Professional Ethics in Occupational Health —Western European Perspectives^a

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Abstract: In this paper, the foundations of professional ethics in occupational health care is described and discussed. After an introduction reminding of the global developments of world economy, communications and trade and reference to cultural and social developments, reference is given the four basic ethical criteria of biomedical ethics of beneficence (“doing good”), non-maleficence (avoidance of harm), autonomy (integrity) and Justice/Equity—The “Appletown consensus” of 1989. These criteria provide the basis for current thinking and practice in health professions of Western Europe. The principles of ethical analysis, as currently practiced is described using a practical case scenario drawn from experience of challenging tasks for Occupational Health Services in Western Europe. Specific challenges to professional ethics are discussed—the growth of knowledge in subjects and academic disciplines relevant to occupational health and the multiple loyalties of occupational health professionals. The principles of ethical codes and their implementation are touched on. In conclusion, the universality of professional ethical principles of bioethics—including occupational health—is discussed in observing global inter-cultural commonalities and convergence on ethical criteria of central importance. Emphatic recommendation is given to continue inter-cultural exchanges with a view to improve understanding of impact of contextual and cultural factors on ethics in professional occupational health practice.

Key words: Occupational health, Professional ethics, Biomedical ethics, Beneficence, Non-maleficence, Autonomy, Justice, Equity

Changing Horizon of Occupational Health

Rapid change and innovation in the world of work pose major challenges to societies, enterprises and workers everywhere and setting new contexts for OHPs in their tasks. Determinant factors are restructuring and shifts in the panorama of work-related ill-health. There is globalization of national economies and increasing pressures to contain costs and to seek effective health hazard prevention.

Professional ethics is expected to bring material contributions in terms of health benefits, to protection of integrity and human values and to make life better for all. Beside the global trends in labour markets and workplaces

there are developments in cultures and sets of value throughout the world. These trends carry implications for ethics of OHPs. The emphasis is set on the practices of the Western world and in particular North Western Europe in discussing ethical dilemmas of Occupational Health Professionals. The challenging issues of multiple loyalties and issues related to ethical codes will be touched on and finally the issue of universality in ethical value sets.

Issues of ethics arise in practically all activities of OHPs. They may be met in health surveillance of enterprise staff, workplace monitoring, interventions aiming at prevention of health hazards, assessments of working ability of employed staff, health examinations on new employment, risk assessments, rehabilitation of workers with health disorders, workplace health promotion etc.

Ethics deals with the questions: ‘How do I know what is

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right to do?’ And “How are we to arrive at value-based decisions”? In terms of a condensed overview of ongoing processes of development and change, the major factors operating are often referred to as:

- Globalization of core economic activities
- Growing dependence on sophisticated technologies
- Organizational flexibility under competitive pressures
- Greater power for management in relation to labour
- Retrenchment of “welfare state” societal functions
- Feminisation and ageing of active workforce
- Emergence of highly educated and international workforce
- Inequality and polarization of labour
- Expansion of labour in precarious employment
- Movements across national borders of migrants and refugees into labour markets of receiving countries
- Marginalization or social exclusion of population segments with little or no collective power—those frail or disabled, elderly, with low-education, migrants etc
- Enhanced ecological awareness among public

These mega-trends and their diverse combinations lead to new scenarios for occupational health professionals to relate themselves to. In Western Europe as well as in other regions we have seen implications of this change in the form of:

- enhanced productivity
- organizational flexibility under competitive pressures
- greater power for management in relation to labour
- retrenchment of “welfare state” societal functions
- inequality and polarization of labour
- expansion of labour in precarious employment
- marginalization or social exclusion of population segments with little or no collective power—i.e. those frail, elderly, with low education, migrants etc.

