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Australasian Faculty of
Occupational and Environmental Medicine

The Royal Australasian College of Physicians

Ethical Guidelines for Occupational and Environmental Physicians

May 2016

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INTRODUCTION

The Royal Australasian College of Physicians' (the College) Australasian Faculty of Occupational and Environmental Medicine's (AFOEM) ethics guidance for its members was last issued in 1998. However the practice of occupational and environmental medicine in Australia, New Zealand and indeed the world, is evolving. There are changes in community expectations; legislative and regulatory frameworks; the scope and style of practice; new technologies; new occupations and indeed new hazards all of which pose ethical questions that were not contemplated in 1998. Since then; AFOEM Fellows' practice explicitly includes occupational and environmental medicine (OEM) which results in the necessity to provide advice to members of the general public, industry, Government and other organisations who may have been affected by environmental hazards.

A shared view of what is and what is not acceptable and ethical behaviour is an important part of our profession and practice. AFOEM does not intend these ethical guidelines to be prescriptive or proscriptive. While some principles are universal, each individual needs to consider how these guidelines can be implemented in his or her practice, particularly within the legal and moral circumstances specific to his or her circumstances. This may be particularly relevant when practising outside Australia and New Zealand.

While mindful of the legal requirements in a particular jurisdiction, the occupational and environment physician (OEP) should be aware that ethics is above the law and that ethical principles endure outside the legal context.

Status of this document

These guidelines are specifically intended for members of AFOEM. They may have relevance for other medical practitioners working in occupational and environmental medicine, and for other health professionals working as part of a multidisciplinary team in occupational and environmental medicine (OEM). There should be an explicit understanding however that at times there are differences in ethical requirements required between those who practise OEM and other aspects of clinical medicine.

These guidelines have been approved by AFOEM's Policy & Advocacy Committee (FPAC) and the broader RACP College Policy and Advocacy Committee (CPAC). They form part of a broader ethics framework for College members. It was deemed necessary to have a specific document for OEM due to the differences in practice that distinguish OEM from other fields of medical practice. The difference largely relates to the different duty of care and therapeutic relationship that OEPs can have with clients who may not necessarily be patients. This document discusses those unique relationships and how OEPs can deal with them.

Ethical Principles

In many ways, the ethics of OEM practice are the same as those for doctors in other fields of practice; however doctors working in OEM face additional ethical issues that are uncommon in other situations. These often relate to potential conflicts of interest because of the involvement of third parties. At different times OEPs have responsibilities to individual patients under their care, workers in a particular workplace, employers, the general public and specific responsibilities under legislation. There may be conflicting responsibilities to these parties. Problems are most likely to arise if potential conflicts of interest are not recognised; particularly if one party is not aware that the OEP has other responsibilities.

Throughout this document the term 'occupational and environmental physician' is abbreviated to 'OEP' and the term 'occupational and environmental medicine' is abbreviated to 'OEM'.

There are four key ethical principles which should be considered at all times in the practice of OEM:

- **Autonomy** refers to the right of an individual to self-determination. People should be able to make their own free choices. Essential to this is access to full information so that the choice is informed. OEPs should not presume to make decisions for others, especially relating to the acceptability of risk, and they should not withhold the information necessary for others to make choices. Problems often occur because of information imbalance and there should be transparency of information.
- **Non-maleficence** is the doctrine of not doing harm. In OEM, this is complicated by having multiple clients (workers, patients and employers) who all have the right not to be harmed. The relative merit of competing claims is sometimes the subject of ethical debate. One must always return to the concept of "above all do no harm".

- **Beneficence** refers to doing good. It is a positive action to do good. There is the potential for beneficence to conflict with autonomy. Taken to extreme, beneficence can become patronisation or inappropriate advocacy on the part of the patient or injured worker.
- **Justice** is the moral obligation to act on the basis of fair adjudication between competing claims. As such, it is linked to fairness, entitlement and equality. It should temper all considerations. This is very much the issue in many workplace situations.

Often these principles should be considered but how much weight is given to each in relation to the others will depend upon the circumstances.

There are many other ethical principles that are also relevant to the practice of OEM, such as transparency, solidarity, community, reciprocity, respect, accountability, veracity and confidentiality. It is beyond the scope of this document to discuss each of these specifically.

Ethics requires interactions, multidisciplinary co-operation, consultation and participation. A code of ethics for OEPs should never be considered as final, but rather as part of a dynamic process involving the community. This community includes medical practitioners; organisations concerned with safety, health and the environment; regulators; employers and workers' organisations, unions and legal practitioners.

