice for their co-workers, may confound the matter for true professionals. Nowhere is this more tangible than when management, not employees/patients, is considered the occupational physician's customer. Note that company values prescribe putting the customer first. Who then can legitimately claim first title to the professional's allegiance? Who ought the corporate doctor to serve?

7.2 Whistle-blowing

Few things regarding employee loyalty generate more controversy than the issue of whistle-blowing; protagonists and those who vilify whistle-blowers diametrically oppose each other. To many people, whistle-blowing constitutes the ultimate act of disloyalty. Some "condemn them as 'finks'" while others praise whistle-blowers "as civic heroes" (Duska, 1993:551). At least one ought to appreciate the dilemma that conflict between duties and loyalties pose and the inevitable moral qualms and contrition it begets. Whistle-blowing that comes easily is ethically suspect. Doubt, misgivings and intense moral rumination are indicative of acute moral awareness – taking duty seriously and carefully contemplating loyalties. Varelius (2009) poses the key question: "Is whistle-blowing compatible with employee loyalty?"

Duska's (1993) point of departure is that companies lack the moral status required to rightly figure as an object of loyalty. However, in so doing he diverts attention away from the real issue of legitimate employee loyalty. When referring to an employer as the object of loyalty, it matters little whether management, colleagues collectively, a closely-knit workgroup or various managers (or in the mind of the worker, the "company") are the actual entity espoused. Human dimensions are much more likely to kindle occupational loyalty than products, brand or enterprise characteristics. Sentiments of employee loyalty defy being pinpointed and apportioned. Attempting to do so without considering the emotional intricacies of devotion on a case-to-case basis serves little purpose. Loyalty is more a heart-felt sensation than the outcome of reason – more inclination than responsibility. Lack of loyalty signifies neither disregard for alliances, nor neglect of duty. Nevertheless, whistle-blowing is better justified by moral imperatives and overriding propriety than by resorting to meta-ethics.

In order to consider the situation of appointed physicians, consequently serving more than one master, the more pragmatic enquiry is asking under what circumstances whistle-blowing does not signify disloyalty. Resorting to such a practical approach does not imply though that whistle-blowing represents prima facie perfidy. The context in which whistle blowing is deliberated is crucial. It determines whether resorting to such an act is morally justifiable or at least defensible. That depends on motive, ethical contemplation and the extent to which all other avenues, short of disclosure, were explored. What also matters is if the prospective whistle blower is actually the person responsible for governance in the field at stake. A primary duty rests on the shoulders

of that person (such as the duly appointed chief engineer responsible for compliance or the occupational medicine practitioner responsible for employee health and safety). He cannot, like a subordinate technician or nurse, argue that someone else is ultimately responsible to intervene.

Firstly, loyalty should not interfere with the express call of duty. This is because to be loyal to any person (at least beyond close family, which is not pertinent to the subject of employee loyalty) is not a moral obligation. Loyalty is complementary, often superfluous, to dedication, respectfulness and being dependable, hard-working, committed and trustworthy. What legitimate, dignified and unadulterated virtue does loyalty hold when there is abundant commitment, honour and resolute veracity? Loyalty risks prejudice because it is more a sentiment forged through relationships than an untrammelled virtue with stand-alone moral value. In the end, sober duty must prevail over loyalties. An employee may have implored his company to heed his concerns but to no avail. After having pursued all reasonable insider avenues in vain, reporting serious risks to public or environmental health and safety to the relevant authority becomes a moral imperative. Ironically, whistle-blowing then becomes a duty – a duty towards those beyond the sheltered inner circle of the employer.

Secondly, employee loyalty that inconspicuously allows injustice to creep in is unethical. Especially those employees whom society on strength of presumed professional integrity endows with their trust ought to heed the reciprocal moral duty to uphold equity and fairness. Occupational or economic ties should not mould what is right and just. Context is important, and pragmatism has a place in business. However, when expedience extends to collective contempt for the truth, to the detriment of others, the virtuous employee raises a red flag. No employee entrusted with much more responsibility than just performing a job well can baulk at exposing injustice if all else fails. When others have no scruples to conveniently, perhaps cowardly, turn a blind eye and knowingly let injustice go unchecked, the brave employee will choose candour over silence. When blowing the whistle is, ultimately, the only way to prevent gross injustice, doing so is noble.

Thirdly, whistle-blowing might well be an employee's last resort to avoid potentially dire consequences of wrongdoing. When this is patently clear to the employee qualified (and probably certified competent) to make such judgements in his field of expertise, whistle-blowing becomes a moral imperative. The experienced civil engineer who has ample evidence that the bridge or dam wall his company is constructing will probably not withstand the force of a serious flood

must speak out. Decency will not allow him to be party to a cover-up. Loyalty extending to wilful collusion constitutes conspiracy. It approximates the despicable loyalty that shapes gangsterism. The worthiness of the cause to which it is mustered inextricably qualifies loyalty. When employee loyalty suppresses imperative information that ought to be disclosed in the interest of everybody but the sly employer, such loyalty is corrupt. Equally, loyalty that cloaks fraud is dishonourable. Crime, corruption and perilous disregard for putting human life at risk justify whistle-blowing when nothing else deters the perpetrators.

Lastly, let me consider the role of those entrusted with the role of governance – classically the auditors. They are employed to police compliance and report anomalies. External auditors will in effect blow the whistle on management by reporting misconduct to the board/shareholders. Beyond financial data, the same applies to quality audits and compliance with health and safety regulations. A safety/quality engineer or physician respectively verifies adherence to standards, policy and good practice.

Consider this classic example of opposing loyalties and conflict between duty and loyalty: An occupational physician is confronted with a small cluster of highly communicable meningitis in a mining company's living quarters. An outbreak might be eminent. Good practice and legislation demand that he informs the local health authority forthwith. The relevant authority must consider vaccination of the community at risk or prophylactic antibiotic as a matter of urgency. Lives might be at stake. However, mine management abhors media attention and anticipates adverse publicity. The company repeatedly postponed the upgrading of the appalling ablution facilities in their hostel due to budget constraints related to low-grade ore. A recent labour strike exacerbated the situation. The last thing they need at this stage of wage negotiations is scrutiny of living conditions on the mine. It would almost certainly derail negotiations, currently on a knife's edge, and add several million Rand to next year's payroll. Millions off the bottom line profit would harm investor confidence. It would also mean that renovating the ablutions will fall by the wayside for another year. Clearly, the employer might exert immense pressure on the physician to participate in battening down the hatches – invoking loyalty and common interest.

In this apparently irreconcilable situation, the proverbial buck stops with the occupational physician. He is ultimately accountable because health legislation (Republic of South Africa, 2003) compels him to report meningococcal meningitis (a life threatening contagious disease) to

the local health authority. If his employer disapproves or attempts to withhold assent, the doctor remains legally compelled and is ethically justified to proceed with reporting the cases of meningitis to the authority. He will be justified to blow the whistle – not to go to the press but to the State Department of Health. A good doctor would attempt to mitigate bad publicity. However, allowing his employer to sway him towards non-reporting because it is allegedly in the company's best interest, and he owes them loyalty, would be unethical and illegal. More than that, if several more mineworkers attract lethal meningococcal meningitis due to non-reporting and lack of timely preventive action, it will haunt the doctor while management would likely maintain that the doctor was responsible for making the call. Under compelling circumstances, employees occupying professional positions involving ultimate accountability cannot shy away from justified whistle-blowing.

7.3 Loyalty: Specific situations in occupational medicine

As described in Chapter 3, the practice of occupational medicine comprises a spectrum of clinical, semi-clinical and advisory situations calling for the occupational physician's professional input. These generally relate to the health and fitness of individual employees and collective workforce health. However, the company doctor's involvement is by no means limited to the field of medicine. Holistic worker safety, employee well-being, sustainable productivity, job satisfaction, risk management and the support of strategic human resources management extend beyond healthcare. Apart from individual patient care, the doctor in industry should care about working conditions, workplace hygiene, worker rights, legal compliance and labour-related social values. Whereas the clinician in a hospital environment has a defined role on which to focus and excel at, the proficient occupational health doctor's field of influence extends far beyond the doctor–patient interface. Consequently, occupational physicians' conduct mirrors not only their bioethical views but also their broader societal ethical values.

The dedicated occupational medicine practitioner will almost certainly find that some practices or behaviour in the workplace clash with his moral beliefs and convictions. When such conduct extends to decisions with which the doctor cannot identify, while the employer enforces it, it gives rise to personal ethical conflict. A common example of such controversy is the employer that wishes for the doctor to reveal confidential medical information that creates the risk of unfair

discrimination. A host of scenarios in occupational medicine has their own unique medico-ethical implications and potential for considerable conflict of interest. When there are conflicting interests and a favourable outcome is crucial, stakeholders are prone to invoke alliance in an attempt to tip the scale in their favour. Having the doctor as an ally could secure pole position for your interests. In occupational medicine, when considering employee health, any suggestion that the occupational medicine practitioner owes it to the employer to unilaterally further, promote, support or expedite the employer's business interests raises a concern. Equally though, when patients in occupational health practice expect the doctor to give preference to their personal interests, it asks for partiality. Inordinate amity or familiarity in interactions with the doctor could indicate a patient's indirect attempt to induce loyalty. These relationships need to remain professional – especially in the situation where the occupational medicine practitioner's tenure extends over many years. Although a worker might have a long relationship with the workplace doctor, it ought to remain professional.

The context of doctor–patient interactions in occupational medicine is defining. It determines the doctor's role. As Plomp (1999:186) explained with his role differentiation model, the wide spectrum of expectations with which the occupational physician has to deal makes for a more complex professional environment. The three fundamental roles he ascribed to the occupational medicine practitioner is that of expert, counsellor and mediator. My contention is that without broad expertise the practitioner cannot fulfil the latter two roles with distinction. Skill and commitment to act as counsellor and mediator are vital because delivering an integrated occupational health service requires more than medical knowledge. To be an impartial advisor to both management and workers on issues as important as health and safety calls for dedication to neutrality, impartiality and practical wisdom. This can be adequately illustrated only by referring to specific practical situations in occupational medicine and considering how to address and resolve the inevitable conflict of interests.

7.3.1 Pre-employment medical assessment

The quality of their human resources is often what separates outstanding from average enterprises. Competent, committed employees are an asset while ill-equipped or indisposed workers are a liability to employers. Understandably then, progressive employers would go to great lengths to secure appropriately qualified and suitably skilled employees. The recruitment process, selection and job interviews with prospective employees aim to identify those individuals most likely to meet the employer's expectations. Beyond ability and skill, the latter is likely to include productivity, sound

character, work ethic and sustainable capacity to perform the job. Customarily employers verify qualifications and require that work experience be substantiated before appointing new employees. The employer might also ask for references from previous employers. Once suitable candidates for vacant positions have been identified, many employers, at least in industry, demand an assessment of candidates' health. This requirement relates to the employer's legal responsibility for employee health and safety. Where the proposed job involves significant exposure to potential occupational health and safety risks, medical assessment is not only justified, it is a legal requirement. Several occupational health and safety regulations prescribe medical assessment and statutory minimum standards of fitness. Among these are regulations related to potential exposure to hazardous chemicals, noise, infective agents, heights and mining dust.

Obviously, an employer cannot consider appointing someone to transport hazardous cargo on public roads who might not pass a statutory medical test to do so legally. Similarly, before appointing an industrial radiographer, who needs a license to handle radioactive isotopes, the prospective employer would demand a medical assessment. Such evaluation of the health of potential employees calls for the input of the responsible occupational medicine practitioner. A decision to advise against the appointment of a candidate has grave implications in that it potentially has the effect of denying an individual the job applied for. Clearly, such a recommendation needs to be warranted and well substantiated. Theoretically, evaluating doctors could maintain that their role is merely to record relevant findings and that they are not responsible for the ultimate decision whether to employ an individual or not. However, in practice, the result of the medical practitioner's assessment of a recruit is construed as either "fit for the proposed position" or "not recommended for the job". For doctors practising occupational medicine to distance or absolve themselves from the inevitable consequences of the assessments they perform in the recruitment process suggests an attempt to evade the very issue of occupational health ethics. The rights, responsibilities and stake of employers regularly conflict with the valid rights and interests of individuals vying for employment. The adept occupational medicine practitioner's role is to not only diagnose and record medical conditions or functional shortcomings when performing pre-employment medicals. That would result in a recruitment officer or human resource manager making the final decision to employ or not employ. Should that be the situation, it is likely to foil the main purpose of the pre-employment medical assessment – to base the decision on whether the candidate can currently (and for the foreseeable future) perform the designated tasks of a job effectively and without jeopardising anyone's health and safety. Rather, if an ailment or limited disability is detected at the time of the medical assessment,

the appointed doctor has the professional insight to evaluate if and to what extent it will impact work-related functional capacity.

Occupational medicine practice in the ambit of recruitment raises several practical and ultimately ethical issues. These ethical caveats are interrelated, but one needs to consider them separately, jointly and in context. Firstly, seeing that candidates for employment do not yet have an established relationship with the employer, their interests tend to be considered subordinate. While employees have well-known rights in terms of labour legislation, the common law rights of individuals, and even statutory rights (such as the right not to be discriminated against and the right to fair process), tend to be overlooked in the labour environment. Doctors in industry need to be aware that some labour legislation also applies to applicants for employment. Inappropriate medical testing is disallowed. Secondly, when applicants fail to make a short list or are unsuccessful because of the outcome of an interview, they probably have little redress. Employers generally inform applicants that if they hear nothing from the recruiting department, they must assume that their applications were unsuccessful – and that is the end of it. However, when a conditional offer of employment is withdrawn on the strength of a medical assessment, the applicant might well decide to challenge it or seek a second medical opinion.

In this author's opinion it creates a situation where the appointed medical practitioner cannot simply invoke the enterprise's employment policy as the reason for not approving appointment in a vacant position. The occupational medicine practitioner is accountable for and must be prepared to justify his verdict on medical fitness to perform a job. Over and above compliance with health and safety legislation, if it is truly a professional opinion, then that professional has to answer.

Thirdly, risk needs to be quantified. An example best illustrates this. Approving the employment of someone with a history of epileptic seizures to the job of driver or rigger would be unsound. In the case of an engineer being evaluated for a sedentary position, one would consider the frequency of attacks, compliance with medication and details of the anticipated scope of work and perform a risk assessment before providing a well-considered opinion. Simply applying, defending or condoning a blanket company policy prohibiting the appointment of anyone who reveals a family history of epilepsy (or another chronic illness) is ethically untenable. Employers might consider it their right to choose who they employ. However, when policy unfairly excludes from employment an applicant with a disability who can nevertheless perform the job applied for productively and safely, it is unacceptable discrimination and (in many jurisdictions) unlawful in terms of employment equity

legislation. The right of employers to select whom to employ and whom not to employ is not absolute. Collusion to unjustifiably exclude individuals from the labour force is unethical. A scenario where the employer unilaterally makes rules related to occupational health and the occupational physician is obliged to implement and apply such management decisions – irrespective whether it complies with ethical medicine guidelines, is often problematic. Risk related to a worker's health or disability that is either imaginary or insignificant, should not be a basis for denying employment.

Fourthly, risk-based medical assessment of prospective workers should not be debased to become merely a process to select workers that are more likely to tolerate harsh or unusually demanding occupational environments. High unemployment results in the abundant supply of especially semi-skilled labour. Under such conditions, crowds of people frequently apply for a limited number of positions. Given the free availability of labour and wishing to optimise productivity, major employers may resort to selection processes that aim to select candidates with above average endurance and physical ability.

A process called "functional assessment" became popular in South African mines. It entails exercising in a test environment and the simulation of physically demanding tasks while measuring cardiovascular response to assess the level of physical fitness and the individual's ability to sustain the performance of tiring work at a given pace. Body mass index, abdominal and hip circumference, etc. are also measured. Usually an occupational therapist would then draw up a report and recommend to the occupational medicine practitioner or the recruiting officer which candidates met the minimum standards set by the employer and who failed on any of the criteria. The author has experienced that approximately 90% of female candidates for apprenticeship as artisans or process controllers in a chemical manufacturing environment fail to meet the set standard for physical endurance.

In the fifth place, much of the criticism that one can level at the practice of pre-employment medical screening relates to the important question of whether it is predictive of long-term outcome. What employers want is for screening to deliver employees that over their career will be more productive, prove to work safer, take less sick leave and be less of a burden on the medical aid or pension fund. The expectation is that all of this is accomplished within the boundaries of labour legislation. Thuraisingham (2013:249) sums up the sentiment of some occupational medicine professionals when she remarks that making employment "conditional on a successful pre-employment medical examination [is] driven more by traditional practices rather than by evidence". These medical

assessments “were originally intended to reduce risks to the health and safety of workers in hazardous workplaces, as well as to prevent spread of communicable disease”. However, today, employers tend to turn it into “a screening process to select relatively ‘healthy’ workers in an attempt to minimize sickness absence and control costs” (Thuraisingham, 2013:250). Nevertheless, to most employers a medical examination of all additions to their workforce seems logical and their occupational medicine practitioners oblige.

While the occupational medicine fraternity is acutely aware of the ethical aspect of pre-employment medical examinations, business managers usually seem oblivious to its potential for posing an ethical dilemma. To grasp the ethical dimension of pre-employment medical screening practices, several aspects require clarification. The rights of applicants for employment must be clear. The doctor–patient relationship needs to be well characterised and transparent to avoid role confusion. While the autonomy of individuals in the role of patient is highly valued in the healthcare environment, the same does not apply to employees (or prospective employees) in the labour environment. The employer evidently has rights as well as obligations, of which much is statutory. Lastly, selection criteria must be relevant, assessment tools reliable, procedures fair and the verdict valid and verifiable.