Values are at the heart of the substance matter of ethics. Recently, US researchers Norris and Inglehart¹⁾ have published insights into ongoing global value changes. Some of these important observations can be summarized as:

- Populations of virtually all advanced industrial societies move toward more secular orientation. Secularization implies systematic erosion of religious values, practices and beliefs
- The world as a whole has more people with traditional religious views than ever before
- People living in Protestant societies of the Western world display the weakest work ethic in developing post-materialistic values. A person adopting post-materialist values sets quality of own personal life in higher priority than to economic growth of community or society

This pattern of change is likely to carry implications for occupational health professionals

Practicalities of Occupational Health Ethics

In order to bring this discussion of ethics into the real world of occupational health, we may visualize a scenario where a major corporation has just managed to take over half a dozen hotels in a merger operation. The objective is streamlining of service output with reorientation towards action holiday programmes. Staff reductions and new recruitments with a new set of profiles are advertised. Staff members express concerns about future prospects. There are signs of heavy mental distress among personnel. The Occupational Health Service (OHS) department is summoned to discuss situation with top management and instructed to set up a programme of health examinations with a view to reduce stress reactions, to strengthen stress coping capability of middle management and staff and to identify staff members who, for health reasons can be assessed to be particularly vulnerable. This leads to questions:

- What information is to be given to whom on objectives of the examinations and their practical content? How are the results of the examination to be used and who will be given access to such information?
- How are the data and other information to be stored and how is confidential information to be handled?
- What test methods are to be used and what is their validity (sensitivity and specificity)?
- Has the principle of informed consent been complied with?
- Which are the requirements on information before health examination programme is implemented and what information is to be given afterwards and to whom?
- Who is entitled to know what about whom?
- Are the data collected to be used for selection of staff to the transformed new enterprise?

Many stakeholders enter this process with differing objectives and motives. Ethical dilemmas arise for the health professionals of the OHS department

On Ethical Questions

Before exploring the subject of ethical problems arising within the broad scope of the professional realm of OHPs in their advisory and counselling roles the question “Which problems are ethical?” needs to be addressed.

Ethical problems can commonly be seen as action related. They arise from what OHPs meet in their daily work and

how they proceed to do what they have chosen or decided to do. In this sense ethical problems are practical. It is, however, necessary to separate them from a range of other practical problems involved in industrial manufacturing or provision of services. Most of these problems are not ethical. Also, there is a distinction of issues of ethics from issues of legal nature.

The distinctive feature of the ethical problem or dilemma is the competition or even a conflict between values of such nature that the actor has to choose which of these values is to be given priority. If one value is selected for first priority the other(s) are, by implication, considered as second grade priority. If, for instance, autonomy or integrity of clients and justice/equity are ethical values and you can fully satisfy the requirements only one of these, you have an ethical dilemma. It is necessary to choose. In the example given above, the OHPs are facing the dilemma of intervening at the workplace with a health screening aiming at strengthening coping capacity of employed staff while having to handle expectations from employer to identify staff members who can be assessed as vulnerable and incapable of coping with imminent change.

The questions to consider in addressing the task to be carried out by the OHS department of the situation described above are:

- Whose interests are involved if the OHS department opts for a health screening programme as requested by the company management
- What consequences will result from implementing the programme?

The Health Concept

New health concepts to replace the earlier well-known WHO definition are at the present time emerging in the philosophical sciences. In them health is seen as a process with person interacting with the surrounding world in seeking to achieve vital life goals. For instance, Nordenfelt²⁾ has in 1995 proposed a definition as follows:

“Health implies a capacity and ability to achieve vital life goals. To be at full health, accomplishment of all vital goals is required. With vital life goal or objective is implied a necessary condition for achievement of minimal life satisfaction.”

This type of definition opens up new vistas with a health conception altogether disconnected from the requirement of subject's having a disease. A person may in this perspective be employable and even healthy although having a chronic

disease. Such a definition of health has ethical implications in that it contributes to opening up to employment and to labour market for persons who do not enjoy full health in the meaning of more conventional health definitions that presence of disease or ill-health determines health status of a person.

Ethical Analysis

In analyses and considerations of adopting a stance in relation to ethical dilemmas, the following basic elements are sought:

- Medical, psychological, social and other facts
- Which are the ethical values involved?
- Whose interests are involved and which are the consequences if one or some other line of action is chosen by the OHPs?

The facts

As a first elementary step, the facts of the problem at hand and the issues involved need to be clarified. In Europe there is at the present time a renewed interest in evidence and Evidence Based Medicine (EBM) or Evidence Based Practice (EBP). An important point of departure has been the introduction of the concepts of Evidence-Based Medicine by Sackett *et al.*³⁾ in 2000, later refined and operationalized for the occupational health field by van Dijk and Verbeek in a World Health Organization publication⁴⁾ in 2006. There are increasing demands on expert knowledge from client systems. Customers are less inclined to take professional advice on faith. This applies also for professional practice in occupational health. The first elementary step is to define the types of facts needed for a decision. It is necessary to manage situations with scarcity or even an absence of hard facts. Facts may imply results of interviews and surveys, searches of literature for relevant published studies or professional consensus statements. Finding the relevant facts and evidence base for action and for judgements may be demanding.

