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The pre-employment medical

Ethical dilemmas for GPs

Background

In many workplaces, employment is conditional on a successful pre-employment medical examination. This examination is usually conducted by a general practitioner on the employers' panel of approved clinics or by an in-house company doctor.

Objective

This article uses a case study to illustrate some of the ethical dilemmas that may be faced by GPs in the course of performing a pre-employment medical examination.

Discussion

Ethical issues discussed in this article include: Is it ethical for employers (based on physicians' reports) to select workers based on 'absence of illness' rather than 'fitness for work'? Should physicians divulge the illness of potential workers to third parties? What are the boundaries of a clinician's duty of care in the pre-employment medical examination setting?

Keywords

ethics; occupational medicine; doctor-patient relations; medicolegal

physician, after obtaining informed consent, added thyroid function tests and an electrocardiogram.

Hyperthyroidism was confirmed by:

- elevated levels of free T4–51.0 pmol/L (normal range 9.0–25.0 pmol/L)
- free T3–15.8 pmol/L (normal range 3.5–6.5 pmol/L)
- low thyroid stimulating hormone levels of 0.01 mIU/L (normal range 0.4–4.7 mIU/L).

An electrocardiogram showed sinus tachycardia.

Treatment for thyrotoxicosis was initiated immediately and she was certified fit for her new position. With her consent, the doctor informed the company that she had an incidental non-life threatening medical condition that would require regular monitoring and treatment until stabilised, the details of which were not divulged as she had not consented to the provision of this information to her employer. She accepted the position and reported for work on the due date, 6 weeks later.

The doctor's decision was questioned by the employer 6 months later because, even though under the company's medical policy employees received medical benefits regardless of whether they were work related or not (with the usual exclusions, eg. dental procedures and cosmetic surgery), the company had incurred recurring medical expenses throughout her term of employment. The company was also wary about the possibility of increased sickness absence in the future.

In many workplaces, employment is conditional on a successful pre-employment medical examination (PEME), driven more by traditional

Case study

A woman, 34 years of age, presented to an in-house company doctor for a pre-employment medical examination before accepting a position as an administrative executive. She was thin, appeared comfortable and alert, but had a 'staring' look. Her pulse was 125 bpm, regular in rhythm; blood pressure 110/80 mm Hg. She had detectable proptosis with eyelid retraction but lid lag was not elicited. Her thyroid was not palpable. She denied weight loss but was troubled by palpitations and anxiety, which she ascribed to work stress, and had led to her resignation from two previous positions for a 'change of environment'.

The company required only standard blood tests and a chest radiograph as part of the examination. Suspecting hyperthyroidism, the examining

practices rather than by evidence.¹ Employers can often choose to revoke an offer of employment if the potential employee refuses to undergo a PEME. However, in some countries, disabled employees are excluded from a PEME under the Medical Disabilities Act.² In public service occupations, such as the armed forces, police force, and fire services, a PEME is mandatory, as these jobs are not only high risk, but unfitness of an employee may also place others at risk.

The PEME is usually conducted by a general practitioner on the employers' panel of approved clinics, or by an in-house company doctor, after obtaining the employee's consent. However, employers commonly do not provide the examining GP with the employee's position description, therefore the GP is unable to relate the PEME to the position's tasks and the interpretation of 'fitness' or 'unfitness' is left solely to their discretion.³

Ethical dilemmas

The *Case study* highlights three ethical issues that may arise during a PEME:

- Is it ethical for employers to use physicians' reports to select workers based on 'absence of illness' rather than 'fitness for work'?
- Should physicians divulge the illness of potential workers to third parties?
- What are the boundaries of a clinician's duty of care in the PEME setting?

Should 'absence of illness' mean 'fitness for work'?

Employees should not be discriminated against unlawfully for purposes of employment because of an illness. Instead, employers should consider the individual characteristics of each applicant in the light of the inherent requirements of the job.⁴

The goal of a PEME is to determine whether an individual is fit to perform his or her job without risk to himself or others. This is more justified when the job involves working in hazardous environments, requires high standards of fitness, is required by law, or, when the safety of other workers or the public is at risk.¹

Unfortunately, some employers may misconstrue the scope of a PEME and use it as a management tool, so that only those without illness are employed.

While GPs may be the legitimate health professionals to detect a medical condition in a potential employee at a PEME, they may not be familiar with the occupational risks inherent in some jobs.⁵ Occupational safety and health physicians are trained to balance the physical and mental demands of job tasks with the health status of employees and, as such, may be better placed to perform these types of examinations.

Is the selection of workers on health grounds to reduce sickness absence an ethical practice for healthcare professionals to be involved in, or is it an abuse of their privileged position in society?

To divulge or not to divulge?

Contractual appointments of panel doctors often stipulate certain conditions regarding provision of patient-sensitive information.⁶ For example, it is common practice in most companies in Malaysia to obtain written consent from new employees authorising the doctor to provide the PEME findings to the company's recruiting officer. Under these circumstances, the examining doctor is no longer obligated to maintain confidentiality.³

In the *Case study*, no such consent was obtained before the examination. Additionally, the employee had personally covered the cost of the extra investigations and treatment.

Duty of care

In the *Case study*, the 'examining doctor'⁶ was bound by a contractual obligation to the company to conduct a standard PEME at the in-house company clinic, requiring not more than basic blood tests and a chest radiograph. The employee told the doctor that she had no regular doctor, and having suspected hyperthyroidism the doctor went beyond the limits of the company's requirements and ordered thyroid function tests (TFTs) and an electrocardiogram, after obtaining informed consent and an agreement from the patient that she would bear the associated costs.

As the employee did not have a regular doctor, sufficient proximity was established

to create a patient-doctor relationship in the PEME. The examining doctor recognised that the reported 'anxiety' was likely an inherent part of her disease state. In the treating doctor's view, her medical condition would not prevent her carrying out the tasks required in the job, so he did not deem her 'temporarily unfit'.³ He determined that her hyperthyroidism required immediate treatment and felt competent to initiate this. The doctor also expected a significant response to treatment by the employment commencement date (6 weeks away). His paramount concern was the patient's long term health, and he was guided by the customary rules of his profession.

The wider responsibility of the doctor to his patient was disregarded by the company in its narrow scope of the PEME. The company was unaware of the employee's exact diagnosis as she did not consent to divulge this information.

Another doctor in this situation may have certified her fit, but not seen the need to carry out any more tests in the absence of an established patient-doctor relationship, and instead, referred the patient on.

A doctor hired under a contract of service may deem his duty of loyalty to the company as more important than the patient-doctor relationship.

At what point does the doctor's obligation become 'supraobligatory', to go beyond what is reasonably expected of the average GP?⁷

Discussion

Pre-employment 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. They were designed to help 'match' workers to jobs they were capable of doing, safely and without undue risk to others. Today however, there is a risk that employers will turn the PEME into a screening process to select relatively 'healthy' workers in an attempt to minimise sickness absence and control costs.

Physicians are bound by professional standards of care to recommend treatment for their patients' wellbeing. They must balance

competing loyalties between the patient and employer, as well as their own professional standards and moral convictions.

The *Case study* demonstrates that ethical issues in clinical practice often have to be dealt with pragmatically, case-by-case, and not theoretically.⁸ Employers today may attempt to set the standards of care and physicians need to be wary of this.

Clear guidelines for the scope of work of GPs conducting PEMEs should be formulated. Doctors should be objective in their assessments, and their role should not be perceived as a way of excluding applicants with existing illness from employment.⁹

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