7.3.2 Work-related injury management

Occupational safety ranks at the top of the responsibilities of employers towards their employees. This is especially true of those industries where workers perform hazardous or high-risk work, such as mining, chemical manufacturing, transport, forestry, civil construction, exploration, etc. In South Africa, annual claims for work-related fatalities, injuries and occupational diseases exceed R2 billion per annum. There is a lack of detailed statistics from the Compensation Commissioner, however. Internationally, statistics indicate around 6 300 fatalities per day and 860 000 injuries per day from accidents at work and occupational illnesses (Deacon, 2017). Undoubtedly, occupational injury is a huge problem in industry. Many would say it is because safety is compromised in the interest of productivity and profitability. Nevertheless, even distinguished enterprises have difficulty to prevent all accidents. The person who is injured or killed at work is almost invariably the breadwinner of a family or dependents whose livelihood depends on his earnings. Workmen’s compensation is a poor consolation.

Although occupational medicine is principally a preventive health discipline, its practitioners are, depending on the size, location and set-up of the workplace, often part of site emergency medical care. Apart from primary clinical care of the injured, the South African occupational medicine practitioner is usually responsible for the holistic case management of injured workers. This entails coordination of healthcare and managing absenteeism, restricted work, rehabilitation, redeployment, disability management and worker's compensation claim procedures. As many doctors in industry would attest, the most demanding aspect of injury-on-duty management is often not healthcare as such but negotiating and resolving the psychosocial equation that commonly results from injury at work. The uninitiated would find this hard to believe. However, consider that in many workplaces the team's safety record is incentivised. Consequently, when the team is denied their regular performance/safety bonus on account of an incident resulting in injury, the injured party is inevitably at best unpopular, often blamed and at worst ostracised. Add to this the real or imagined prospect of financial compensation, and the care of a simple injury that ought to heal without complications has the potential for objectivity and subjectivity to become distorted. Often injured workers attempt to downplay injuries that occurred on the job. They do not want to let down their team or fear job insecurity. On the other hand, some exaggerate their injury, claim to have lingering pain or are reluctant to resume work after the injury has apparently healed. Misconceptions about eligibility for compensation are sometimes responsible for peculiar behaviour in occupational health situations. The challenge is for occupational physicians, themselves part of the team, to transact the situation while establishing a decent doctor–patient relationship. At the same time there is the need to keep management informed without disregarding the injured worker's right to medical confidentiality.

As discussed in Chapter 8.2.1, the management of work-related injuries calls for the occupational physician to forge doctor–patient relationships resembling the time-honoured kind. Treating injuries demands a therapeutic relationship based on trust, justice, beneficence and respect for autonomy. If such relationships are to be true and authentic, it has to prevail over unwarranted interference by the employer or management. The worker needs to be comfortable with having his injuries treated by the employer's occupational physician or the occupational medicine practitioner appointed in terms of the Occupational Health and Safety Act. That will only be the case if the doctor is competent, visibly professionally independent and gives precedence to his patient's valid interests. With that goes the obligation to refer to or consult with a better qualified colleague or a specialist when appropriate. The right which patients generally have to a second opinion also applies to the management of work-related injuries. If the employer, the workmen's compensation authority or even the treating doctor in any way create barriers to affording injured workers referral or a second

opinion, it invites discontent. Especially in the case of more serious injuries and if the injured worker has an existing close relationship with his family doctor, it behoves the occupational physician to contact that doctor and afford the injured the opinion of his regular, trusted doctor.

One vexing barrier is that employers tend not to be keen that the injured worker's private doctor becomes involved. The belief (not always unfounded) is that the latter would be more liberal or lenient in certifying sick leave. Paid leave related to injuries at work is practically unlimited. As long as the injured worker presents certificates from a registered medical practitioner to that effect, he need not return to work. Not resuming at least restricted work on the first shift following the injury causes the incident to be recorded against the business's safety performance as a "lost workday injury". Another barrier is that the South African workmen's compensation system is fraught with bureaucratic delays of payment for healthcare expenses – to the extent that many doctors and specialists refuse to become involved in the treatment of injury-on-duty cases. Few doctors would agree to a consultation if no party accepts responsibility for their fees upfront. The combination of psychosocial issues, an often dysfunctional compensation apparatus, the employer-supervisor-worker hierarchy and the near-futile pursuit of injury-free production renders the management of injuries at work the Achilles heel of occupational medicine. In South African mines and industry, it is very much part of the job description of occupational physicians. The International Commission on Occupational Health (2014:9) rightly emphasises that "ethics in occupational health is by essence a field of interactions between many partners". An intrinsic feature of good occupational health is that it is inclusive rather than exclusive. Doctors practising medicine in the workplace cannot circumnavigate the numerous legitimate stakeholders. While they fulfil their roles, the doctor has to engage with the patient and vigilantly shield the doctor–patient relationship from improper intrusion and meddling – even if at times it means stepping on toes.

The management of injuries at work accentuates the ambiguity of healthcare delivery in the ambit of labour and how that environment complicates occupational medicine and its relationships. Chapter 8 highlights the uniqueness of the doctor–patient relationship in occupational medicine. That uniqueness is due to the inevitable involvement of stakeholders with legitimate vested interests in occupational health. Whereas management's interest in the general health of their employees revolves around empathy and approval of illness absenteeism, in the case of work-related injuries or illness, they are legally obliged to launch an in-depth investigation. A team is formed to enquire and analyse what happened, probing possible causes, calling witnesses and going all out to get to the root cause of the incident. Quite frequently, probably because various

parties attempt to absolve themselves from guilt, evidence conflicts and the employer resorts to polygraph testing to find the truth. As a key "witness" in the investigation, the occupational physician is expected to describe injuries or the nature of an illness in detail for the investigation team to determine (in spite of their lack of medical knowledge) if it corroborates with the evidence of witnesses.

The frequency of such incident investigations in a major industrial enterprise is such that secondary but notable relationships are forged with time. The doctor–patient relationship is seldom unburdened and free from interference by what is going on beyond the clinic. As employees themselves, occupational physicians have relationships with their medical colleagues, the nursing staff, safety managers, their own manager, labour union representatives, family practitioners, medical specialists and health and safety authorities – all valid role-players. Unlike what generally applies in healthcare – that all presumably have the best interest of the patient at heart – these role-players have disparate interests and motives. Logically, the latter include not being implicated in causing the incident, shifting blame, avoiding disciplinary action, preserving a section's good safety record, forfeiting a safety bonus and even retaining a lucrative contract. A serious life-threatening injury to a worker of a contractor has dire consequences for the contractor. Even in the case of less serious injuries, a contractor might lose a contract if the incident investigation afterwards reveals that the contractor's safety system was flawed or corners were being cut. A poor safety record can potentially disqualify a contracting firm from tendering for future work.

Always maintaining a clinical doctor–patient relationship under such circumstances, often with a degree of agency and fiduciary duty, is soberingly difficult. Imagine having built the trusting relationship required to manage a patient's slowly healing injuries and stress, to then to be confronted with allegations that your patient is a fraud, you are naïve to believe his lies and it is costing the team their good safety record. The reality is that production-oriented managers often tactlessly carry into the occupational health arena the same commanding demeanour which serves them well when confronting subordinates about poor performance or insubordination. While the doctor–patient relationship requires respect, trust and solace, management easily comes across as critical and offhanded. The medical staff's priority is decent care of the injured, but the supervisor and company safety officers immediately start gathering information and evidence. They need to compile a detailed incident report because management demands to know what happened, why and who was at fault. An incident investigation is mandatory, and an

investigating team is formed that will interrogate witnesses, supervisors and the injured worker. The occupational safety fraternity propound the theory that every safety incident was caused by a sequence of faults that need to be delved into in order to identify the root cause and determine what and who contributed to the incident. Often human behaviour is identified as the critical flaw and the injured worker is often the "culprit". The occupational physician is then faced with a patient recovering from an injury while being confronted with disciplinary action of which the outcome can easily be suspension or even dismissal. Dealing with such psychosocial stress adds trepidation to injury and sets a trap for the medical staff who need to stay clear of taking sides. This becomes awkward when the physician senses that either the employer is unfair to the injured employee or there is strong suspicion that the injured worker is manipulative.

Relationships are bound to be aligned with commitment to mutual goals. The norm for occupational physicians' relationship with patients, whether clinical, fiduciary or that of "independent doctor" are well documented in the literature (see Chapter 8.2.3). It is their relationships with the different role-players within management which are ambiguous. In spite of barriers and challenges, working relationships based on respect and cautious trust and underpinned by an understanding of what drives industry are essential to practise occupational medicine in a gruelling labour environment.

Large production facilities are generally austere, challenging places; a culture of "survival of the fittest" would not be misplaced in traditional mining. Production, productivity and competitiveness are the prime drivers. The environment in which most of the occupational physician's patients spend their work hours is far removed from the air-conditioned boardrooms or sparkling white clinic. An operator's contextual experience of an injury on duty differs from that of a manager and very much from that of the doctor. An operator might not even be aware of a small cut on his finger, only noticing the blood much later when removing his safety gloves. Should he not formally report an injury, he could face disciplinary action for non-reporting. If he reports it, he is likely to face a full-scale investigation into the incident to determine if unsafe behaviour, or even negligence, was the cause. What is to the medical staff a minor injury, requiring only first aid, is to the occupational safety fraternity an injury that should have been prevented – their slogan being "zero harm". Inevitably, the focus is not on healing the injury; it is on analysing how and why it occurred and what should have been done to prevent it. Hypothesising that all occupational injuries can be prevented means that direct and indirect

causes must be identified; otherwise the investigating team failed. The problem with that approach is that the injured individual is mostly in the line of fire.

For the occupational medical staff to trivialise less serious injuries or slight the safety manager's insistence on detailed investigations of minor incidents would be denigrating and harmful to the inter-disciplinary relationship. Like medicine has clinical protocols and methodology, safety professionals follow so-called best practice processes and techniques for incident investigation. To gain the respect of the whole spectrum of managers in business, occupational physicians must forge relationships with colleagues based on mutual respect and support. The physician who depends on the respect and trust of management to practise medicine well in the ambit of industry have to respect the knowledge, skill and accomplishments of the managers of industry. Physicians treat injuries but cannot prevent injuries down in the mine; mine management can. Their function in industry is even more critical than that of occupational physicians.

In reality, occupational safety requires a concerted effort from all stakeholders. The management of injuries cannot be more important than its prevention. Occupational physicians establish a doctor–patient relationship to treat and rehabilitate an injured worker. But to contribute to the prevention of injuries at work they need to successfully build relationships with all levels of management across the spectrum – a feat that is much more challenging than patient work.

7.3.3 Medical surveillance

The South African legislator defines medical surveillance as a planned programme of examinations (inclusive of clinical examinations, biological monitoring and medical tests) of employees by an occupational health practitioner or, where prescribed, by an occupational medicine practitioner (Republic of South Africa, 1993a). The idea is that all workers who are potentially exposed to significant health or safety hazards in their workplace ought to be monitored by suitably registered healthcare workers appointed for that purpose, to determine their ability to continue performing the work without undue risk of suffering work-related injury or developing occupational illness. In his glossary of available strategies, Gochfeld (1992:76) defines medical surveillance as "the longitudinal evaluation of potentially exposed people for early detection of biochemical or pathophysiological changes indicative of significant exposure, performed by occupational health professionals on individual workers or groups". The author distinguishes between surveillance and screening by pointing out that the latter rather refers to

"a cross-sectional evaluation of a population" (Gochfeld, 1992:68) – often once-off. Medical surveillance implies the periodic examination of individuals on a recurrent basis in order to allow for the longitudinal comparison of data over time. In other words, it is about keeping diligent watch over persons where there is suspicion of potential health hazards. The goal is the prevention of harm through the timely detection of and reduction of exposure to potential occupational health risks.

Furthermore, the aim is also "the protection of persons other than persons at work against hazards to health and safety arising out of or in connection with the activities of persons at work" (Republic of South Africa, 1993a). In other words, the safety of co-workers, clients, the community and the general public must not be jeopardised by allowing medically unfit persons to perform specific tasks – such as driving and operating machinery. To this end, certain identified occupations are subject to mandatory medical surveillance. Occupational Health and Safety Act regulations (Republic of South Africa, 1993a) stipulate health precautions related to occupational exposure to noise, lead, hazardous chemicals, ionising radiation and asbestos. Similarly, the Mine Health and Safety Act (Republic of South Africa, 1996a) mandates preventive occupational health in that industry – inclusive of annual medical surveillance of all workers in mines and controlled works. The latter relates to ore handling, tunnelling, quarries, etc. In the South African mining environment, miners still refer to their fitness certificate as a "red ticket" – after the colour of the card they were long issued with.

Specific statutory periodic medical assessments are also found in the aviation and road traffic environments. Aircraft pilots and professional drivers routinely have the safety of their crew, passengers and the public in their hands and any functional impairment poses a risk. Logically, the probability that something can go wrong and the potential impact of error or misjudgement determines how intensive/extensive the health assessment ought to be. The potential consequences of an unexpected bout of dizziness in a warehouse forklift driver, the driver of a long-distance road tanker and a Boeing pilot on take-off differ greatly. Medical surveillance should thus be customised not only to address the potential hazards but also to reflect the magnitude of the risk. Flight medical certification is withheld when there is any doubt at all about things such as the potential side-effects of medication. Aviation authorities are prescriptive and adherence to rigid standards are enforced. In factories and mines, where the risk does not generally extend to the public, appointed occupational medicine practitioners have more leeway to apply their professional discretion.

Good occupational health practice requires that medical surveillance should be risk based. That implies that the medical examination and any medical testing must be relevant to the specific risks and aimed at evaluating the possible effect of the workplace hazards on the individual worker or the collective workforce. For example, medical surveillance of a fireman, a painter and a crane driver differs. One would want to know if the painter is exposed to lead-containing paint or the various organic solvents used to manufacture and/or dilute paint. Are effective dust masks used when old paint is removed? Are suitable gloves supplied when solvents are handled? A blood test can periodically be performed to measure and monitor blood lead concentrations and detect the deviations associated with early or imminent lead poisoning. Similarly, blood tests for liver function can monitor if solvents that pose a health hazard are being inhaled or absorbed through the skin. Benzene is carcinogenic. It has the potential to cause a type of leukaemia. Periodic urine testing is indicated to monitor benzene exposure and systemic absorption. Diabetes or hypertension might render a firefighter medically unfit for his job, but not the painter. Firefighting is a physically demanding occupation where extreme conditions often occur. Naturally its practitioners have to be subjected to periodic fitness and health evaluation. The same applies to mine rescue workers; the bar would be set high to preclude as far as possible situations where a rescuer needs to be rescued by his mates. On account of the heights a crane driver works at, his neurological and cardiovascular health status would be pertinent.

Occupational hygienists are trained to perform health risk assessments, identify and quantify occupational hazards and advise on appropriate mitigating interventions. They are indispensable to supply the environmental measurement data occupational physicians need to in turn plan and direct medical surveillance effectively. Medical surveillance is an integral and essential component of occupational health and safety; it periodically ensures that every worker has the functional capacity to perform his job effectively and without undue health and safety risks – neither to the individual worker and other workers, nor to the user of products or the public. Especially in inherently risky occupational settings, medical surveillance of workers has indisputable utility. However, mandatory health assessment in the labour environment undeniably stands to compromise employee confidentiality. It is critical to health and safety in the labour environment but riddled with ethical contention. Among the issues that render occupational medical surveillance ethically awkward, loyalty features prominently. It pervades every aspect of occupational medicine, adding to the peculiar entanglement that stems from delivering healthcare in the workplace and creating a constrained situation.

Underlying the latter is the inescapable reality that employers and employees have different, often opposite, interests when it comes to the assessment of fitness to work and employability. What is at stake for employers is a healthy, reliable and productive workforce. In order to flourish and compete successfully, the quality of their human resources is a critical success factor. Furthermore, occupational safety in industry is imperative. The pragmatic route towards a top-calibre workforce is selective recruiting the fit and healthy and seeding out employees who no longer meet the set standard. Periodic health surveillance provides the tool to regularly (and legally) evaluate fitness for the job and identify those whose health is faltering. For workers who no longer meet the benchmark, there usually is a formal company medical incapacity procedure to be followed, which might well lead to termination of employment. Excessive sick leave can also trigger such proceedings, because regular absenteeism is indicative of illness incapacity.

Clearly, for individual workers subject to mandatory medical surveillance at work, there are similarly much at stake. The implications of failing to meet the fitness standard set by their employer are dire. For the employer, who may have a workforce of a couple of thousand, learning that one or two per cent of its employees no longer meet the required fitness standard poses a management challenge. For affected employees, on the other hand, facing medical incapacity interventions immediately impacts their work security. Being declared unfit for work is catastrophic for most workers. Their very livelihood and ability to support their families depend on gainful employment. For occupational health physicians, having to manage the entanglement between medicine and labour/employment creates the constrained situation which is unique to their profession. An individual's health data is intrinsically private and confidential, while labour hinges on contractual agreement, the capacity for work and candour.

The very role of occupational medicine is to orchestrate the interface between labour and health; to reconcile respect for the individual and medical confidentiality with reasonable productivity. If this is not achieved, conflict between management's stake (production yield and cost) and the interest of the worker (privacy and tenure) escalates and can become untenable. The employer remunerates employees for their labour. When the ability to perform that labour is compromised by ill health or incapacity, employees might fail to meet their responsibilities in terms of the labour contract. Inevitably, in interpreting and advising on the outcome of medical surveillance and adopting what can be seen as a mediating role, the question of where the doctor's loyalty lies will at times arise. What degree of occupational impairment ought to be reasonably easy to

accommodate without undue hardship for the employer, and at what stage it becomes untenable, is open to interpretation. Whenever the incapacity is neither trivial nor extensive, it calls for the occupational physician to apply his professional discretion. With both employer and employee at times arguing convincingly in favour of their preferred outcome, either party can suspect that presumed loyalty to the other party is colouring the doctor's position.