The fundamental ethical questions related to revisiting and collections of the facts are therefore:

- Which facts are needed? In example given above, the pertinent facts concern strengthening of coping capacity of personnel and identification of health-wise vulnerable persons who need particular consideration or need to be protected.
- Which efforts should be made to assemble an accurate, complete and reliable basis of facts? And who is to do it? It is a professional axiom that it is unethical not to have

the best possible information and database for decisions in matters of occupational health.

Norms / values

The second step is to identify the values involved in the case-at-issue and to use them in the analysis. The selection of values is to be explicit, clear and transparent. The values involved may conflict, implying a dilemma. An example of widely accepted values in the biomedical field of the Western world is the concept of Appletown (US) consensus of 1989. It consists of a basic set of four fundamental values or ethical principles. These are:

- **Beneficence** (The prima facie principle and obligation to contribute to the welfare of others). The beneficence principle implies an obligation to take positive steps for this objective, not only to refrain from harmful acts. The beneficence principle or criterion is the classical cornerstone basis of bioethics and medical ethics. It is basically doing good deeds.

- **Non-maleficence** is the prima facie principle and obligation not to inflict harm on others.

- **Autonomy** is a complex concept in that there are differences across the world. Autonomy is in itself commonly understandable. It concerns, on the individual level an obligation for all people to respect others right to self-determination. When looking a bit deeper into this concept it is obvious that its connotation differs between cultures. Autonomy occupies a sphere of considerable scope in Western and in particular US-oriented cultures. In countries with more of the Confucian traditions of East Asia there are more community-oriented and duty-based traditions making for more room for harmony and consensus and less for individual autonomy. See Norris and Inglehart 2004¹⁾ and De Castro in 1999⁵⁾.

- **Principle of Justice / Equity**

This principle requires some reflection to be properly grasped. It is a double principle in having a construction based on two seemingly opposed principles—likeness (equity) and difference, respectively.

- Principle of Equity

This principle implies an obligation to observe that all persons have a prima facie right to greatest possible freedom of action which is compatible with all other persons having the same right regardless of ability to pay, age, gender, nationality, religious faith, ethnicity etc.

- Principle of Difference

This principle requires that dependent and vulnerable persons have a right to claim and to obtain satisfaction of

needs if their own efforts fail to achieve this. Inequity is ethically defensible only if it brings advantages to those who are least privileged. This second principle (difference) according to the US philosopher John Rawls is commonly seen to be close to principle of solidarity—implying solidarity with less privileged or de-privileged segments of our societies.

There are also other values which can be used as criteria or tools in ethical analyses. These may be referred to as Human rights, Solidarity, Cost-benefit or Cost-Efficiency or Harmony. For references see Westerholm, Nilstun and Øvretveit 2004⁶⁾.

The stakeholders

Occupational Health Professionals have many masters to serve. The full perspective of the loyalties of OHPs is effectively of considerable scope. It is quite obvious that the OHPs may often be confronted with claims and demands from many sides leading to situations where the needs and aspirations of all involved just can not be satisfied.

Decisions on matters related to occupational health in enterprises often concern many people. It is therefore important to identify all persons involved and concerned, thereby making visible who will be affected by the decision to be taken. Commonly involved are:

- Employer and management of enterprise/organization on issues or problems related to health, prevention or rehabilitation—policy and strategic levels
- Staff of enterprise/organization as a collective (Trade Unions) on same substance matter on policy and strategic levels
- Individual employees or management representatives on concrete person- or workplace-related problems
- Medical care consultations on the individual level—limited to medically trained OH professionals
- Societal organizations (social security agencies, insurance companies, labour inspection etc.)
- The OHS organization itself
- The OH professional in personal capacity
- Families of employed staff, communities and taxpayers at site of enterprise may also emerge as stakeholders in taking decisions involving ethical values

In the practical example referred to earlier an overview of the ethical issues involved in launching a health screening survey of staff in proposed reorganization can be obtained by a simple cross-tabulation of stakeholders and selected ethical value principles. The ethical analysis may be structured in examining:

Table 1 is used for entering of notes on consequences of

Table 1.

