

# Do we have the training?

## *The ethics of workplace drug testing and the GP*

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**BACKGROUND** Workplace drug testing has been in place in Australia since the early 1990s. In some industries it is required by legislation, while in others, employers have introduced it as an apparent cost effective way of improving productivity, safety and the health of its workforce while reducing absenteeism, accident rates and even deaths. There are national standards in place for workplace drug testing regarding specimen collection and testing, and well documented processes to follow in establishing a drug screening program within a workforce.

**OBJECTIVE** This article explores the ethics of workplace drug testing and questions the assumed rights and obligations of employer, employee and the clinician involved in occupational medicine.

**DISCUSSION** It is questionable whether most general practitioners have the appropriate training to deal with these ethical issues comprehensively.



The estimated cost to business of recreational drug use in the USA, where an estimated 70% of illicit drug users are in full time employment, has been put at \$81 billion annually with 86% of these losses attributed to alcohol. Marijuana, amphetamines, cocaine and tobacco were responsible for the majority of the residual.<sup>1,2</sup> In Australia, the social costs of drug abuse in 1992 was estimated to be \$18 845 million (this includes the impact of morbidity and mortality, cost of loss of unpaid services/work and hospital costs). This represented a 26.5% increase since 1988 and \$1684 million of this cost was due to illicit drug use. In this period the real costs attributed to alcohol rose by only 1%, tobacco by 17% and illicit drugs by 25%.<sup>3</sup>

Amanda Vanstone, Australian Federal Minister for Employment, once

declared that it was reasonable for an employer to know who was using drugs within the workplace. As such, use equated to a comprehensive risk of abuse, and this outweighed the right to privacy of the employee.<sup>4</sup> Of course, a similar point of view could be applied to pre-employment medicals and potential employees. This is not an unreasonable stance to adopt if the risks of drug abuse in the workplace to employees' health, safety and productivity are as great as is often thought; and there is evidence that recreational drug use (principally marijuana) within the workplace does have an impact on these outcomes.<sup>5-8</sup> Reinforcing this, pre-employment drug screened positive employees (for marijuana and cocaine) have been shown to have adverse employment outcomes as absenteeism, accidents, injuries and discipline.<sup>4,9</sup>

However, the effect is not as great as one would expect, and more importantly, it appears to be related to certain industries and subcultures.<sup>6</sup> An important question to ask is, does the employer have the right in this day and age to hold such paternalistic opinions and instigate similar work practices?

### Duty of care

Employers do have a duty of care under the Occupational Health and Safety Act to prevent injury, damage and loss of production by placing employees and other personnel at risk from the abuse of drugs including alcohol and nicotine. Likewise, employees have a similar responsibility not to expose others as well as production to risks due to their drug abuse.<sup>10</sup> It is relatively easy to monitor those abuses related to alcohol and smoking, but for

other drugs (in particular marijuana) the control is not so simple. For marijuana, unlike alcohol, there is no specific tissue level that correlates with impairment and furthermore the clearance of marijuana and its metabolites from the body is not consistent either in relation to the mode of use or amount used. They can be detected in the urine for up to 21 days or more after exposure.<sup>11-23</sup> There is a case reported of positive urines 95 days after cessation of use.<sup>24</sup> Thus, any regulation regarding workplace drug testing and marijuana that the employer wishes to impose will affect the employees' right of choice on how he/she spends their leisure time; what company they keep, the risk of passive exposure and 'social use' of marijuana (as opposed to regular and heavy use). Given that in 1998, 39% of the population had tried or was using marijuana, such social activity is/would be considered within the norm.<sup>25</sup>

This ethical issue is further compounded by the fact that the commonly abused recreational drugs, alcohol and tobacco, are frequently used within the work/employment environment during social functions, team building sessions and the like; yet they too, are no longer acceptable in the actual workplace.<sup>26</sup>

## Free will

In an environment where there is a disciplinary stigma associated with drug abuse, it surely is questionable that all urine samples or other specimens requested for drug testing would be given willingly. There is undoubtedly an element of compulsion or obligation on behalf of the donor, for refusal would/could imply guilt. The ethical arguments about the employee giving a specimen willingly and of his/her own free will has been comprehensively covered by the Privacy Committee of New South Wales in 1992.<sup>1</sup> Their conclusions, to avoid coercion, were that workplace drug testing should only take place where:

- (a) a person's impairment by drugs would pose a substantial and demon-

**Table 1. Procedure for the collection of drugs of abuse in urine after AS/NZS 4308:2001**

### Minimal precautions

- To deter dilution at collection site, use toilet colouring agent, no other accessible water source within the voiding enclosure
- Unequivocal identification of donor

### Collection procedures

- After washing hands the donor shall remain in the presence of the collector and have no access to any water, soap, cleaning agent or other materials that might adulterate the specimen
- Donor shall provide specimen in an area allowing individual privacy
- Upon receiving the specimen the collector must confirm the sufficiency of the sample, validate sample by confirming the temperature is between 33°C and 38°C within four minutes of voiding, inspect urine for colour and look for any indication of adulterants and record any suspicion
- If specimen is suspect another specimen must be collected as soon as possible and both sample forwarded to the laboratory
- The specimen must remain in view of the collector and donor at all times until sealed and labelled
- A portion of the specimen shall be place in another bottle, the 'referee sample'
- The collector shall request the donor to observe the transfer of the specimen in to a tamperproof sealed container and sign the appropriate seals
- After sample has been provided and submitted to the collector the donor will be allowed to wash his/her hands

strable safety risk to that person or to other people

- (b) there is reasonable cause to believe that the person to be tested may be impaired by drugs, and
- (c) the form of drug testing to be used is capable of identifying the presence of a drug at concentrations which may be capable of causing impairment.<sup>2</sup>

The Privacy Committee also concluded that workplace drug testing should be prohibited by legislation other than when the previous points (a)–(c) apply; and workplace drug testing that is permitted, should be subject to procedural standards, set out in legislation, to protect the privacy interests of those who are tested.<sup>27</sup>

## Procedural standards

The 2001 Australian and New Zealand Standards (AS/NZS 4308:2001) are those procedural standards.<sup>28</sup> Any specimen collected and transported (by 'chain of custody') and subsequently examined according to these standards will stand in

a court of law, if and when there is any redress to an employer's action against an employee or vice-versa.

Unless specifically trained in occupational medicine, most doctors are unlikely to be aware of AS/NZS 4308:2001. Any specimen of urine collected outside these guidelines will legally invalidate the result. Unfortunately, the procedures for urine collection could be deemed as a gross invasion of personal privacy as it requires the donor to be minimally clothed, searched and observed while urinating (Table 1).

## Discussion

The doctor performing a pre-employment or employment medical has a dual responsibility first to his employer, the company that has contracted him/her to examine the (potential) employee, and second to the patient/client. The doctor needs to make sure that any specimen given for drug testing has been donated with full and informed consent, and not assume that the

candidate agrees to all aspects of the examination by his/her presence. This may be contrary to the wishes of the employer. Urine or other specimens examined without consent is an invasion of physical privacy. This ethical dilemma is further compounded by the physician's duty of care and the obligation to follow up any result of investigations with the patient/client and to offer treatment where appropriate. This also will undoubtedly involve issues of privacy of information between the doctor, employer and the patient.

Although, in their current training programs, most doctors have addressed confidentiality and the responsibility of practitioners to ensure that a patient's privacy is maintained, a more detailed understanding of not just the invasion of personal but also physical privacy is required to be able to deal with these difficult dilemmas. The recent privacy legislation introduced into Australia means patients have more rights than ever before, and doctors need to be aware of the implications for their practice. These moral and ethical dilemmas may be compounded by the doctor's perception that his/her primary responsibility is to his patient and not to the employers or other bodies with whom he/she may have been contracted for items of service.

## Conclusion

We propose that all doctors should ensure that they cover privacy legislation and its interaction with the rights of employers as part of their continuing professional development. Aspects of this training are already being provided by many divisions of general practice and doctors should avail themselves of the opportunities that are available.

In the long term, the skills required to deal with these dilemmas need to be introduced into the medical undergraduate curriculum and then built upon further in postgraduate training. In this way we will produce doctors who are truly ready to work in Australia in the 21<sup>st</sup> century.

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