Conventional thought dictates that medical surveillance is there for the benefit of workers and their protection from occupational hazards. The aim of occupational health and safety is after all noble. Workers ought to be protected from hazards that cannot be removed or neutralised. Traditionally, health monitoring entailed, for instance, regularly performing blood or urine tests on workers occupationally exposed to hazardous substances such as lead, mercury and benzene. Individuals with blood levels raised beyond certain biological thresholds would be removed from exposure until their test results had returned to acceptable levels. It was simplistic, and raised test results could usually be traced back to high exposure levels or non-compliance with preventive measures such as personal protective equipment.

Over time, occupational health surveillance developed to include an evaluation of general health and occupational fitness. Currently it would almost always routinely include things such as body mass index, blood pressure, lung function, cholesterol levels and blood sugar. In addition to a clinical medical examination, a health questionnaire is invariably included to record existing medical conditions or risk factors. Employers now have a legal obligation to have the health of their employees monitored if they are exposed to any potential health and safety risks at work. The right to be informed on the fitness of employees automatically follows – although it does not extend to knowing all the details or inappropriate access to confidential information.

In dealing with the outcomes of medical surveillance, the resourceful occupational physician would avoid appeasement of either employer or employee. Allowing loyalty towards any party to influence decisions has to be avoided in favour of objective contemplation of the case specifics. But just as loyalty does not stem from resolve, disregarding loyalty requires resolution. Is it even possible to negate the influence loyalty is prone to have on complex decision-making where there is unlikely to be only a right and a wrong?

Chapter 8: The doctor–patient relationship

To attend those who suffer, a physician must possess not only the scientific knowledge and technical abilities, but also an understanding of human nature. The patient is not only a group of symptoms, damaged organs and altered emotions. The patient is a human being, at the same time worried and hopeful, who is searching for relief, help and trust. The importance of an intimate relationship between patient and physician can never be overstated because in most cases an accurate diagnosis, as well as an effective treatment, relies directly on the quality of this relationship. (Hellín, 2002:452)

8.1 The traditional doctor–patient relationship

Traditionally, the ethical criteria of beneficence and '*primum non nocere*' were central to the doctor–patient relationship (Kaba & Sooriakumaran, 2007). Doctors, with their expert clinical and anatomical knowledge, examined the sick, formulated the diagnosis and prescribed to the patient the appropriate treatment. The physician's role involved deciding what would be in the best interest of patients and then acting in their best interest. A 'good' patient would submissively follow the doctor's instructions. The focus was less on symptoms and the patient's experience of illness and more on accurate diagnosis of pathological lesions and processes – the biomedical model. It resulted in an active–passive relationship, characterised by paternalism.

In the latter half of the twentieth century, doctors' paternalistic style of interaction with patients progressively came under scrutiny. Among the four bioethical principles popularised by Beauchamp and Childress (2009) around the 1970s, respect for autonomy of patients stood out and introduced a (then almost novel) approach to the doctor–patient relationship. It focused on confidentiality, informed and voluntary consent, and the individual's right to hold views, make choices and act in accordance with personal values; even if it is not the best option in the eyes of the treating doctor. It heralded the era of patient-centred medicine where the therapeutic model involves listening to the patient at great length and developing a genuine communicative relationship (Kaba & Sooriakumaran, 2007). Patient-centred medicine involves a biopsychosocial perspective which implies a willingness to become involved in the difficulties patients bring to their doctors rather than just the biomedical aspect of it. There has been a shift away from the 'guidance–cooperation' relationship model to a 'mutual participation' model, in

which both power and responsibility are shared with the patient. The former model leans towards paternalism; the notion that the doctor invariably knows what is best for the patient, and patients should therefore submit, obey and follow instructions. Mutual participation means that doctor and patient, by listening attentively to each other's viewpoints and sentiments, reach an agreement on what therapeutic approach would be most appropriate for this individual under these circumstances. Patients are then not coerced (or even casually bullied) into accepting a course of treatment that they soon resent.

A practical example best illustrates the different approaches. Numerous medical conditions can be managed satisfactorily with what is termed a conservative approach. For example, by losing weight, adhering to dietary advice and with the interim use of acid reducers, heartburn caused by occasional gastroesophageal reflux and hiatus hernia can be relieved and even eliminated. It can also be cured by surgery, but there are risks – of which recurrence is one. However, if the doctor says you need an operation, many patients would submit to being booked for an operation – the technicalities of which they understand little. In practice, whether the conservative (non-surgical) approach or surgery is proposed and accepted by the patient would often depend on whether a surgeon or a gastroenterologist (internist) was consulted. By the very nature of their profession, surgeons prefer a surgical approach to disorders amenable to surgical correction. Physicians trained in the non-surgical disciplines of medicine are logically more prone to resort to medical solutions and refer a patient to a surgeon only if those fail. Where the "guidance–cooperation" doctor–patient relationship model applies, patients would in all likelihood submit to surgery in spite of their unspoken reservations, telling friends and family "the doctor says he has to operate". Possibly the patient did not have the nerve to tell the doctor that is not what she wants – anticipating subtle or visible indignation at the lack of trust in his judgement and his advice being rejected. The situation where patients easily accept whatever their doctor proposes because "he knows what is best" is exactly the paternalistic approach in the doctor–patient relationship that has come under scrutiny. The atmosphere in the consultation ought to encourage patient autonomy. It entails the patient's real participation in deciding on the therapy of choice after considering all the information provided by the doctor, the relevant pros and cons and the patient's preferences.

This simple example shows how crucial the undertone of doctor–patient interaction is to healthcare where respect for patient autonomy is one of the ethical principles. It impacts the very nature of the clinical relationship. Bending (2015) analysed whether a contractual model or

fiduciary model best typifies the prevailing doctor–patient relationship in Australia. A contractual model presents the therapeutic interaction between doctor and patient as grounded in a private contract for the supply of professional services. It views the relationship as the commercially negotiated interaction of equals. On the other hand, the fiduciary model implies that the doctor is entrusted with power and property to be used for the benefit of another and legally held to the highest standard of conduct. Bending (2015) rejects both models. The contractual model does not acknowledge the power imbalance between the parties and the patient's vulnerability; although it promotes patient autonomy and informed decision-making. Most importantly, such a model "fails to encapsulate the essence of the therapeutic exchange and expectations of patients. It does not reflect the obligations of fidelity and veracity owed by physicians to their patients" (Bending, 2015:190). The fiduciary model perpetuates a fundamentally paternalistic paradigm; it reinforces the ascendency of physicians, mandating their power of discretion and entitling them to act on behalf or in the interest of their patients.

There is something unique about the nature of a sound clinical relationship that transcends commercialism, as well as only the clinician accepting the responsibility to treat someone's illness and restore holistic wellness. Fidelity distinguishes the practice of medicine from business practices and marketplace relationships (Beauchamp & Childress, 2009). So do the virtues of trustworthiness and reciprocal trust. If the patient has little trust in the doctor, it very likely would hinder healing. The patient would either be disinclined to relate to the doctor her full symptomatology, emotions and circumstances, or she would accept therapy half-heartedly. A precondition to patients' trust is that physicians instil it – both by being trustworthy and through the medical profession's reputation for professionalism. The ideal might be that a patient trusts a doctor merely because he is a doctor. That is probably often the case, unless that trust is violated. Trust is fragile, can imperceptibly be destroyed and is difficult to restore once lost. Whereas businessmen generally have to work hard at gaining the trust of their clients, doctors customarily enjoy their patient's trust and only have to guard against losing it. Trust is an essential and moral feature of the doctor–patient relationship. It is a remarkable relationship "for its centrality during life-altering and meaningful times in persons' lives, times of birth, death, severe illness and healing. Thus, providing health care, and being a doctor, is a moral enterprise" (Goold & Lipkin, 1999:S27).

8.2 The doctor–patient relationship in occupational medicine

Could it be that the cherished, even idolised, bond between trusting patient and dependable doctor is compromised, even altogether absent, in the occupational health arena? Given that the doctor–patient relationship is at the heart of orthodox medicine, would that not make occupational health a heartless outfit? It might be the elephant in occupational medicine's room. Where there is a lack of trust, the conventional doctor–patient relationship is likely to be defunct and cannot be successfully faked. The occupational health physician is hardly ever a worker's doctor of choice. The principal aim of occupational medicine is very often the promotion of occupational health and safety, not the personal interest of the patient. Clearly, the working doctor–patient relationship in occupational medicine differs from that which is prevalent in the clinical set-up.

Much of the literature in the field of occupational health ethics, when considering the doctor–patient interaction, poses the question "Does a physician–patient relationship, in essence an expressed or implied contract, exist?" Rischitelli (1995:584) maintains that, in many circumstances, the existence of such a contract may not have been established in an ordinary or legal sense. Similarly, Tamin (2013)) points out that the relationship between occupational physician and worker is generally characterised by less trust, the power imbalance is less marked and fiduciary obligations do not apply. The quality and nature of the relationship would depend on the situational context and role in which an occupational physician finds herself. Ethical and legal duties vary according to the purpose of the patient contact. Clearly, in many situations, health and safety legislation, a myriad of regulations and collective interest take precedence over privacy and an individual patient's wishes. With several legitimate stakeholders in the occupational health arena, interests are likely to be disparate and even conflicting.

The individual patient's perception is important: does he or she consider that in occupational health a traditional doctor–patient relationship exists? Cognisance must be taken of the patient's expectation – which ought to be judged by the standard of reasonableness. In occupational medicine, similarly to insurance medicine, the context of the "patient" being examined for the sole benefit of the employer (like the insurer) is common (Rischitelli, 1995). This situation is typical of the pre-employment examination of candidates. But it does not absolve the physician from the general obligation towards reasonable care and showing respect. It qualifies the confidentiality privilege to allow disclosure to the extent reasonably necessary to protect some sufficiently substantial other interest. The latter interest is commonly the only reason for the

intervention in the first place – such as to determine whether a miner meets the fitness standards set out in a Code of Good Practice approved in terms of the Mine Health and Safety Act (Republic of South Africa, 1996a) to work in a certified risk area in a specific mine. The doctor–patient relationship merely extends to clearing a legal hurdle in the client's employment process. In fact, the candidate for employment would hardly fit the definition of "patient". The yardstick of reasonable necessity applies – reckless, unnecessary disclosure is always ethically untenable.

Plomp (1999) proposed a useful role differentiation model to explain the great variability of doctor–patient encounters in occupational medicine. He relates this variability to the more complex professional role of the occupational physician – implying varied expectations and demanding a greater behavioural repertoire from the doctor. Plomp differentiates three principle roles: that of the expert, the counsellor and the mediator. These roles are derived from the purpose of the encounter and what patients would reasonably expect of each type of "consultation". In describing the situation of occupational physicians in the United Kingdom, Tamin (2013) better clarifies the roles medical doctors in the workplace have to adopt.

8.2.1 The "quasi-therapeutic" role

This role comprises the more traditional clinical patient contact for an injury, ailment, clinical intervention or treatment. Unlike in the United Kingdom, occupational health clinics in South Africa, especially those in the mining environment and major manufacturing enterprises, provide varying degrees of clinical healthcare and treatment. Much of that relates to the management of injuries, but in many on-site occupational health clinics the resident nurses and doctors would treat workers who fall ill at work or are recovering from injuries. The clinical role is the traditional situation with which doctors are comfortable and in which they often excel and earn the respect and trust of their patients. The expectations of the patient are that confidence in technical skill will be instilled, "bedside manners" will be acceptable, a reasonable amount of information will be imparted, questions will be answered and effective treatment will be provided. A caring demeanour evokes satisfaction and trust – even more so if the medicine works. Although a free choice of doctor is unlikely in the occupational health setting, these encounters are usually at the patient/worker's initiative and he realises that it is to his benefit. Also, apart from knowledge of the attendance, possibly concise temporary work restrictions and perhaps a sick leave certificate, no specific health-related information is imparted to

management. The odd phone call from a supervisor asking "What was wrong?" is easily met with a non-specific reassurance.

This role allows the occupational physician to establish the time-honoured version of the doctor–patient relationship – forged through professionalism and trust; even if it is not a long-term association. By at least sometimes adopting the classic therapeutic role, the physician whose focus has to be workforce health and safety has the opportunity to display uncompromised commitment to patient care. Unless workers and management occasionally experience the occupational physician not as a health manager but as a good doctor, the respect without which nobody can effectively practise medicine will be eroded. In her article discussing the role of occupational health professionals, Rodham (1998) asks the question "manager or medic"? She concludes that they are often neither but rather a combination of the two. The doctor adopts the role of "medic with managerial skills" or "manager with medical skills" (Rodham, 1998:83). In deciding which role is more appropriate, one pertinent factor would be that the employer probably employs numerous managers and only one or a couple of occupational physicians. Evidently, occupational physicians are appointed on account of their registration as medical practitioners and their healthcare skills rather than for their managerial acumen. When occupational physicians have to (or choose to) completely relinquish their therapeutic role, they are in effect no longer physicians – at least in the eyes of the workforce. They are health and safety professionals and managers. Definitions of "physician" generally refer to practising medicine, diagnosing, treating and restoring health.

8.2.2 The "independent expert" role

Occupational physicians are often required to assess and advise in matters such as eligibility for employee benefits, applications for ill health retirement, insurance claims, medical aid issues and the drafting of related policies. Whether it relates to a specific worker, to certain categories of employees or to human resources and safety policies in general, management consults the doctor and relies on his expertise and knowledge base. The role calls for honesty, trustworthiness, objectivity and impartiality. Unlike a lawyer presenting a client's case in court, the occupational physician's approach needs to be unbiased (Tamin, 2013). Counsel and judgement must be unequivocal and impartial. The doctor does not represent the "patient". Nor does he have a duty to promote the patient's interest. On the contrary, he is obliged to be objective, neutral and

disinterested (inasmuch as he has no personal involvement, receives no personal advantage and is thus free to act fairly).

An important responsibility of the company doctor is to evaluate medical reports and documents sourced from the worker's healthcare providers, looking for subtle partiality and seeking to corroborate diagnoses and opinions. Personal medical practitioners are expected to promote their patient's best interest and it is likely to be the patient's wish to either be medically boarded or to return to work. One can argue that one's personal doctor ought to support one's application for benefits – whether it is eligibility for early retirement benefits or to keep on working in order to earn a livelihood. While recommendations by private doctors carry due weight, the trustees of a retirement fund cannot rely solely on them. Their fiduciary duty is to validate information in order to grant benefits only where it is valid and appropriate. Because occupational physicians are au fait with the worker's occupational environment and the job specifications, they are in a favourable position to objectively assess capacity for work and employability.

As for the relationship between doctor and "patient" in this model, it would at best be one at arm's length. Often there might be no direct contact at all. The occupational physician merely reviews the evidence collated in support of an application for disability boarding. The level of trust required in the relationship is limited to reliance on the doctor being appropriately trained, qualified and experienced to do the assessment called for. Such trust bears little resemblance to that which prompts a patient to practically entrust his long-time family doctor with his health and life. In addition, in order to provide independent advice, the fiduciary principle implicated in the traditional doctor–patient relationship is incompatible with the occupational physician's role as independent expert. There can be no suggestion of duty or undivided loyalty when independence is the crux of the matter. With the doctor in this role, an authentic doctor–patient relationship is not established.

8.2.3 The "impartial doctor" role

Plomp (1999) refers to this role as that of a mediator. Aptitude, skill and finesse in informal mediation are probably what differentiate a great occupational medicine practitioner from a good one. How the doctor positions himself in situations in which he transacts with the employer to advocate a worker's case – or vice versa, to serve the company's interests in regard to workers – is a cardinal factor in workers' evaluation of the encounter. What is relevant in the occupational

medicine practitioner's role as mediator is his ability to influence management, perceived independence, devotion to fairness and his moderated dedication to workers' valid interests. Managing work-related impairment and implementing work restrictions, reasonable accommodation, return-to-work decisions and redeployment fall into the ambit of consultations calling for the role of mediator. A well-established, sound professional reputation, projecting contextual wisdom and having a holistic approach afford the occupational medicine practitioner the trust of both employer and employee – vital to the effective facilitation of interventions. Obviously, a working knowledge of labour law related to minimum conditions of employment, employment equity, labour relations and occupational health and safety law is indispensable. It allows the medical practitioner to mediate with confidence and command respect in management circles**.**

Doctor–patient encounters in occupational health requiring supportive intervention also call for the role of counsellor. Counselling relates to dealing with more complex impairment, requests for advice, or the need for reassurance, support or health-related information. Uncertainty, apprehension and a measure of anxiety are often present, hence the need for circumspection. If anxiety goes unnoticed or is not addressed, the "patient" is likely to evaluate the contact negatively. Plomp (1999) warns that the doctor's affective behaviour is essential for a satisfying encounter with the worker – the quality of the interaction being characterised by verbal and non-verbal empathy. A good example of these encounters, calling for counselling on realistic expectations and the weighing of options, is that of the artisan who injured his back on duty a decade ago, has been accommodated in a maintenance planning capacity and recently heard rumours that the company is contemplating the outsourcing of some non-production activities. Intrinsic to occupational medicine is the reality that the worker/patient often feels vulnerable (Plomp & Ballast, 2010), frequently related to work insecurity or past experience of intimidation and coercion.