Persons involved or affected	Ethical principles		
	Beneficence	Autonomy	Justice
Employees			
Employer/management			
The OH professional			
Staff of OH service			

action taken for persons/stakeholders involved with regard to ethical principles chosen. The four stakeholder categories are those primarily involved in case-at-issue and the listing is certainly far from exhaustive. In the example given, the requested health screening programme with purpose as framed by the management would most probably imply violation of fundamental professional ethical values as seen by occupational health professionals in Western Europe and probably also in most other world regions. It is a programme imposed on company staff without consent of those involved, it requires occupational physicians to make health assessments to be used for decisions to retain or to lay off staff members for health reasons and it may imply exclusion of vulnerable persons. Moreover, the scientific basis of evidence for the programme in its entirety would most probably be questioned.

The last step of an ethical analysis is to take a decision. After having examined available action alternatives the decision will be value-based. Sometimes the issues involved in the decision are of considerable complexity, carrying both long term and short term consequences for health and life conditions of many people. Civil courage may be an essential asset in the decision-making.

Multiple Loyalties

The multiple loyalties, implying necessities of balancing and resolving divergent interests and underlying values while safeguarding professional integrity and independence is one of the most difficult problems in occupational health services. See review by London in 2005⁷⁾. The ethical challenges inherent in the day-to-day work of occupational health professionals are known to all OHPs. In the International Code of Ethics for Occupational Health of the ICOH it is explicitly stated as a norm that “The purpose of occupational health is to serve the health and social well-being of workers individually and collectively”. Nonetheless, the balancing and resolution of the various interests, expectations, values

and practical implementation of ethical criteria remains as the most demanding challenges in health professional ethics of today. There is no law of nature or law of man to resolve such dilemmas. It is for the health professional to choose action or non-action on the basis of societal civic values, professional values and personal set of values in combination. House has in 1993⁸⁾ suggested the following principles in coping with multiple loyalties: a) non coercion; b) non-manipulation and support for democratic values and principles; c) transparency.

One basic principle to keep uppermost in the minds of occupational health professionals dealing with multiple loyalties is transparency and unmistakable declaration of own role in agreements, contracts and commitments. I recall an African proverb, quoted by the bioethicist researcher Godfrey Tangwa of Yaounde University, Cameroon⁹⁾: “A handshake should not go beyond the elbow.” In terms of a metaphor, this sentence carries a powerful message. I choose not to pursue it with an explanation. Metaphors are at their best when they provide a starting point for reflection. The explicit explanation may sometimes be perceived by some as unnecessarily brutal, thereby forming an obstacle for the dialogue which is the essence of professional ethics. So, I will round off the metaphor in reminding that many of us have witnessed how professional colleagues have lost one arm or perhaps even more—still speaking in terms of the metaphor—in allowing a handshake to go beyond the elbow.

Ethical Codes

There is in public agencies and in professional organizations an increasing attention paid to promulgating professional ethical codes, codes of conduct and guidance in health service organizations and in health related research. This also applies for the world of trade and commerce in seeking to frame principles of Good Practice. There is certainly a need for such norms even if one is well advised to be aware of the limitations of such guidelines. It is commonly accepted that it is not possible to draft rules providing detailed guidance in the many differing situations dealt with by occupational health professionals at work. So, to summarize:

A Professional Ethical Code is:

- A set of principles and practical guidance framed in normative language
- An attempt at translating into terms of professional conducts, the values and principles of Occupational Health

- Basis for national or specific professional code instruments

A Professional Ethical Code is not:

- A textbook on Ethics
- An analytic instrument
- A final instrument which there is no need to revise

Codes are commonly aspirational and well intentioned, but most often not enforceable. They vary significantly in clarity, depth, emphasis, strength and relevance. The reader commonly finds no guidance in them for resolving of ethical dilemmas. Focus in most codes is set on individual health professional conduct, less on conduct of organizations.