The greater the vulnerability factor, the greater the need for trust in the occupational health fraternity. When employees' livelihood is at stake and their options are limited, they will go to almost any length to convince the occupational physician that they can cope with whatever necessary to secure their jobs. Blaming a worker for perhaps obtusely arguing and acting in his own interest could cause an occupational medicine practitioner to experience a degree of aversion – almost to the point of thinking "just listen to me and don't be so obstinate". Understanding

one's own emotions and focusing on respect for autonomy prevents one from moving beyond the point of justified irritation.

Company doctors, who regularly have to make a call on occupational safety risks after considering the potential scenarios, occasionally experience that, after a decision was made, an accident happens that might have been prevented by an ultra-conservative approach. Would it be seen as professional negligence, an error of judgement or a sound, well-considered decision followed by an unfortunate occurrence that could not reasonably have been foreseen? The other side of the coin is workers being restricted from following their occupation or earning a livelihood that are never involved in incidents which they were thought to have been at risk of. Is that not also wrong? The point is that the occupational physician is not clairvoyant and right or wrong ought not to be subject to retrospective judgement. Consequently, the occupational medicine practitioner who has an exaggerated sense of protecting his own interests by over-zealously restricting workers from performing work when there is a remote risk of injury to the individual is overstepping his function. No one can guarantee that the driver declared medically fit today on good grounds will not be involved in an accident tomorrow. Mediation in such situations means that occupational physicians resort to their knowledge base and rational reasoning to address misperceptions, allay fears, seek common ground and reach consensus.

Chapter 9: A virtue ethics approach to occupational medicine

Misselbrook (2015:226) writes: “We have become used to guidelines telling us what to do and documents telling us how doctors must behave”, and then concludes: “We cannot operate in the real world by an increasingly complex series if rules. The real world demands professional judgement. So perhaps, instead of asking what we should do we should be asking what sort of people we should be”. What the author hints at is the concept of virtue ethics; also sometimes referred to as “character ethics”. The idea is that the focus is primarily on the virtuous character traits of people rather than on their acts in specific circumstances, its potential consequences and if they followed general moral rules. An act is then not seen as morally sound because it was the good\right thing to do according to some moral code or because it would presumably have a good outcome for the majority, but on account of the virtuous character of the person acting.

Virtue based ethics is the oldest and most durable system of ethics in both Western and Eastern cultures (Pellegrino, 2002:380). It was the dominant theory of ethics until the Enlightenment and is closely associated with the ancient Greek philosophers – especially Aristotle. “The cardinal virtues expounded by ancient Greek philosophers are courage, prudence, temperance and justice” (Gardiner, 2003:298). In *Nicomachean Ethics* Aristotle (2004) contemplates what traits of character shape a good man that will flourish and distinguish two kinds of virtue – those of intellect and those of character. The former “owes its origin and development mainly to teaching, for which reason its attainment requires experience and time” (Aristotle, 2004:1103a-3b). Virtues of character is a result of conditioning. “ So virtues arise in us neither by nature nor contrary to nature, but nature gives us the capacity to acquire them, and completion comes through habituation” (Aristotle, 2004:1103a-3b). In discussing virtue of character, Aristotle repeatedly refers to the desired disposition being the mean between excess and deficiency. Furthermore he allows for context and appropriateness. “But to have them at the right time, about the right things, towards the right people, for the right end , and in the right way, is the mean and best; and this is the business of virtue” (Aristotle, 2004:1106b-7a). Pertinence is emphasised. “Agents must always look at what is appropriate in each case as it happens, as do doctors and navigators” (Aristotle, 2004:1104a-4b).

Instead of focusing on desirable traits of character – virtues – to define the good person, modern philosophers came to rather ask what a good person should do (Rachels & Rachels, 2010). After

all, actions and conduct seem more pertinent than inclination and sentiments. It sparked moral theories such as utilitarianism, Kant's deontological philosophy and the social contract idea. But in the end these moral theories all had deficiencies. Utilitarianism fails mainly on the count of justice, human rights and often not being able to predict consequences. Deontology, or "rule morality", can be faulted on account of inflexibility and the issue of how to resolve conflicting rules. It caused MacIntyre (1981) to conclude that since the Enlightenment our moral culture had become characterized by arbitrariness; there are just too many rival moral alternatives. "We possess indeed simulacra of morality, we continue to use many of the key expressions. But we have – very largely, if not entirely – lost our comprehension, both theoretical and practical, of morality" (MacIntyre, 1981:2). MacIntyre called for virtue to once again be established as the fulcrum of the moral life. Two decades earlier, Anscombe (1958) raised similar critique of the moral theories of modernity and their proponents. "The second [thesis] is that the concepts of obligation, and duty – *moral* obligation and *moral* duty, that is to say – and of what is *morally* right and wrong, and of the *moral* sense of 'ought', ought to be jettisoned if this is psychologically possible; because they are survivals, or derivatives from survivals, from an earlier conception of ethics which no longer survives, and are only harmful without it" (Anscombe, 1958:1). She in effect discounts "the best-known writers on ethics in modern times" as appearing to have "faults as thinkers" and charge Bentham and Mill with not noticing the "difficulty with the concept of 'pleasure'" (Anscombe, 1958:2).

"Traditionally the physician's role is interwoven with moral responsibilities and obligations towards the patient" (Gelhaus, 2012:103). But rules of conduct, guidelines on respectable behaviour and ethical principles that tell us what actions to take do not take into account the nature of the of the moral agent. Gardiner (2003:297) does not "consider it wise to strip this process [making moral decisions] of affect or attitude and focus on reason alone". Pellegrino (2012:24) best conveys the need for virtue ethics in medicine.

> Ultimately, each patient, and society as a whole, depends on the physician's formation of a good character, i.e., on the acquisition of the virtues that make for a good physician. What is crucial is the kind of person one actually is, not the kind of person one thinks will allow one to 'fit' with some ethical theory. After all, the physician is the person who interprets the ethical theory he or she espouses. Any ethical theory is shaped by the mind through which it passes. In its interpretation and application any theory can be converted

> from benevolence to malevolence. That is why virtue is an unavoidable element of any system of medical ethics.

Gardiner (2003:297) argues that virtue ethics adds a unique and essential dimension to ethical considerations and relates how, on studying ethics under Prof Gillon, she experienced that "virtue ethics resonates with my experience of life". As a medical practitioner she considers the "nature of our character" of fundamental importance. The author then lists five advantages she believes virtue ethics has over the popular four principles of bioethics. Virtue ethics recognises that emotions are an integral and important part of our moral perception. It also considers that the motivation of the agent is of crucial importance; decisions are anchored in the characteristic virtuous disposition of the moral agent. Thirdly, because virtue ethics does not involve rigid rules to be obeyed, it allows for adapting options to the particulars of a situation and the people involved. Flexibility encourages the pursuit of creative solutions to tragic dilemmas. Lastly, virtue ethicists recognise that adversity can rarely be resolved to everybody's complete satisfaction or without leaving some remaining pain and regret (Gardiner, 2003).

Conversely, much of the value of virtue ethics resides in its supplementation of other accounts of ethics such as principle- or duty-based ethics. One needs to "embrace the virtues without eliminating or disparaging these other ethical concepts" (Jansen, 2000:263). Without the latter, virtue ethics would be nebulous and the outcome of ethical deliberation open-ended. "Virtue theory presupposes that one cannot simply assume those qualities for the occasion, the way one might don a white coat, One must devote a good deal of effort over time to mastering and internalizing those patterns of behaviour, and in making one's thoughts and attitudes internally congruent with outwardly observable behaviors" (McCammon & Brody, 2012:258). In different words, this echoes what Aristotle professed about the virtues of intellect (Aristotle, 2004:1103a-3b). Much has been written about the virtuous physician and medical professionalism (also see chapter 5.2). Virtue ethics has an indelible place in the ethical practice of medicine.

Were one to accept, and it seems unavoidable, that practising medicine in the field of occupational health and safety by its very nature involves ethical contention, then the discipline's professionals have to identify and pursue the most promising route towards a remedy. No panacea seems even remotely possible but, at least in the long term, mitigating interventions should bear fruit in the form of enhanced trust in the professionalism and collective moral identity of the profession. For this to realise, the ethical milieu of occupational medicine first has to be

well-defined and then its guiding principles need to be communicated to and understood by all stakeholders in the domain of occupational health and safety. In other words, there is a place for a code of ethics. However, its value lies more in informing stakeholders on what to expect and what not to expect from their occupational physician than in telling the physician how to handle each case with ethical responsibility. For the latter, no document will suffice and there is no salve. It calls for a more comprehensive moral armamentarium which, I will argue, encompasses what Szasz (1977) terms the moral physician and Pellegrino (2002) the good physician. Gardiner (2003) also advances a virtue ethics approach to moral dilemmas in medicine. "Virtue ethics is a framework that focuses on the character of the moral agent rather than the rightness of an action" (Gardiner, 2003:297).

9.1 The need for virtuous occupational physicians

Although codes of ethics for occupational medicine (refer to chapter 3.5) provide valuable guidance to the discipline's practitioners, such codes are of limited value when it comes to decision-making in cases of moral conflict. Nevertheless, codes of conduct are easily accessible and provide a practical point of departure to explore the foundation of, rationale behind and moral underpinning of occupational medicine ethics. The Australasian Faculty of Occupational Medicine (1998) opens their guideline on ethics with the following general principle:

> In many ways the ethics of occupational medical practice are exactly the same as those for doctors in other forms of practice, but doctors working in occupational health may face some additional ethical issues that are uncommon in other situations. Often these relate to potential conflicts because of the involvement of third parties. At different times occupational physicians have responsibilities to individual patients under their care, workers in a particular workplace, employers and the general public – as well as specific responsibilities under legislation. Responsibilities to these parties may conflict. Problems are most likely to arise if potential conflicts are not recognised; particularly if one party is not aware that the occupational physician has other responsibilities.

In the preamble to their society's code of ethics for occupational medicine (DGAUM/VDBW, 2009), German occupational physicians state:

> Occupational medicine is based on an individualized and holistic view of a working person and takes into consideration somatic, psychological and social processes as well as the stress and strain involved in a specific workplace or activity. Occupational medicine is evidence-based medical science that also uses knowledge and methods from other scientific disciplines.

Occupational physicians at all levels are particularly subjected to conflicting loyalties when working in industry, in organizations and associations, but especially as a company doctor, where conflict of interest between employers and workers can arise. It is impossible to offer training or to cover all eventualities in an ethical code or guideline.

"An ethical code is a consensus of opinion regarding minimum professional standards of practice with the goal of patient protection" (Whorton & Davis, 1978:733). Westerholm (2009) identifies positive aspects of professional codes of ethics. They might define acceptable behaviour, promote standards of practice, provide a benchmark and establish a framework for professional responsibilities. Guidelines are likely to consider laws and regulations and reflect basic professional values.

For physicians practising occupational medicine, ethical guidelines can only be that – a guide on executing the professional duties and responsibilities generally expected from them. These guides (see par. 3.5) mainly address the aims and scope of occupational health practice, identify bona fide stakeholders, refer to statutory regulations and list the duties of occupational health and safety practitioners. A salient point to correctly understand the discipline's most authoritative code of ethics, that of the International Commission on Occupational Health (ICOH, 2014), is that the document is not only aimed at occupational physicians. The code "is relevant to many professional groups carrying out tasks and having responsibilities in enterprises as well as in the private and public sectors concerning safety, hygiene, health and the environment in relation to work" (ICOH, 2014:5). Consequently it neither focusses on medical ethics, not does it in any way address key issues in occupational medicine such as the doctor-patient relationship. Reading through the ICOH (2014) code of ethics for occupational health professionals (see addendum A), there is a striking paucity of any direct reference to virtuous character.

Competence, integrity and impartiality are mentioned only in relation to what professionals ought to do or refrain from doing. They "must base their judgments on scientific knowledge and

technical competence" and "refrain from any judgments, advice or activity which may endanger the trust in their integrity and impartiality" (ICOH, 2014:23). One guideline implies virtue that can be summarised as resoluteness – in a positive manner and admirably purposeful. "Occupational health professionals must under no circumstances allow their judgment and statements to be influenced by any conflict of interest" (ICOH, 2014:23). It calls for conscientiousness and above all, being principled. What transpires is that virtue ethics seemingly has an indispensable place in the quest for ethical occupational medicine practice. However, while there is copious literature on the desired moral attitude of physicians and the virtue ethics approach to moral dilemmas in medicine, virtue ethics hardly at all features in the literature on occupational medicine ethics. The latter mostly focusses on compliance with ethical guidelines and principlism. The question that arises is whether the role of virtuous character in occupational medicine practice is that much less important than what it is in clinical medicine. Or is it, given the multitude of stakeholders with divergent interests and the interference of labour issues in the ambit of health care (the very bane of occupational medicine), even more crucial to consider physician virtue in occupational medicine? Could it even be that the occupational health fraternity is consciously shying away from admitting the moral faults of its own? While evading cynicism, it would be hypocrisy to ignore reports of ethically questionable conduct of appointed occupational physicians occasionally reported in the literature.

Wharton & Davis (1978:736), admittedly from an era hopefully gone by, relates the following incident:

> In California a general practitioner went to work as a plant physician after many years in private practice. While in practice he felt that he had good relations with his patients. Now he is depressed because his patients (the workers) distrust him and he says that he cannot understand why. However, at an educational meeting of the local medical association he became irate when his plant was cited as an example of poor-industrial-hygiene practices for the control of lead. He publicly stated that health problems at the plant were due to workers' sloppy personal habits and to their disregard of orders – despite the fact that another plant 15 miles away making the same product and utilizing safer methods had no lead intoxication problem. Considering this physician's view of the workers, it is little wonder they mistrust him.

This scenario relates to an aphorism formulated by Britain's first medical inspector of mines a century ago (refer to chapter 2.1). "Unless and until the employer has done everything – and everything means a good deal – the work man can do next to nothing to protect himself, although he is naturally willing enough to do his share" (London, 2000:5). It remains a truism and to it one has to add that misplaced loyalty, and for an occupational physician to align with the interests of his employer to the detriment of the work force, is morally questionable.

My argument is that notwithstanding the value of an extensive ethical code of conduct, as stand-alone its value is limited. That is not only because such codes are not widely distributed and implemented (Aw, 1997) but they are open to interpretation and unenforceable. Ethical guidelines address factors such as required training, expertise, policies, principles, communication, impartiality and non-discrimination (ICOH, 2014). They do not deal with character, core values and moral attitude of professionals. It is as if virtue is a given and it would be presumptuous to imply otherwise. Also, occupational health and safety legislation is generally far-reaching and quite detailed. To a large extent statutory law already prescribes and regulates the responsibilities and duties of employers, employees, safety managers and appointed occupational health practitioners. Consequently, a code of ethics that steers clear of virtue ethics mainly supplements health and safety statutes but does little to establish which virtues a good, ethical occupational physician is likely to need or ought to foster.

Having identified that in the field of occupational medicine, virtue ethics has probably not received ample attention in the literature, I will firstly consider its role in the medical profession in general. Secondly I will argue for a greater role for virtue ethics in occupational medicine and finally consider how, through the integration of codes of ethics, principlism and virtue ethics, the profession's ethical milieu can possibly be defined. A better understanding of the origin of ethical contention in occupational medicine and what perpetuates the profession's moral dubiousness, should shed light on how its ethical discontent can be tempered.

9.2 Virtue based occupational medicine

The spectrum of workplace healthcare and the duties of occupational physicians are discussed in chapter 3.3. "In professional life, the traits that warrant encouragement and admiration often derive from role responsibilities" (Beauchamp & Childress, 2009:33). From their various roles and commitments one can thus postulate which traits of character or virtues are desirable in order

for occupational medicine practitioners to practice ethically. The virtues traditionally associated with the practice of medicine are mainly derived from care – the fundamental virtue expected from good doctors and nurses. It implies virtues such as compassion, empathy, benevolence, equanimity, altruism and respect (Wynia et al., 2014; Gelhaus, 2012.). While one can rightly argue that these are traits of character which all doctors should demonstrate, the demands of different professional roles and disciplines inevitably call for distinct moral inclination. It seems rational that being a great trauma surgeon and being responsible for palliative care in a geriatric facility requires different faculty and strengths of character. Whereas in the hospice environment faithfulness, compassion, respectfulness and advocacy of human rights are the cornerstones of end-of-life care (Giblin, 2002), in the emergency room other virtues are much more pertinent. The American College of Emergency Practitioners (2009) considers vigilance their most emblematic virtue. Courage and justice also have essential roles in their discipline and resilience is vital. Like in the case of occupational medicine, the context of a discipline confronts its practitioners with ethical challenges that are typical, though not necessarily unique, of their branch of medicine. By taking cognisance of a medical professional's specific duties and the source and tenor of potential ethical dilemmas, it should be possible to work out which virtues would likely consolidate the doctor's moral frame of reference.

9.2.1 Tactful stakeholder interaction

Firstly, an occupational physician needs to acknowledge all valid role-players in the immediate labour environment and recognise their stake in occupational health and safety. The spectrum of stakeholders varies from manual workers and highly qualified professionals to human resource managers, shop stewards, legal advisors, business vice presidents and private doctors in the community. The inclusive nature of occupational medicine was pointed out in chapter 3.4. In contemporary institutionalised health care the multiplicity of stakeholders that typifies occupational medicine, is no longer unique. It has invaded even some clinical disciplines. The American emergency medicine fraternity laments: "The courageous physician advocates for patients against managed care gatekeepers, demanding employers, interrogating police, incompetent trainees, dismissive consultants, self-absorbed families and enquiring reporters, just to name a few" (ACEP, 2009:A3.). Such involved parties, each with its own objective, add complexity to doctor-patient relationships – if not to healthcare ethics in a holistic sense. On the one hand, failure to gain the respect, trust or at least the regard of role-players would complicate the physician's work. On the other hand, if earning their trust means having to unfairly prioritise

the interests of one or more stakeholder to win their approval, justice will not be served. Consequently, respect can only be earned through unbiased appraisal of case detail, fairness and demonstrable compliance with legislation and codes of good practice. On account of the hierarchical nature of the labour environment and the authority which various stakeholders wield, less empowered parties (especially workers) can feel that they are slighted or even bullied, and their interests subordinated. Owing to the predominance of employers and their managers in labour-related disputes around health and safety issues, someone has to fend for the workers. Labour union representatives have such a role but their input is generally heavily biased in favour of the worker/employee and consequently not always credible. Advocacy, rather than representation, would be appropriate. What is required is that an impartial party with unquestionable expertise, credibility and a track record for ethical conduct, trusted by the key stakeholders, adjudicate. The question then is: what virtues would qualify an occupational physician to fulfil that role with distinction?

Codes of ethics for occupational medicine accentuate the reality of several stakeholders having a legitimate stake in the occupational health and safety of individual workers – to the point of inclusivity rather than exclusivity. Those suffering from work-related injuries and illnesses therefore cannot be afforded the level of privacy and confidentiality associated with ordinary healthcare. “It cannot be overemphasised that ethics in occupational health is by essence a field of interaction between many partners” (ICOH, 2014:9). The employer, legally appointed safety managers, state department of labour officials, etc. are involved and not only have interests but also specific duties. To carry out the latter they gain (and to a degree need) access to facts and even some basic clinical information. This would typically extend to things such as fractures, the need for surgery or stitches, the likelihood and expected duration of temporary disability, the nature of complications and pre-existing health factors that might have predisposed to injury and illness. Being at the centre of this equation, the legally appointed occupational medicine practitioner’s role can be seen as that of linchpin. If worthy and successful in that role, the case is likely to be concluded to the satisfaction of all stakeholders. If not, one, some or even all players can end up disenchanted or feeling that justice did not prevail. This could be the outcome if any lawful participant was not even-handedly heard, bias transpired or facts and/or circumstances were distorted. Arguably, virtue can avert the bulk of all such potential fallouts.

With experience and by gauging the obvious, and perhaps some undisclosed interests of the involved parties, it is possible to anticipate the issues that will have to be dealt with – for instance

in relation to work-related injuries or suspected occupational illnesses. Foremost, it is imperative to pre-empt a mentality of "us" versus "them". At times animosity arises between two or more interest groups. This tend to occur when some stakeholders focus on fault, allotting blame or disciplinary action while the centre of attention should be healthcare, determining why preventive measure failed and how to prevent similar future mishaps. Divergent interests mean that role players in the ambit of occupational health and safety are likely to have different aims and pursue different outcomes. The participants in the arena are the worker/"patient", the direct supervisor and first line manager, the safety officer, the senior safety manager, a business unit vice president, the shop steward and senior union representative, any close co-workers, witnesses of the incident, the ambulance crew, the emergency room nursing staff and the occupational medicine practitioner. Depending on the magnitude of a work-related injury or illness, the worker's private medical practitioner, medical consultants/specialists, supplementary health care practitioners such as a physiotherapist and occupational therapist, as well as the enterprise's corporate medical director, could all be involved and provide, or are asked for, unique input from their point of view. Understandingly, an injured worker's family and the sentiments they harbour, also comes into play. Furthermore, in the case of serious, mostly life- or limb-threatening accidents, an inspector of the state Department of Labour will investigate and the occupational compensation authority becomes involved. The company's legal advisor then also has a role.

If this seems like a daunting equation, difficult to comprehend by outsiders, it serves to further demonstrate the ethical milieu of occupational medicine – at least in South African industry. The treatment of occupational injuries and healthcare of occupational illnesses as such are basically no different from traditional medical practice. It is the psychosocial intricacies, valid interests of stakeholders and, at times when the stake is high, opportunism, which complicate the management of occupationally-acquired health problems. The health and safety record of business enterprises is carefully monitored by the authorities, investors, rivals and pressure groups. Injury rates are calculated, benchmarked and reported on in the company's annual reports. Many companies incentivise their safety performance. It means that when expectations do not materialise, performance bonuses are forfeited. Consequently, even lesser injuries at work have implications for the whole team. The end result is often that the actual incident is less injurious than the ostracism reported by some workers after an injury at work.

The occupational physician's role in this scenario can be summarised by saying that she has to maintain impartiality, objectivity, acknowledge each valid stakeholder's dignity and legitimate

interests, defuse antipathy between key role-players and be recognised for her professionalism. This does not happen overnight. Trust, the fulcrum of medical professionalism, has to be earned and will only be accorded in due time. Trust in the doctor/patient relationship differs from trust in the business environment. The former is easily assumed or taken for granted; but the medical profession's laurels are worth little in the business arena. Physicians in industry must earn the trust of various stakeholders and cannot rely on status to afford them reverence. I argue that it is creditable conduct, underpinned by contextual virtue that will see the occupational physician flourish in the role of mediator and advocacy of fairness and legal compliance in relation to health and safety in the work place.

Tact is the first supposed virtue that comes to mind when picturing stakeholder relationships in the occupational health and safety arena and the mantle a physician in industry takes on. This in spite of reservations about its apparent ambiguity as virtue. Some read civility into tactfulness and err in their "thinking about civility, namely, that to be pleasant is to pander to another's ego" (Laverty, 2010:232). I will argue that rather than approximating tact with respectfulness, tolerance and docile agreeableness, it can partner with the virtues of equanimity, judiciousness and ultimately, in context of occupational medicine, professionalism. The unique context of a physician committed to applying ethical health care principles in the tough arena of industrial productivity and profitability calls for novel approaches to principled conduct, especially in communication. The picture of a revered, white-coated medico relieving suffering, writing prescriptions and saving lives is far removed from the mine- or factory clinic. In non-clinical deliberations about occupational health and safety issues, the occupational physician is more the professional subject-matter expert and advisor than the decision-making authority. In that role tact, commensurate with context and climate, is more virtuous that assertiveness or resolve. "When you are tactful, others find it easier to hear what you have to say" (Virtue of the week: Tact, 2018). Occupational physicians particularly need role-players to listen to, understand and give credence to their opinion and recommendations.

Naukkarinen (2014:27) writes that although tact as a virtue is "on the boundaries of ethics and aesthetics, the topic has been given attention ever since Aristotle's *The Nicomachean Ethics"* (2004). The term "tactful" appears only once in Roger Crisp's translation but Aristotle indeed addressed social conduct approximating tact and tactlessness. "Some people seem obsequious in an attempt to please us, they praise everything and are never obstructive, thinking that they must not cause any pain to those they meet. At the opposite extreme, people who obstruct everything

and think nothing of causing pain are called bad-tempered and belligerent" (Aristotle, 2004:1126b-7a). Being tactful and acting in accordance with social context are implied when Aristotle says of "the person corresponding to the mean state" that "in each case he will do what suits the occasion" (Aristotle, 2004:1126b-7a). Sensible tact should qualify as a sound social skill. "Saying and listening as one should is the mark of a tactful individual" (Laverty, 2009:234). When someone is whole-heartedly committed to a cause it is easy to get carried away in discussion; talking and explaining one's own views without listening attentively to others. When the subject is health, physicians can inadvertently dominate a discussion in a pedantic way that offends others who are professionals in their own right. Believing that they should take charge and lead debate towards the "right" decision, they might rather tactlessly jeopardise an amicable outcome. To many it would seem "that there are more important and pressing issues with which to concern themselves than the social graces" (Laverty, 2009:228). But while tact might appear to be mere politeness that can be dispensed with, tactless conduct is obtrusive and frankly presumptuous. Naukkarinen (2014) recognises this dimension of tact. "Often, tact is only recognised as an issue through negation, that is, when dealing with a lack of tact" (Naukkarinen, 2014:25).

What surrounds tact as a virtue with ambiguity, is suspicion that it sparks compliance, maintains the status quo and demands restraint and submitting to authority. There is no denying that in situations calling for creativity and where so-called lateral thinking is valued, tact is more likely to quell originality. But then, that would be misguided tact or out of context tact; which is no longer legitimate tact. Tact is considered a life skill and relates to acting appropriately in context of the situation. Tactful behaviour is an indication of situational sensitivity – a competent, confident and resourceful person who spontaneously improvises and naturally acts according to circumstances (Naukkarinen, 2014:32). Tactful people can be creative and come up with extraordinary ideas when the occasion calls for it. On the contrary, tactless participants would ruin creative initiatives like they would any other occasion. And so would those that carry tact to the point of conformity at all cost. The art of tact is not a preoccupation with correct behaviour. Which brings one back to Aristotle's aphorism of virtue representing the mean between two vices (Aristotle, 2004:1126b-7a).

I argue that the context of occupational medicine in the industrial enterprise environment particularly calls for tact on the part of occupational physicians. We practice preventive health care and strive to flourish in the domain of engineers, scientists and accountants whose ethos can

be worlds apart from ours. Doing that creates a backdrop that invites contention and even a degree of rivalry for decision-making dominance. Occupational physicians' role is to make well-argued decisions related to occupational health. They might have to persuade business managers and executives to accept their findings and carry through their recommendations. But ultimately, in industry, engineers, accountants and industrialists are the ones responsible for the bottom line. They heed the advice of their subject matter experts such as legal advisors, human resources managers, public relation consultants and occupational physicians. For the latter to successfully fulfil their role they must be able to hold their own in every business circle up to that of the captains of industry. The quasi therapeutic role and impartial doctor role of occupational physicians (see chapter 8.2) demand healthcare-related virtues; but forging effective relationships within the management team of an enterprise takes a good understanding of context and healthy tact.

9.2.2 Expertise, objectivity and impartiality

The reliable evaluation of an individual's health status in relation to functional capacity, especially in context of occupational fitness and competence, is a cardinal responsibility of occupational physicians. What renders this role of an occupational physician, that of independent expert (see chapter 8.2.8), challenging and even arduous, is that the verdict practically determines if someone is eligible for an important, even life changing, benefit. That might be as simple as access to a discretionary fringe benefit such as additional sick leave, or it could determine whether a lifelong disability pension is granted or denied. Though the occupational physician does not make these decisions alone, she advises human resources managers, line managers, the pension fund board of trustees, etc. Without trust in the expertise, impartiality, objectivity and integrity of the occupational physician, management will not feel comfortable implementing far-reaching health- and safety-related recommendations. Contentious decisions or rulings that might constitute unfair labour practice, are likely to be referred to the Commission for Conciliation, Mediation and Arbitration. Either a disgruntled employee or a labour union can refer a dispute. A ruling against an employer who in good faith acted in accordance with the occupational physician's advice, potentially reflects on the latter's professional reputation. Over and above this scenario, as is the case with any registered medical practitioner, a complaint can be lodged with the Health Professions Council of South Africa against an occupational physician. Many conclusions in occupational medicine have grave consequences for employees and prospective employees. For an individual it can make the difference between gainful employment and

unemployment. For an employer it can confirm or blemish a reputation for fair labour practice or responsible health and safety measures. Much hinges on sound occupational health advocacy.

After the ability to muster stakeholders for the cause of occupational health and safety, the occupational physician secondly needs acumen to evaluate occupational fitness or impairment, consider the facts and context of a case, contemplate its intricacies and come to a judicious conclusion. The focus here is on identifying virtues which would likely see the occupational physician consistently making well-founded, responsible decisions. The point of departure would be meticulous fact finding, corroborating evidence from different sources and personal observation. Three main sources of evidence are pertinent: medical reports from the individual's own healthcare professionals, documentation provided by the employer and personal interview/observation. The authenticity, reliability and accuracy of reports have to be evaluated. While the occupational physician needs to be emphatically impartial, reports emanating from an employee's private doctors have to be scrutinised for bias. The same applies to documentation provided by management. Medical reports specifically provided for the purpose of either medical disability boarding, or for resuming work, often, and probably inevitably, tend to be biased in support of the patient's wishes. It seems unlikely that a patient asking his doctor for a letter to gain access to disability benefits, would get a report recommending the opposite. It might be construed as a violation of the biomedical ethical principle of beneficence. Should the doctor give preference to the principle of justice and write a report suggesting that disability pension is not justified, his patient is likely to choose not to provide his employer with the report. Evidently, not taking private physicians' recommendations at face value, potentially sets the occupational physician up for accusations of prejudice. I propose that in such circumstances virtue is a pillar of defence.

A pitfall in occupational medicine is the reality that physicians cannot possibly be sufficiently knowledgeable about all disciplines in medicine. To attempt to assess and advise on every case without seeking the expert input of appropriate specialists, is an ethical minefield. Rapid developments in disciplines such as oncology, neurology and transplant medicine make is near impossible to keep up. Therefore the astute occupational physician should not venture a prognostic opinion without consulting the relevant specialists. Nevertheless, conscientious healthcare professionals utilise continuous professional development opportunities for their knowledge to remain current. Apart from being included in codes of ethics, ongoing learning is an inalienable element of professionalism. Studiousness allows for a better grasp of context and

understanding of impairment related to various medical diagnoses. An additional caveat is that occupational physicians dare not overstep the limits of their qualifications, expertise and competency. Being to a degree isolated from mainstream medicine practice, it could happen that occupational physicians lose perspective and unconsciously attempt to advise on all matters instead of recognising the limits of their scope of practice. At times management could pressurise their company physician to be decisive when a matter is actually beyond his competence. It then requires integrity, confidence and candour to decline to make decisions and insist on seeking counsel. If in such situations an occupational physician perseveres, it adds to his reputation for professionalism.

9.2.3 Virtue in clinical relationships

So far I have argued that tact in the occupational physicians' moral armamentarium, bolstered with equanimity and judiciousness, will stand them in good stead in their dealings with stakeholders. Then I reasoned that competently fulfilling the duty of independent expert in the field of occupational medicine demands, over and above expertise, impartiality, objectivity and integrity. It leaves the clinical role – or what Tamin (2013) terms the "quasi-therapeutic" role (see chapter 8.2.1). That is because the occupational physician is seldom if ever, his patient's regular doctor or doctor of choice. Consequently, the quality of the doctor-patient relationship seldom matches that of the traditional clinical relationship for depth of the bond – which grows over time. In occupational medicine most clinical or semi-clinical encounters take place without there having been an existing relationship. Generally, the duration of workplace-based clinical relationships at most match the recovery time of the current injury or ailment. Once an incident at work that necessitated a consultation has run its cause, the doctor-patient relationship for all practical purposes ends. Therefore, in occupational medicine, enduring doctor-patient relationships are not the norm.

This scenario has the effect that a working doctor-patient relationship has to be established from scratch with almost every worker who is for whatever reason, cast into the role of the occupational physician's patient. Likening it to a situation where the doctor is consulted by new patients all the time, one can better picture the challenge of establishing adequate rapport. Yet, good rapport is not only conducive to good healthcare, it could well be a prerequisite. In the emergency room of major hospitals a similar situation exist, but there the patient is usually in dire need of immediate clinical intervention and the doctor-patient relationship takes second

place. What uniquely complicates the rapid establishment of a sound doctor-patient relationship in the labour environment of occupational health, is the omnipresence of non-healthcare stakeholders and the suspicion of split loyalty. The occupational physician's patients very often experience anxiety beyond the injury or illness. The likes of loss of income, disciplinary codes, safety bonuses, having let down the team and job security are many times in the back of their minds. An account of how pervasive this hapless aspect of occupational health and safety can be, is found in a report of the U.S. House of Representatives (2008:2). "Workers report wide spread intimidation and harassment when reporting injuries and illnesses. Reports, testimony and news accounts show that many employers have fired or disciplined workers who report injuries and illnesses or complain about safety hazards". Hence, against that background, a knack for successfully forging an impromptu doctor-patient relationship is a valuable asset in occupational medicine. And trust is the crux of that relationship.

"For the virtue-based physician, the relationship with the patient could not be a contract or a commodity transaction. It is a covenant of trust, a special kind of promise to serve those who require her expertise" (Pellegrino, 2002:384). The ability to instil instinctive patient trust in most situations, is seemingly an art that some clinicians unwittingly develop over time. But if such trust is ill-gotten, undeserved or superficial, it is bound to prove fragile and short-lived. Trust without a foundation of trustworthiness is due to eventually end in disillusionment. It follows that the virtue of trustworthiness, which in this context encompasses expertise, impartiality, veracity and fairness, is the crux of ethical occupational medicine relationships. However, as illustrated, the patient seldom has the opportunity to gradually establish a relationship build on trust with the occupational physician. Although the individual worker/patient usually has no prior experience of the doctor's touch, the workforce at large has. That experience reflects in the occupational physician's reputation. Workplace grapevines are very effective because workers share their experience of the workplace clinic and its staff. Clinical acumen is not all that shapes the reputations of physicians; their general disposition and conduct do not go unnoticed – by management, their peers, staff and especially their patients. Giblin (2002:235) reminds us: "There are daily choices about actions, words, and tone of personal encounters". Thus, in the plant clinic, doctors' reputation precedes them and is a strong indicator of what patients expect of the doctor-patient relationship. Trust in an occupational medicine practitioner emanates from the workforce, management, the nursing staff and peers rather than, at least initially, from patients. Such shared trust has to be earned through trustworthiness and cherished because it translates into respect for and faith in the occupational physician's professionalism.