Despite these limitations and accepting that the responsibilities and obligations of an occupational health professional can not be detailed in a formal code of a set of rules, professional codes may—depending on contents and pedagogics and also depending on the underlying process and discourse—bring important reminders to the professionals targeted. They can crystallize what can be seen as the best practice and encourage people to follow it. They can provide a compass in describing the type of considerations, should be brought into play in defining the obligations of health professionals. For these reasons codes are, in principle, helpful and sometimes even necessary. They may, moreover, be edited as to be:

- determinate in focussing on specific aspects of professional action
- communicable and open to criticism
- open to alteration as appropriate
- tools serving transparency in democratic processes

For a more exhaustive discussion of professional codes see Griffiths and Lucas in 1996¹⁰.

Three professional ethical codes or guidance documents are given for reference:

- ICOH (International Commission on Occupational Health) International code for Occupational Health Professionals - issued by the ICOH and last revised in 2002¹¹)
- Guidance on Ethics for Occupational Physicians (Faculty of Occupational Medicine (FOM) of the Royal College of Physicians, London 2006, UK)¹²)
- International Code of Conduct (Ethics) for Occupational Safety and Health Professionals (Ladou *et al.* 2003)¹³)

International codes and guidance documents on professional ethics in occupational health are important in that they may be used to promote intercultural and inter-professional dialogue. In finishing off the subject of codes I shall leave for consideration the following hard questions

which all carry ethical implications:

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

The last question assumes particular importance where professional occupational health services are carrying out service tasks in operating as commercial agents on a market under the strains of competition.

Universality of Professional Values

For final question to approach in this paper, I have taken the universality of the professional value set of occupational health professionals. It is a question constantly deserving our close attention. Space constraints do not allow me to go into the depths of it. When looking, however, at some contemporary official documents on universal values derived from organizations carrying weight, such as UN, UNESCO, Declaration of World Religions in Chicago in 1993 and many others it is soon found that many of the norms and values referred to are repeated. See Bexell 2002¹⁴). They could possibly be condensed and accommodated into a basis with the characteristics of a common morality. This would embrace the protection of life, creating safety for all human persons, the principle of human dignity—sometimes referred to as The Golden Rule. One fundamental ethical demand which comes out very clearly from such documents is that every person is to be met and treated with dignity, regardless of age, sex and race as an end and never as a means. Ethical analyses should aim at opening up the fundamental concepts of morality to make them accessible to scrutiny and a discourse on their meaning and possible dependence on cultural and contextual conditions.

In such examination and discourse, a shared understanding may be achieved of how, in identically similar ethically challenging situations involving occupational health professionals drawn from different cultural settings, the moral solutions arrived at may differ even considerably. Nonetheless, the worldwide agreement on these norms is quite remarkable. The convergence is, of course, not perfect. There are debates on the precise list of principles. Should veracity and fidelity be seen as independent principles or can they be boiled down to the essential value of respect for other human beings as moral equals?

Also, in the specification of contents of ethical criteria divergences are observed. This applies equally in drawing moral rules from the corner-stone principles. There are cultural factors operating in this process which need to be described and communicated in a process of dialogue. Such culturally rooted determinants may apply for whole cultural spheres - although with considerable variations - as has been brought up by De Castro in 1999⁵⁾. Such aspects have also been discussed by Flanagan in 2000¹⁵⁾. In the end of the day, universalization can be understood as a process of putting together a collage of varying perspectives without having to assert a neutral standard of measure in a normative sense. This process of dialogue is essential to accomplish closer cross-cultural cooperation and understanding.

Concluding Comment

To finish with my credo in form of punch-lines—here they come:

- We need to learn to discern changes in values and beliefs and to identify the moral fabric in our societies and communities, i.e. both the civic morals and the health professional ethos and ethics
- We need to identify our own personal set of values
- We all need to develop the necessary skills and instincts in finding out facts
- We need to learn making decisions consciously value-based
- We need to develop an awareness of our own professional identity—implying the feeling of “we” as a collective body, while recognizing the competencies and professionalism of other professions
- We need to maintain an international discourse on ethical values involved in the daily work of occupational health professionals

If these above punch-lines are accepted as valid we are wise to recognize that we have much to do. There are good reasons for OHPs to reflect on their roles in the ongoing transformation of the World at Work. The changes in process are likely to affect the basis of existence of millions of people all over the world. The future of occupational health will depend not only on chosen policy goals and strategies of national governments and in bodies of collective labour power but also on currents of ideas in identity-based social movements such as professional bodies of health professionals.

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