Aptitude that enables the physician to establish a sound doctor-patient relationship already during the first consultation, deserves further thought. Encounters with workers/patients that require the occupational physician to adopt the quasi-clinical role usually, and preferably, take place in a clinical venue such as the emergency room or an examination room. While the physician still does not act as the patient's personal medical practitioner, the patient, for all practical purposes, would consider and probably experience the relationship as one of doctor-patient. Consequently it is predictable that medical care-related ethical conduct, and virtues, such as compassion, altruism, conscientiousness and faithfulness would become relevant. So would the ethical principles of biomedical endeavour: beneficence, nonmaleficence, respect for autonomy and justice (Beauchamp & Childress, 2009). Especially respect for patient autonomy would grow in importance in comparison with its lesser status in the non-clinical aspects of occupational health. Notwithstanding the call for traditional healthcare virtues, the overarching occupational medicine context remains a compelling factor. As a result, some well recognised healthcare virtues might have a somewhat diminished role in the occupational medicine milieu. Similarly, other or supplementary virtues could have a significant role in the professional lives of occupational physicians. It is on such somewhat unique virtues which I will focus when arguing that the quasi-clinical responsibilities in occupational medicine demand an extraordinary virtue amalgam. From the ethical difficulties that occupational physicians at times face, and by referring to my own experiences, I will explore how virtue can possibly avert a situation akin to an ethical labyrinth.

I will consider two challenges which occupational physicians typically face in context of their dealings with and management of patients in their unorthodox clinical setup. Firstly, their discipline historically commands very little respect within the medical fraternity – sometimes to the extent of derision. Secondly, in occupational health, work-relatedness not uncommonly adds a confounding psychosocial angle to the recovery from injury. In addition, the workman compensation dispensation creates a dimension that resonates in the clinical course of therapy and rehabilitation.

Generally, the medical fraternity regards occupational medicine with disdain. Walters (1982:1) reports: "The literature on the politics of occupational health and safety … is highly critical of company doctors who, it is argued, have served the interests of employers to the detriment of workers' health and safety, and helped to legitimize relations of domination on the workplace. This image is very close to common stereotypes of the incompetent, unsympathetic company

doctor who 'retired' to a sinecure". Almost 30 years later little has apparently changed when it comes to the status of occupational medicine. In a survey Plomp & Ballast (2010) recorded a response from a medical specialist. "I never met an occupational physician, but I think I have low trust in him" (Plomp & Ballast, 2010:267). Walsh (1987:5) has no qualms about reporting that in the USA "occupational medicine remains a backwater". She sees the occupational physician as being responsible for the medical profession's "dirty work". "Those who do it are often isolated from the occupational mainstream, to exonerate the 'good people' from responsibility for the dirty work carried out in their midst" (Walsh, 1987:13). This author has not experienced overt contempt from colleagues in private medical practice. Disinterested ignorance is rather the prevalent attitude towards occupational medicine. With it, seems to come a degree of disbelief that a well-qualified doctor chooses being a "factory doctor" above lucrative private practice. I recall an incident while attending a continued professional development conference. A presentation on occupational medicine was next on the program and a delegate asked the doctor next to him "what is occupational medicine? I overheard the response: "I don't know but I think it is about those doctors who go to factories to draw patients".

As a result, physicians who are driven by esteem and peer pressure might not flourish in occupational medicine; for the discipline is seldom if ever awe-inspiring. Any admiration due to the occupational health practitioner might come from workers amongst the lower echelons rather than from the elite. To a significant degree occupational physicians ply their trade amongst the working class. Perhaps rightly so, because after all, it is the suffering of the proletariat that was the catalyst for the birth of modern occupational medicine (see chapter 2.1). It follows that compassion, humanitarianism, dedication and self-effacement would likely characterise the contented occupational physician's moral makeup. Caring for and protecting every patient, no matter how humble or inconsequential, shows compassion and a humanitarian disposition. In the world of occupational medicine not only clinical acumen counts. Often the physician might sense that a situation calls for standing up against injustice and disrespect against a patient. The hierarchy in the workplace is such that it makes it very difficult for a co-worker, colleague or lesser manager to defend the rights of an injured or ill worker. But the occupational physician has the gravitas and professional standing to do so – and ought to also have the inclination. Therefore, on merit and on account of moral duty, the virtuous physician ought not to baulk at speaking up for what is fair and right. Fulfilling the role of advocacy in occupational medicine without fear or favour is both rewarding and worthy of respect. Even more so when voluntarily advocating for the vulnerable out of compassion.

The term dedication, in context of the occupational physician's commitment to promote occupational health and safety and practice ethical occupational medicine, is chosen in order to avoid referring to it as loyalty. While "loyalty" is generally favouritism based on sentiment (see chapter 6.5), for the occupational physician, principled commitment to a worthy cause is commendable. In professional endeavour where many role-players, wielding different amounts of influence, demand that their interests are protected, keeping the end-goal in focus demands dedication. Regularly visualising occupational medicine's raison d'être, workplace health and safety, helps to align role-players. Any interests not aligned with that mission have to be considered subordinate. Being committed to consider everyone's legitimate stake on merit and to judge if satisfying anybody's wish jeopardises health and safety, are the occupational physicians' challenge and should be their professional passion.

9.2.4 The injury-on-duty scenario

The injury-on-duty label with which the bulk of an occupational physician's clinical caseload presents, at times becomes a psychosocial albatross that threatens to impede holistic patient care. Several factors could render the management of patients who were injured at work awkward. Many such factors have been enforced in industrial workplaces for so long and so vehemently that they are entrenched and seem unassailable. Due to the paucity of literature on occupational medicine beyond academic circles, little has been written about prevalent but questionable occupational safety practices in South African industry. Reports emanating from the USA allows for a glimpse of unethical practices that are seemingly almost impossible to eradicate.

In many quarters, a worker who blemishes their employer's and their team's safety record by getting injured on the job or alternatively by reporting an injury, is unpopular and even face stigmatisation. "The direct intimidation of workers to discourage reporting of injuries and illnesses take many forms, both subtle and overt" (U.S. House of Representatives, 2008:15). While non-reporting of an injury on duty is a serious disciplinary offence, reporting it almost inevitably has dire consequences. "Workers in the steel industry report that they risk their jobs when they report safety hazards or even minor injuries. Steel workers describe 'bloody pocket syndrome' where workers who may have as little as a cut on their hand will hide it, fearing retaliation, and wait until after their shift to go to the hospital" (U.S. House of Representatives, 2008:16). This adversity might extend to the occupational physician. "When workers must receive treatment, employers may 'bargain' with or even threaten doctors to prevent the

diagnosis of a recordable injury or illness" (U.S. House of Representatives, 2008:19). Incentivisation of safety, usually in the form of staff bonuses for reaching a predetermined monthly or annual benchmark, creates additional enticement not to report a work-related injury (such as pretending that it happened elsewhere and obtaining a sick certificate from a private doctor). "General foremen, superintendents, craft superintendents, job superintendents and project managers on the California Bay Bridge project received significant monetary awards and 'merit cards' essential for salary increases and individual career advancement. But the awards were dependent on no injuries or illnesses being reported. Foremen, fearful of losing their bonuses, would pressure workers not to report, and workers, afraid of angering their foremen, would comply" (U.S. House of Representatives, 2008:21). What creates an especially awkward situation is when reaching the end-of-financial-year safety bonus threshold is already anticipated and an injury is sustained only days before the annual bonus vest. What is described in the USA document to a significant degree reflects the author's South African experience. The U.S. House of Representatives (2008) aptly use the words "hidden tragedy" in the title of their report.

My focus is on practices which is likely to have a direct effect on the management of injuries by the enterprise's medical team. While small and medium employers obviously do not have in-house medical facilities, the majority of mining and major industrial concerns have. In big-business, employees consequently would experience a vast difference between sustaining a relatively minor injury at work or in their private capacity. In fact, any significant injury sustained at work invokes not only two Acts of Parliament (Republic of South Africa, 1993a; Republic of South Africa, 1993b.), but also the mandatory health and safety policy and disciplinary code that employers must have in compliance with labour legislation. Though some of it might seem like a formality, it greatly complicates the matter, stirs emotion and could even poison relations in the workplace.

Several common practices, enforced by health and safety policy, have the potential to at times do more harm than good. Calling an ambulance to the site of the accident, however inconsequential the injury might seem, is mandatory. Injured workers are deprived of almost all autonomy in that they cannot choose whether their injury justifies seeking medical care. Not reporting an injury to one's supervisor without delay is a transgression; so is not submitting to an examination by the appointed occupational physician before the end of the current shift. But it is especially the entrenched practice of incident investigation that can disrupt workplace relationships and court psychosocial turbulence. In an environment where the workforce takes

pride in their safety record, displays, communicates and on a weekly basis compares their safety accomplishment against their incentivised target, an individual who injured himself at work, easily becomes the black sheep. Incident investigation starts with safety officers and managers converging on the site of the incident to take photos, make measurements and interview the supervisor, co-workers and any witnesses, in an attempt to determine wat caused the incident. Next the injured worker is questioned and the occupational physician is asked for the diagnosis, what treatment would entail and how the injury is being classified in terms of an internationally benchmarked system of occupational injury classification. As soon as feasible, a meeting is called with safety management, safety specialists, line management, witnesses and the injured worker present to deliberate what caused and contributed to the incident and why it was not prevented. It is not unusual for the injured worker and even witnesses to be asked to take a lie detector test (polygraph).

When a back injury from lifting a heavy toolbox or a torn ankle ligament from tripping on a stair unleashes the above scenario, human nature dictates that the injured party would have misgivings. It follows that the occupational physician's patient often experiences anxiety and feelings of anger, rejection and dismay; or even of being victimised. Only naïve medical professionals would underestimate the influence a patient's mind-set has on the healing process and rehabilitation; though it seems as if safety and human resources managers are oblivious to the psychosocial ramifications of their practices and how it impacts clinical outcome. Many injured workers must experience confusion because the occupational medicine fraternity attempts to create a safe, caring, supportive atmosphere while the mood in their section of the business probably leans towards blame and deceit. The latter could be the result of a preoccupation to identify a culprit and invoke the business's disciplinary code; ostensibly to demonstrate management's unwavering commitment to safety and prevent future similar incidents. Given that the outcome of the disciplinary process could even be that someone is fired, attempted deceit is understandable. Although the injured party is in the proverbial line of fire, other individuals might be implicated. The supervisor for giving incorrect instructions, the manager for poor control or failure to perform a formal job risk assessment, a colleague for opening the wrong valve, or the safety officer for not having prescribed and issued the appropriate personal protective equipment. If responsibilities are deemed to have been neglected, finger-pointing might ensue.

Painting the backdrop that many times turn what ought to be simple injury management, into an occupational medicine conundrum, serves to contemplate the virtuous occupational physician. Negotiating the ethical pitfalls and coping with the burden of reconciling business processes such as safety management with morally accountable occupational healthcare, will always be a challenge. One can argue that experience is the key but that alone raises the question whether time does not merely mellow, or erode, the occupational physician's stance against some questionable occupational safety practices in industry. How long can an advocate of fair and above-board practices and occupational medicine codes of ethics persevere against pragmatism? Occupational physicians are inextricably involved in the management of occupational injuries and ultimately responsible for at least the clinical outcome. At times it would seem pragmatic to compromise here and there on rigorous ethical principles. After all, occupational medicine's context is distinct from that of conventional healthcare. But moral pliancy, which might initially seem like benign acquiescence, can in time imperceptibly slide towards capitulation of ethical principles. I argue that virtue would then stand between perseverance in principled occupational medicine practice and acceptance of a more hard-nosed business approach to occupational health and safety. It is where the occupational physician has to lead.

9.3 Beyond caring

Beyond the virtues that are generally associated with ethical physicians, compassions, altruism, conscientiousness, trustworthiness and faithfulness, I have mentioned dedication, humanitarianism and self-effacement in relation to the occupational physician's choice of professional discipline. In context of their duty to deliver sound healthcare while having to confront and deal with the ethical ambiguities of occupational injury management, I argue that impartiality, fairness and veracity are desirable virtues. To compliment dedication and conscientiousness, determination and perseverance are critical because their very virtue lies in not giving up. Impartiality, in context of occupational medicine, is the virtue that morally equip occupational physicians to consistently make unprejudiced, objective, even-handed and fair recommendations within their professional domain and thus build a reputation for equitability. It means that all role players are afforded respect and opportunity to state their points of view. Impartiality does not allow for sentiments of loyalty to bias verdicts or justify preferential treatment. Neither should any alliance, such as an employee-employer relationship or a highly-rated doctor-patient relationship slant a judgement. Recognising that many of an occupational physician's rulings, such as fitness for work, has financial implications for one or more

stakeholder, professional independence and non-alignment are important. Not that the ramifications of decisions should be ignored, but the guiding principle in occupational medicine has to be worker health and safety. And there will always be borderline cases that has to be decided. That is what makes the occupational physician's work morally challenging and it is a strong argument in favour of virtue ethics being the key to tackling many of the profession's dilemmas.

Impartiality alone cannot guarantee fairness but it should be a non-negotiable prerequisite if justice is to be served. It is fair to be impartial. Justice also requires veracity, which embraces not only truthfulness and honesty but also accuracy, authenticity and frankness (The Free Dictionary, 2019). One reason for referring to the virtue of veracity rather than just honesty is the disparity between the physician's access to a whole body of medical knowledge and the limited information and grasp that patients and the medical layman have of medicine. Therefore, being truthful in discourse with workers and management, occupational physicians are honest, but unless they explain in considerable detail and understandable language the basis for their decisions, the process can be flawed for lack of authenticity and openness. It is probably best illustrated with an example of an everyday occurrence in occupational health – the construction worker who had what seems like an epileptic seizure.

For the construction manager the logical drift of the argument could be simple. Jack had an epileptic attack and can have it again. It can happen while Jack is on scaffolding and he will fall. If Jack falls it can kill him. People with epilepsy cannot work in construction. Therefore Jack's employment has to be terminated. Jack can apply for disability pension. We are a responsible employer that does not take risks. As for Jack, his mind-set and viewpoint differs. He is adamant that it was just a matter of not having eaten on the morning of the incident and he won't allow that to happen again. He has years of experience and cannot see that there is any risk that he might fall off a scaffold. If he is to lose his job his family would be on the street within a month. He has no insurance or pension fund and would definitely lay a complaint with the country's labour authority for unfair dismissal if he is to lose his job. Jack has implored the occupational physician to declare him fit to resume construction work – the only trade he knows. Jack cannot believe that someone who is a doctor would even consider causing him to become unemployed. What especially infuriates Jack is that the note which he obtained from a doctor in his hometown (and for which he claims to have paid R 450), stating that he was examined and found "fit for

any work", is apparently being ignored. Simultaneously, the construction firm is insistent that they "take no chances with safety".

On the face of it, what Jack expects is for the occupational physician to bring compassion and altruism to the table in his support. Management on the other hand, expects the physician to align with their inflexible values of legal compliance and risk aversion and be assertive to remove Jack from their site. However, calling on objectivity, justice and veracity, the occupational physician's professionality dictates a principled approach to reconcile divergent opposing interests. It is an approach that starts with a detailed neurological assessment and diagnosis, considering the effectiveness of medication, proof of compliance with medication, patient education, risk assessment, a safety inspection of scaffolding and fall-arrest equipment, accommodation of temporary occupational impairment and extending to long term follow up. When a decision is taken to either resume unrestricted work or redeployment to similar ground-level work involving no, or negligible, risk of serious injury, it is transparent, well-considered and underpinned by contextual virtue. A significant proportion of individuals who suffered a single epileptic seizure has no discernible brain lesion and never has another attack. The bulk of the rest can be well-controlled with medication.

Given adequate resources and an employer who is able and willing to provide or procure quality occupational health and safety services and comply with legislation, the difference between ethically sound and indifferent occupational medicine practice is bound to be the occupational physician's moral constitution and particular virtues. Considering the ethically contentious milieu in which occupational physicians practice and the potential for enduring controversy, context determines which virtues are suitable. In occupational medicine relevant experience is paramount and equally important is being sensible and resourceful. These are qualities that resonate with Aristotle's key intellectual virtue of practical wisdom or *phronesis.* It is a virtue primarily related to human interaction rather than mere knowledge.

> "From what we have said, then, it is clear that wisdom is scientific knowledge, combined with intellect, of what is by nature most honourable. This is why people say that Anaxagoras, Thales and people like them are wise, but not practically wise, when they are seen to be ignorant of what is in their own interest; and that their knowledge is extraordinary, wonderful, abstruse, godlike, but useless, because it is not human goods they are looking for. Practical wisdom, on the other hand, is concerned with human affairs,

> namely, with what we can deliberate about. For deliberating well, we say, is the characteristic activity of the practically wise person above all; but no one deliberates about what cannot be otherwise, or about what has no goal that consists in a good achievable in action." (Aristotle, 2004:1141b-1142a).

Occupational medicine's scientific knowledge base is in no way significantly unique. What is unique about the discipline is the context in which its practitioners deliver a professional healthcare service. That uniqueness renders practical wisdom an invaluable asset in the moral makeup of the seasoned occupational physician. Where particulars are of concern, Aristotle valued experience above knowledge. "Nor is practical wisdom concerned only with universals. An understanding of particulars is also required, since it is practical, and action is concerned with particulars. This is why some without knowledge – especially those with experience – are more effective in action than those with it." (Aristotle, 2004:1141b-1142a)

Chapter 10: Conclusion

The context of occupational medicine, a niche discipline within the extensive field of medicine, differs from all other disciplines. Its origins can be traced to hazardous occupations and perilous eighteenth century mining operations. “Industrial medicine” hints of the discipline’s coming of age in the era of the industrial revolution. Heroes in the field greatly contributed to trigger social reform related to improved public hygiene, better working conditions, the abolishment of child labour and the introduction of progressive occupational health and safety legislation. They mainly hail from the nineteenth century when they were agents to revolutionise working conditions in shockingly unsafe mines and dingy factories. The 1830s saw the ground-breaking introduction of legislation to try to regulate working conditions in the burgeoning factories of Britain. Yet, it was not until the turn of the century that the first physicians were appointed to exclusively attend to the state of the labour force in mines and other industries. All of this benefited the working class; industrial medicine was borne out of a sense of social justice. Workers are its patients and the discipline is primarily focused on prevention of injury and ill health. In enterprises involving controlled work, such as mining or the production and handling of hazardous chemicals, occupational physicians now have a statutory role in that they are appointed and accountable in terms of legislation. More recently, the focus on physical occupational hazards was also extended to the negative social and psychological effects of work, such as stress, anxiety, burn-out and the perils of shift work. Thus, the term “industrial medicine” was dropped in favour of “occupational medicine”.

Unlike advances in medicine, progress in the field of occupational health depended less on the brilliance of its physicians and more on the initiatives of the legislature – often prompted by organised labour and socialist sentiments. Labour-related legislation, especially occupational health and safety laws, had a much more prominent impact on the scope and practice of occupational health than healthcare statutes. But practising medicine in a labour environment (often an industrial set-up) where business principles rule, is what renders occupational medicine so prone to ethical controversy. The currency of profitable production, namely money mostly, and that of medicine, namely responsible care and altruism, conflict. To avoid an ethical stalemate, finding middle ground is essential. Occupational health and safety is a worthy social cause that cannot be subordinated to the interests of any other stakeholders – employers, managers, workers or the community.

In an egalitarian society, labour policies cannot go unchecked; people have rights. Since these rights include the health and safety of workers, it is a vital responsibility of government to regulate and enforce conditions in the workplace so that the health and safety of workers are kept secure. This regulation and enforcement must proceed, as far as possible, with the cooperation of the relevant employers and manufacturers. It must include the gathering and dissemination of knowledge bearing on workplace health and safety, setting of appropriate standards, and, where needed, the making of laws that embody those standards and adequate provision for their enforcement. (Gerwirth, 1986:34)

This scenario casts the occupational physician in the crucial role of custodian of occupational health and key participant in the promotion of occupational safety. That role is partly medico-legal, partly clinical, at times agency or fiduciary, and often involves governance.

Occupational medicine is, and will for the foreseeable future remain, a distinctive, irreplaceable but unsung discipline in medicine. That is because, rather than primarily healing and caring for the sick and being lauded for their patient-oriented loyalty, its practitioners' mission is to make workplaces safe and healthy environments for all workers. Despite their creditable role and aim, occupational physicians are seldom acclaimed in the way that accomplished clinicians in the more glamorous fields of medicine are. The public is interested in the lifesaving dramas of the emergency room and operating theatres. Assessing occupational disability and selecting who is fit to safely drive a school bus is not that awe-inspiring. The outcomes of occupational hygiene and occupational health interventions are not only less enthralling than organ transplant and cutting-edge neurosurgery, successes can also only be measured in the long term. The success of measures to sustainably bring down the fatality rate in mining over a period of ten years or to curb occupational cancers in a generation is a huge accomplishment from which future generations of workers benefit. But it does not generate the same interest as a single life being saved by brave paramedics while bystanders look on. Occupational physicians' loyalty lies with enduring workforce health and safety more than with sick and injured patients. Their discipline is primarily a preventative one, similar to community health, but with significant individual and personal patient contact.

In Chapter 3 the nature, spirit and ethics milieu of occupational medicine were elucidated. The overarching ethical sphere of medical care inextricably extends to occupational medicine. Beneficence, non-maleficence, respect for autonomy and justice – medicine's ethical principles

– universally apply to medical endeavour. Malevolence, disrespect for those in need of healthcare and injustice have no place in the medical profession. But the context of occupational health and safety goes beyond the individual requiring healthcare. Society has a major stake in safety and health. Safe construction, transport safety, the safe handling of hazardous chemicals and reliable emergency services all depend on ensuring that those in control are fit and able to perform critical jobs. Accordingly, special codes of ethics have been developed for professionals (mostly doctors) in the field of occupational medicine. Of these, the International Commission on Occupational Health's code is most authoritative (see Addendum A). There is generally consensus that the occupational health context differs from that of conventional medicine to such a degree that it not only warrants but necessitates a distinct code of ethics. To a significant degree, occupational physicians can be said to march to the beat of a different drum.

Ethical codes for occupational health address several ethical aspects that is either unique to the discipline or require particular attention. Considering the aim of occupational health practice, it is understandable that the field needs its own customised guidelines for ethically sound practice. Its primary focus is not patient care.

The aim of occupational health practice is to protect and promote workers' health, to sustain and improve their working capacity and ability, to contribute to the establishment and maintenance of a safe and healthy working environment for all, as well as to promote the adaptation of work to the capabilities of workers, taking into account their state of health. (ICOH, 2014:11)

As in other disciplines, medical practitioners' knowledge, competence and expertise must be above reproach. This includes a scientific and technical understanding of occupational health, work-related safety hazards and available mitigating measures. An important aspect of the occupational physician' responsibility is to promptly inform the relevant executive management when steps need to be taken to remedy a situation or remove undue health and safety risks. Such information should not be withheld from worker representatives and health and safety authorities.

Respect for autonomy features prominently in ethical guidelines. The labour milieu in which contemporary occupational medicine is practised is not conducive to respect for autonomy and confidentiality – essential characteristics of ethical healthcare. Stakeholders insist on access to relevant health-related information and labour legislation mandates much of that. Indeed, critically important stakeholders in occupational health and safety, such as employers, legally

appointed and accountable managers, labour union representatives, the safety inspectorate, pension fund trustees and the compensation authority, cannot fulfil their roles without adequate information. Medical surveillance, the periodic screening for health deviations, "must be carried out with the non-coerced informed consent of the workers" (ICOH, 2014:20). The outcome of occupational medical examinations is conveyed to management in terms of fitness for the envisaged work or limitation/restrictions imposed in the interest of health and safety. The detailed results of tests on individuals need not and should not be communicated to management. Where the physician judges that it is in the interest of a worker's health and safety that more be revealed to a supervisor or manager, the worker's consent is sought. For example, if a farm foreman is made aware that his tractor driver is allergic to beestings, he could ensure that appropriate first aid is available if an incident occurs far away from a medical facility. Overzealous confidentiality is counterproductive if it potentially stands in the way of worker health and safety. On the other hand, some ill-advised or inflexible employer might refuse to employ a worker with beesting allergy on a farm (even though the worker lives on a farm). Some employers believe the best way to avoid accidents at work is not to employ someone who constitutes any risk at all, not caring that a person is excluded from work on misguided grounds. Confidentiality in occupational medicine is a nuanced topic; it calls for inclusive discretion and practical wisdom.

In two concise paragraphs, the International Commission on Occupational Health (2014:23) manages to capture the essence of what makes for a good occupational health professional: "competence, integrity and impartiality" and "professional independence". Worker health and safety is their prime concern, their judgements must be based on scientific knowledge and technical competence and they must not do anything that endanger trust in their integrity and impartiality. To seek and maintain professional independence is paramount. They can never allow any conflict of interest to influence their advice and verdicts. Neither should the health of workers or the public be threatened because of such conflict.

To pre-empt the matter of professional independence, it is strongly recommended that it should be specifically addressed in the physician's contract of employment. Conditions of employment that significantly limit professional independence or are incompatible with desired professional standards or ethical principles should not be accepted. Occupational physicians have to build relationships of trust, confidence and equity not only with "patients", but with all stakeholders in occupational health and safety. To do that successfully and sustainably requires the

professional freedom to practise medicine in a way that command respect and trust. Custodianship of occupational health and safety in an enterprise that involves hazardous working conditions is an onerous duty. It demands a concerted effort from all role-players in the field and that the responsible physicians are free to do the right thing to potentially save the lives of workers. If their hands are in any way tied, parties who are not committed, or not sufficiently knowledgeable, might make ill-informed but far-reaching decisions that potentially can compromise health and safety.

Without an overview of labour-related health and safety statutes, the legal status and obligations of occupational physicians would be unclear. A healthy, safe and secure workforce is a prerequisite to productivity and a nation's sustainable economic growth. Four parliamentary acts of the Republic of South Africa were briefly discussed in Chapter 4 to describe the legislative context of occupational medicine. A South African peculiarity is the divarication of laws and government departments that govern health and safety in mines and in non-mining facilities – also extending to worker compensation. It relates to the high prevalence of mineworker phthisis in the gold mines of yesteryear and the political clout that mineworkers once had. To a varying extent these acts lay down rather detailed regulations for the monitoring of worker health, the reporting of deviations and periodical fitness for work certification. Ethical issues such as confidentiality and voluntary consent are addressed only briefly and inconsistently.

The health and safety of the workforce, and in many situations of individual workers, is the heartbeat of occupational medicine. Its fulcrum is a sensible, committed physician. One aspect of the occupational physician's responsibility is to steer clear of an unnecessarily unyielding stance on confidentiality that would obstruct rather than facilitate workforce health and safety. In the context of occupational health, a moderated approach is much more likely to spark collaboration towards the improvement of working conditions. The appointed physician is a necessary catalyst for curbing work-related injuries, but to sustainably improve occupational health and safety, a concerted effort, involving all parties, is required. That does not mean confidentiality is trampled; discretion is the golden rule – coupled with informed consent to reveal information where and when appropriate.

To unravel the theme of occupational physicians apparently having to serve more than one master, it is illuminating to consider who such masters potentially are and what the outcome might be if they are afforded such a role. For this purpose, a "master" is defined as "a person

who has control over or responsibility for someone or something" (Cambridge Advanced Learner's Dictionary, 2008, s.v. 'master'). Traditionally, physicians serve the sick. It is their duty. But patients do not tell doctors what to do. Providing a service, even a duty-bound service, does not establish a master–servant relationship. While doctors are in many situations obliged to respond to a call from sick persons, they are not controlled by their patients. Doctors' duty to provide healthcare arises from society having afforded them resources such as privileged education and years of specialised training. The unwritten social contract attached to that privilege and the trust placed in doctors is highly esteemed. In the doctor–patient relationship neither patient nor doctor is the master. In occupational medicine, worker health and safety is supreme. But the worker (who constitutes the patient in that environment) is not the sole beneficiary of measures to promote health and safety (as is generally the case in clinical medicine). Therefore, the occupational physician cannot always do what is best for the "patient". The aim is to do what is in the best interest of the patient's occupational health and safety. Risking a potentially life-threatening injury or progressive disease because the worker chooses to keep on working despite the risk is unjustifiable and even negligent. Running such risks also jeopardises the safety of co-workers and the public. Removing a worker from a high-risk job often goes against the wish of the individual. Occupational health patients can many times not have what they ask for if health and safety considerations dictate otherwise.

Dual loyalty, supposedly being committed to serving the interests of both employer and employee, is a common aspect raised in the literature on occupational medicine ethics. Consequently, it is fitting to dedicate a chapter to the presumed virtue of loyalty. Loyalty also features strongly in Chapter 5, where the physician's allegiances and professionalism are discussed. Loyalty in the context of employment and the contentious matter of whistle-blowing justify a separate discussion. No argument about the worthiness of loyalty and its potential for going astray would be complete without reference to Josiah Royce. Having debated the potential inappropriateness of loyalty in the context of professionals in employment, a brief remark should suffice. Occupational physicians cannot afford to succumb to sentiments of loyalty in their professional relationships. It would jeopardise the trust of all stakeholders in their independence and impartiality, which is imperative to the role of occupational physicians. Trust is pivotal, and hints of loyalty raises lasting suspicion of partiality.

"Managers" (a term which is used here to refer to supervisors, senior managers or the employer) are used to being the "masters" in their domain. The labour field dictates a hierarchical

management structure; everybody has a boss. The boss is master of his domain. Managers are contracted, expected, performance rated and remunerated to control their subordinates. In the workplace, managers expect to be in charge. And production and functional managers across a business are obligated to cooperate towards unified business targets. All managers have their performance measured and their contribution towards enterprise targets evaluated – a wholly reasonable expectation. However, such targets are unlikely to include the workforce's satisfaction with the demeanour of the occupational physician or the doctor's ethical track record. Apparently, the higher up managers are in the hierarchy, the more they tend to find it odd that the interest of a worker also carries considerable weight with the occupational health manager/physician. Unfortunately, the physician in the workplace is easily seen as the odd one out who is not unconditionally dedicated to management's business targets. Collectively, management is the "natural master" in the workplace. Occupational physicians have to demonstrate, even create, a culture in which the physician is professionally independent and his verdicts are only subject to the consensus of his professional peers. Such professional independence also implicates ultimate accountability. In occupational medicine, no prima facie "master" can be held liable for medical matters; physicians can and will be. They cannot afford a master – or even worse, many masters competing for territory.

One side of the occupational health coin is not having masters who direct and sanction the efforts of the occupational physician or need to be pleased. The flip side is the physician feeling obliged to prioritise the interests of one stakeholder – be it on account of the party's leverage, peer pressure or loyalty. One can conceive a situation where no party overtly attempts to seize the role of master by obstinately insisting that its interests are paramount, but the physician nevertheless afford their concerns preference. In fact, literature on occupational medicine ethics argues that some occupational physicians indeed consider themselves to be "on the side of management". According to Rodham (1998:83), one physician said: "We are all here because of our specialist background, but we are really here to support the business in its objectives". The point is whether it is in support of the business's health and safety objectives or rather productivity and profitability. Rodham (1998:83) also interviewed a manager who praised their occupational physician for wanting to be part of the management team, which is good. Disturbingly, though, had the physician associated with the workforce (the "patients"), he would apparently have been isolated by management. And that, being an insider or outsider, is the factor that creates an awkward moral situation for the occupational physician employed by business. Is firm support of management's objectives expected and dutiful or is it instinctive compliance?

The employer/management possesses great leverage to influence the outcome of occupational health consultations. In clinical medicine, consultations are confidential interactions between doctor and patient. In occupational medicine, the focus is usually the worker's capability to safely perform the work expected from him. So, the supervisor, safety manager, training and human resources practitioner provide their opinion of the worker's work performance and the potential risks inherent to the job. But when management has concurred that the worker should not continue on the job, they seek endorsement from the occupational physician. The legally appointed senior production manager has the authority and accountability to hire and fire. In the formal labour context, the latter would mean either termination of the worker's employment contract or being medically boarded for disability. Whether the doctor declares a worker fit or unfit for work, management can remove the worker from the job in any case. If there is agreement, the worker is likely to qualify for disability retirement benefits; if not, the worker stands to be terminated without such benefits. The crux of the matter is that the ill health retirement authority or fund acts on the physician's recommendation while the employer can act contrary to the physician's advice. This means that if the doctor does not agree with management that a worker is significantly and irreversible impaired from doing the work, the worker will still lose his job, but then without early retirement benefits. Disagreement with management is to the detriment of the worker. In occupational health, the employer has leverage in most matters. Unless occupational physicians determinedly maintain a high degree of professional independence and ethical conduct, they might in time give in to employers.

If the dominance of employers, who after all fund all occupational health activity, discourages occupational physicians from maintaining their professional impartiality, peer pressure can also add to their ethical woes. As leaders in occupational health teams, occupational physicians inevitably have management responsibilities in addition to clinical and professional duties. In South Africa, the principal occupational physician would typically be a member of the safety, health and environment management team. This might include sub-disciplines such as behaviour-based safety, process safety, product stewardship, occupational hygiene, waste and water management, etc. In industrial enterprises, these managers, mostly engineers rather than other healthcare professionals, are the occupational physician's peers. They all work for more senior managers. However, the occupational physician, while also reporting to a senior manager, really "work for" the workforce, not for management. This aspect, generally not recognised by those outside of healthcare, creates a version of peer pressure that is difficult to deal with. It is

implied rather than spoken. It causes conflict because it pressurises occupational physicians to also focus on management's business targets, possibly to the detriment of diligent healthcare.

Peer pressure inevitable raises the issue of loyalty, an aspect addressed at length in Chapters 6 and 7. Occupational physicians are required to be committed to the cause of health and safety at work. They equally have to be dedicated to sound and ethical healthcare for the workforce and those workers who become their patients – whether for once-off treatment of an injury or over the stretch of a career. Professionalism is required to earn the respect of workers, patients, colleagues, peers, management and labour union shop stewards alike. Without respect, no doctor can perform his duties effectively. Respect for a physician translates into trust. Occupational physicians are in a unique and challenging position. They do not only need the trust of their patients to practise; they have to gain the trust of all stakeholders in the inclusive occupational health field. By building a sound professional reputation, these doctors ensure that potential patients, the workforce, recognise their trustworthiness. Occupational physicians provide the workforce and the employer with peace of mind related to health at work. For that, everybody needs to trust the skill of the appointed physician. If loyalty equals dedication and commitment, the variety of loyalty saluted by Royce (1908), then occupational doctors have to be exceptionally loyal. If, in the context of occupational medicine, the result of loyalty is to selectively further the interests of one party to the detriment of another, it is disreputable.

The trust of pertinent role-players is critical for occupational physicians to perform their duties with distinction. Much of their duties involve applying special knowledge, experience and discretion in the interest of good judgement. If workers or employers experience or suspect that an occupational physician identifies with one party or allows loyalty to influence his judgement, all of his decisions become questionable. This is even more so because often neither party understands the clinical details of medical conditions leading to a degree of impairment and how it creates a health and safety risk. A common example is when a fitter experienced a single epileptic seizure and investigations do not yield any causative abnormalities. For the employer, it seems too great a risk to allow the worker to resume fitter work unless he has no further epileptic episodes for two years. But the worker, anxious about job security, insists on returning to unrestricted work after six weeks – and presents a letter from his family practitioner to that effect. It is the occupational physician's duty to make that decision in the context of the case details and accept accountability. Incidentally, the employer is likely to focus on the probability

of another episode (at work). The more relevant issue is the probability of a serious injury on the job, should there be another seizure. Evidently, loyalty has no place in such decision-making.

In Chapter 7, three common scenarios that typify ethical contention in occupational medicine were presented. The purpose was to shed light on some of the morally controversial practices confronting occupational physicians. Pre-employment assessment of applicants and prospective employees is one such area. For physically demanding work, a job interview alone does not suffice to select suitable candidates. Many employers insist on a medical assessment of fitness to work and, especially in the mining industry, a work capacity assessment is often mandatory. It involves testing cardio-respiratory fitness, muscle strength, lifting ability and body mass index in an occupational therapy facility. While "fitness" criteria are set and tested against, borderline cases are common. The occupational physician's duty is then to rule who passed the test and can be employed and who did not. In an environment of vast unemployment, poverty and desperation, a process of selecting the fittest and excluding many from the only work they are likely to find can be heart-breaking. Management, being removed from the actual pre-employment assessment and focused on productivity, strongly believes in the process's utility. Consequently, occupational physicians are obliged to participate and deal with their ethical qualms.

Work-related injuries are an outcome of failed safety precautions. Therefore, it reflects poorly on management – especially on safety managers, whose performance rating depends on preventing injuries. The safety fraternity preaches "zero tolerance", proclaiming that all injuries are preventable. Every injury thus represents failure. One pragmatic way to exempt management from responsibility is to show that the injured worker acted irresponsibly or contrary to rules. The result is often that the employer–employee relationship is soured. Thus, a simple injury stands to degenerate into a psycho-social equation. When that happens, subjectivity and sentiments such as blame, indignation and manipulation colour the incident. There is a risk of confrontation between management on one side and patient and physician on the other. Having to forge a clinical doctor–patient relationship in order to manage the injury creates an unpleasant situation where the physician is easily seen to be siding with the injured. Dealing well with workplace injuries and all its quandaries requires an understanding of the ethical ambiguity that so often permeates occupational medicine and how to pre-empt and negotiate stakeholder sentiments.

The process to monitor the health of workers potentially exposed to health and safety hazards is termed medical surveillance. It complements the monitoring of ambient conditions in the workplace, such as air sampling for chemicals, by occupational hygienists. Medical surveillance typically entails periodic medical examination and, depending on what the risks are, tests such as chest X-ray, lung function testing, screening audiometry, etc. Chemical exposure is monitored by way of blood or urine sampling – called biological monitoring. As discussed in Chapter 7.3.3, much of biological monitoring is mandatory to detect excessive exposure and safeguard worker health. The most ethically contentious aspect of medical surveillance is the confidentiality of the results of individual workers. Employers carry the cost of all occupational health interventions, and line managers and safety managers alike tend to demand seeing the results. Ethical codes for occupational health professionals universally advise against physicians giving employers access to the detailed results of individuals.

> The results of the examinations prescribed by national laws or regulations must only be conveyed to management in terms of fitness for the envisaged work or of limitations necessary from a medical point of view in the assignment of tasks or in the exposure to occupational hazards. (ICOH, 2014:20)

This ethical principle is easily circumvented by requiring employees to sign a blanket consent form; ignoring the fact that it can hardly be considered voluntary, informed consent. Once workers give consent that their confidential health-related data may be shared with management, the physician cannot deny the employer access. By and large, unsophisticated South African workforces seemingly have no scruples about medical confidentiality in occupational health – presumably because occupational medicine is seen as an occupational matter. Protecting confidentiality when the relevant individual does not care makes little sense. In other jurisdictions, such as Europe, the opposite applies; confidentiality is taken for granted and staunchly upheld.

As in the broader ambit of medicine, the appropriateness and quality of the doctor–patient relationship sets the scene for gratifying and successful occupational healthcare. Chapter 8 focused on how, in occupational medicine, the purpose of a doctor–patient interaction determines the tone of a consultation. Treatment and healing are often not the aim. Generally, it is about assessment only and providing a third party, with a vested and valid interest in the patient's health and occupational fitness, with an educated opinion. Though, given the legal status of duly

appointed occupational medicine practitioners, that opinion generally mandates appropriate action. The primary goal is not to serve the patient's interests (such as earning wages and job security); occupational health and safety is ultimately the mission. Obviously, the latter also serves the occupational health patient's own interest – personal health and safety. But collectively, workforce health and safety take precedence over the wishes of individual workers to carry on working in the face of identified risks. The ideal is to resolve occupational health and safety risks in such a way that their impact on individual workers is minimised. That is not always possible. However, reasonable accommodation, redeployment, workmen's compensation, unemployment insurance, retirement funds and social grants provide a social safety net.

While experienced physicians are well-versed in the complexity and varying dimensions of doctor–patient relationships in occupational medicine, their patients tend to have a different viewpoint. Workers who are or become the occupational physician's patients are familiar with the traditional version of the doctor–patient relationship. By and large, at least in the South African context, they trust doctors to do what doctors generally do – to care for their patients. To them the nuances of a variety of doctor–patient relationships are often less obvious. Unless they grasp (or are explained) the extraordinary, unorthodox role of occupational physicians and the realities of the work-related doctor–patient relationship, patients stand to be disillusioned. Their inclination is to believe that medical doctors care for and help people who come to them. In reality, that care extends to occupational health and safety but cannot be holistic. In occupational medicine, the legitimate interests of other parties than the patient/worker can never be side-tracked. While the patient deserves due respect and consideration, the focus of occupational medicine, namely worker health and safety, take priority. Making the right decision in borderline cases of risk versus fitness-to-work is the occupational physician's foremost responsibility.

In occupational medicine, professionalism under all circumstances must be the foundation of relationships involving the physician and the enterprise's various functional managers. Respect must be earned, not taken for granted. Management cannot be expected to respect the role of occupational physicians merely on account of their vocational status. One cannot expect respect for who you are; only for your acumen, conduct, dependability, actions and reciprocal respect. Trust in relationships is earned if the foundation is firm and trustworthiness is constantly affirmed. Respect and trust mean that management has confidence in the physician's competency and can rely on him to use professional discretion, adhere to ethical norms and advise wisely.

In chapter 9 the focus is on virtue ethics in the context of occupational medicine. Where ethical codes and guidelines for the profession's practitioners fall short, is that they cannot deal with character, core values and moral attitude. By considering the various roles which occupational physicians are required to adopt in their everyday practice, I contemplate which virtues befit occupational physicians. Being the custodian of worker health and responsible for ethical healthcare practice in an environment otherwise dominated by business and labour interests, demand rectitude. Thus, I argue that while integrity is pivotal, tact is also a critical virtue for occupational physicians in order to convince decision makers to support/accept their professional recommendations. In part it relates to the fact that in occupational health and safety, being a medical doctor alone, does not command respect and trust. It has to be earned through tangible impartiality, commitment, expertise and trustworthiness.

Despite having practised occupational medicine for many years, I still often have to negotiate ethical issues inherent to the discipline. In this dissertation I set out to introduce the context of South African occupational medicine and apply reason to address, rather than conclusively answer, some of the ethical questions occupational physicians are confronted with. If they have "masters", who are they and what does the occupational physician owe them? Is the conflict of interest apparent, imagined or real? One theme in occupational health is the question who the doctor in industry identifies with. In discussing the role of the occupational health professional, Rodham (1998) asked "manager or medic"? It is of critical relevance if it determines the occupational physician's disposition. My experience is that it does matter. Being a patient-oriented doctor in an environment where business managers call the shots is at best challenging and at worst disparaging. The doctor's commitment to the welfare of the workforce and individual workers can easily prove to be irreconcilable with management's objectives. It is inevitable that managers responsible for meeting the enterprise's performance targets (and rewarded for reaching those targets) would expect the company physician to likewise commit to their business objectives (and share in the reward).

Given the ethical conundrum that seemingly haunts occupational medicine, it is difficult to untangle physician allegiance, professionalism, doctor–patient relationships, universal medico-ethical principles and legal obligations. Inevitably, there are defeatists and there are occupational physicians who emulate the industrial medicine heroes of yesteryear. A noted former Harvard School of Public Health and Boston University professor believes occupational health inherently invites ambivalence:

> Industrial physicians stand hopelessly mired in grievous moral conflict, responsible but powerless, divested of the essential symbols of a physician's social status, and emblematic of the deteriorating future of medicine – the last of the independent professions – as it succumbs to the bureaucratic imperative. (Walsh, 1986)

A notable South African occupational medicine academic is carefully optimistic about the discipline:

> For many reasons, it is insufficient and probably ineffective to locate the problem in an individual practitioner's behaviour. Critical is the need to look more broadly at the institutional context in which ethical behaviours 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 can do to support members through advisory and ombudsman functions to promote ethical professional practice, and, particularly, to support colleagues whose isolation facilitates their victimisation for their ethical stances. Precisely because the choice to follow an ethical course of action may lead to adverse consequences for the OHP [occupational health practitioner] (London, 2005:329).

Prof. London pinpoints a key reason for the apparent ethical vulnerability of occupational physicians in industry. The company's physician is invariably the sole guardian of healthcare ethics in an enterprise dominated by business executives and managers who chase business targets to prove their worth for the company and reap the rewards. The doctor has the daunting task to deal empathetically with the injuries that a team of safety managers failed to prevent and handle cases of workers who unfortunately fall ill. The occupational physician's patients are the workers who are "responsible" for much of the unproductivity that managers need to root out.

Not having a professional regulative body with some statutory authority in the field of occupational medicine is a shortcoming in that it exposes individual occupational physicians to being opposed or overruled. While statutes regulate the health and safety obligations of employers, the legislator cannot prescribe ethical behaviour or control and police unethical conduct. In spite of membership of a society for occupational medicine, South African occupational physicians are pretty much on their own – the sole agents of injured and ill workers in the labour environment and dependent on management to accept their consultancy. It is a field

in which labour unions seldom have significant expertise and influence to be a constructive role-player. Unless ample respect, trust and support is forthcoming from senior management, occupational medicine, specifically its ethical practice, can be a lonely place. Still, such respect, trust and backing have to be earned. It requires an occupational physician with an undeniable reputation for professionalism, trustworthiness and unbiased constancy.

In closure, from the literature on occupational health and occupational medicine specifically, it is evident that ethical ambiguity and even confusion are omnipresent in this limited but material branch of medicine. Occupational medicine practice transcends patient care in that its ultimate social good, the health and safety of people at work, the productivity of a nation's labour force and, indirectly, its economy, is paramount. On account of the specialised knowledge and expertise required, the responsibility rests on the shoulders of physicians. But physicians are trained and indelibly imprinted with the notion that the patients' needs are paramount – their overarching duty. Ethical conflict is thus inevitable and inescapable. In occupational health, there are necessarily several bona fide stakeholders, while in medicine confidentiality is almost sacred. Giving preference to the interests of any party – overtly, through precedent or even inconspicuously – will escalate ethical controversy. Occupational physicians cannot serve any masters. Their guiding principle is to serve the health and safety of all workers and that of everyone at risk of illness or injury related to the incapacity of workers – whether the latter are airline pilots, rock drill operators or abattoir staff. Only the level of risk differs. Overzealous protection of a pilot's privacy potentially risks the lives of many. Similarly, a mine captain with cognitive impairment, such as impaired judgement due to a serious mood disorder, could jeopardise the lives of his whole team.

The apparent conflict of interest in the profession of occupational physicians is thus not illusory or merely theoretical; it is real, well-documented and pervasive. It presents a formidable challenge to occupational physicians in industry. Questionable ethical conduct is hardly amenable to legislation and ethical guidelines of professional societies and commissions are not enforceable. Prescriptive ethics cannot succeed just as authentic professionalism cannot be regulated. Morality can be said to be in the heart of someone and in the eye of the beholder. Professional discretion, rational judgement and the astute occupational physician's moral compass are more valuable than formalised ethical guidelines that can never address unique scenarios. Ethical medical practice in the context of occupational medicine allows subordinating respect for autonomy of the individual to the greater good of society. A patient and a worker are

two different entities and ethical subjects. Patients enjoy rights and the special moral status attached to patienthood in contemporary western medicine. Workers, on the other hand, are subject to their labour contracts and a plethora of statutory regulations that rule the labour environment.

Workers who become patients on entering the occupational health clinic do not cease to be workers. For the physician, they are patients, but for all other role-players they are firstly workers. Temporarily being a patient does not absolve a worker from his contractual duties and, at least in the eyes of the employer, does not afford him additional rights or moral status. Patient rights extend only to the clinic door and the doctor–patient relationship – rights rooted in bioethics that do not have to be earned. All other relationships in the workplace remain hierarchical. While the physician works on establishing a relationship with a new patient, the labour relationship could come under pressure on account of the worker having sustained an injury or illness. Either way, relationships in occupational health are multilateral and, on account of divergent stakes, often awkward.

In summary, to better deal with the intrinsic ethical burden of occupational medicine, pursuing the following avenues should prove fruitful. Firstly, role-players, and not least the occupational physician, should recognise that occupational medicine is not a patient-centred mission; its raison d'être is healthier and safer working conditions. That does not mean that occupational physicians are divorced from medicine and its ethical conception. Occupational medicine is already ethically suspect for its presumed association with employers. Without durable moral construct, occupational physicians' credibility would at best be dubious; at worst, the discipline's claim to an ethical grounding would be mere pretence. Workforce health and safety is paramount, but in all their endeavours to promote that goal, medical practitioners in industry, like all physicians, have to respect individual patients, constantly consider their well-being and live by the ethical principles of medicine. While the context of the labour environment inevitably modifies the approach to patient autonomy (what degree of autonomy is reasonable and attainable), beneficence, non-maleficence and especially justice equally apply in occupational medicine.

Secondly, ethical codes for occupational medicine ought to be disseminated more widely. In a survey (Aw, 1997) of 70 occupational physicians from the United Kingdom, the Netherlands and Singapore, only 13 (19%) were aware of the code of ethics of the International Commission on Occupational Health (the most authoritative of such codes). Given the extensive literature related

to occupational health ethics, spanning some four decades, one could deduce that most doctors practising occupational medicine do not consult such codes, are unaware of the valuable guidance that is available or deal with ethical issues intuitively. However, the ethical challenge occupational physician's face is less a matter of what to do; it is more about stakeholders accepting or rejecting the physician's counsel and affording their unbiased professional opinion credence or questioning it. Convincing stakeholders, especially safety managers and executive management, might be less laborious and frustrating if they have a better understanding of what drives occupational physicians' professional conduct. Taking cognisance of what leading national and international organisations in the medico-legal and labour field expect occupational physicians to comply with should foster a good doctor–employer relationship. If occupational physicians as well as business managers are more aware of the standard of practice and compliance with ethical guidelines expected in occupational medicine, they will be less prone to accept or condone questionable conduct or mediocrity.

In spite of its indisputable utility, occupational medicine, like many other beneficial systems, is open to exploitation and abuse. No doubt, unscrupulous employers can attempt to co-opt occupational physicians to promote unilateral business goals. It might take the form of health-related retrenchments, playing down health hazards or declaring illnesses non-work-related when the opposite cannot be ruled out. Walsh (1986:792) refers to "dirty work" and suggests that "corporate physicians are 'indentured'", they are "tools of the boss" in the "ghettoized company doctor system". Coming from a highly regarded public health professor, such scathing criticism can only mean that in the past some corrupted occupational physicians conspired with employers.

The discipline's moral track record is not untarnished. Even though such poor conduct would hardly be tolerated in a progressive society, ethical codes provide a yardstick for good practice. The option of referring stakeholders to a widely acclaimed code of ethics in times of ethical misgivings renders the occupational physician less isolated – less of a solitary voice opposing pragmatism extending to ethically dubious practices. Business management has little or no insight in the ethical domain of occupational medicine ethics. Debating medical ethics in the boardroom is of little value. When occupational physicians are expected to participate in or sanction decisions that would transgress their ethical code, being able to refer to a respected code of ethics would be more convincing. It is worth their while to be familiar with such ethical codes.

Thirdly, the duty of occupational physicians lies in the ambit of occupational health and safety. It means that they are responsible and accountable to minimise the negative effects that work and the workplace environment potentially have on workers. It also involves the health and safety interface between a business enterprise and society – how the business's activities, products and services potentially put the public at risk. Occupational physicians' role is to serve the enterprise, its workforce and society through managing the risk of injuries and ill health brought about by the enterprise's activities, not to save it money or boost its profitability. Others take care of the finances, marketing and technology. The occupational physician's contribution is to help the enterprise to build an exemplary reputation for health, safety and stewardship. That is an asset that in the long run enables a business to excel. When company physicians, on account of demands to be part of business management, become too involved in short-term business targets or operational issues, their focus is prone to shift from health to business. Physicians in occupational medicine ought to remain bona fide doctors, honour their profession and not be lured by the status of executive management if it entails relinquishing their agency related to injured or ill workers. For ages, occupational physicians attended to the health and safety of workers. Their utility primarily resides in healthcare, not in managing human resources for the benefit of employers.

Finally, occupational physicians are medical doctors that workers, employers, labour unions, relevant authorities and society need to believe they can trust with stewardship of the health and safety of workers. They do not preferentially serve the interests of one or some. Such trust entails confidence in their judgement and engenders respect – but only if it is earned. The seed for trust in and respect for physicians lies in the orthodox esteem for the profession of medicine, but trust, being fragile, needs to be nurtured through befitting professional conduct. Virtues expected of occupational physicians would encompass trustworthiness, integrity, compassion, sincerity, fairness and impartiality. Guided by the four ethical principles of medicine – namely beneficence, non-maleficence, respect for autonomy and justice – occupational physicians need to individually set their moral compasses. Ethical guidelines show the direction but cannot suffice. Commitment to the discipline of occupational medicine and the cause of occupational health is required. In addition, practical wisdom, which comes with experience, enable physicians in the labour environment to untangle the complexities of their profession.

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Addendum A

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