GLOSSARY

Autonomy	Essential to this is the need for full information and transparency so that the choice is informed. OEPs should not presume to make decisions for others especially relating to acceptability of risk and should not withhold information.
AFOEM	Australasian Faculty of Occupational and Environmental Medicine
Beneficence	This term means doing good. This is more than the opposite of nonmaleficence; it is a positive action to do good. It should not be confused with patronisation or inappropriate advocacy.
Employer	A person or organisation that employs people. This has become more complicated in recent years with the advent of employment agencies, self-employed persons, and subcontractors. Volunteers may at times be considered to be employed by an organisation who is their employer.
Examinee	A person who is examined.
Justice	The principle of justice is the moral obligation to act on the basis of fair adjudication between competing claims. As such, it is linked to fairness, entitlement and equality. Justice must be considered in all cases.
Non maleficence	It is the doctrine of not doing harm. In OEM this may be complicated by having multiple clients or agents who all claim the right not to be harmed. It is the relative merit of completing claims that are often the subject of ethical debate.
OEM	Occupational and environmental medicine
OEP	Occupational and environmental physician
Patient	A person receiving or registered to receive medical treatment.
RACP	The Royal Australasian College of Physicians/ the College
Should	Indicating a desirable or expected state. ⁱ
Must	Be obliged to. ⁱⁱ
Therapeutic relationship	This is the ongoing relationship between a health practitioner and a client/patient established to support the client/patient's therapeutic goals. ⁱⁱⁱ
Worker	A person who works, in particular a person who does a specified type of work or who works in a specified way. This includes persons who perform an occupational task or activity for money, reward or on a voluntary basis.

Note: References for the glossary can be found on p.23

CONFLICT OF INTEREST

A conflict of interest is a set of circumstances that creates risk that professional judgement will be unduly influenced by secondary interests. For the OEP, this usually involves the perceived risk of bias towards the party who pays for the service.

To mitigate such risk, the OEP must be transparent with all parties concerning potential conflicts of interest.

CONSENT

Consent is the process where a worker, patient or client is given sufficient information to be able to understand the consequence and freely agree to a proposed action. The elements of consent are: disclosure, understanding, competence and agreement.

For OEPs, many consultations are arranged by third parties. This adds an obligation on the OEP, when obtaining consent, to openly disclose their relationships with the commissioning party and the conflicts of interest this may imply. The OEP should always maintain a clear understanding of his or her current role and ensure that all other stakeholders are aware of that role. Ideally, this should be defined in and guided by appropriate policies and procedures.

During any assessment, the OEP must inform the patient/client about the purpose, content and consequences, and ensure that the patient/client understands and consents to the process. The patient/client should be allowed to make comments on, and give feedback at each step. Depending upon circumstances, further consent may be necessary at other stages in the consultation or assessment. An example for this would be to obtain consent to continue with a physical examination.

Competence to give consent must be considered where a client/worker suffers from a head injury, is intoxicated, where there is a psychiatric disability, educational, cultural or language difficulties which may limit comprehension. If language is a problem, an interpreter must be involved; this person should not be a family member or friend.

A patient/client may withhold his or her consent at any stage of the process and cannot be compelled to proceed. He or she should be informed about procedures to follow if he or she does not understand, is not satisfied with, or does not consent to any part of the assessment. Refusal to proceed with the assessment should be clearly documented. Where consent is withheld, the OEP may offer to assist in locating an alternative clinician.

Release of medical information

It is important that there is a clear understanding between the OEP and the patient/client regarding the release of medical information when he or she is being assessed at the request of another person, such as a prospective or current employer, or an insurer. The patient/client must understand and should acknowledge verbally or in writing that a report of the examination will be forwarded to another party and that in some instances, a copy will not be made available to the person. Written consent is important when the disclosure of information may have consequences for the person's employment, social or personal life. Patients/clients can withdraw consent up until the information has been transferred and it is important that the OEP inform them of this.

Consent for test results

The OEP may wish to report certain results of tests (for example, a high blood lead level) to management or to Government so that appropriate action can be taken. This action, which would follow from test results, should be explained to the patient/client, ideally before the test is taken and included in the informed consent.

Providing information without consent

In exceptional circumstances an OEP may have reason to provide information without the person's consent; for example in order to prevent serious harm to others or when required by law, for statutory or court-ordered examinations. There are certain legal circumstances when medical practitioners are required to provide information to third parties. The OEP should first seek advice and guidance from his or her professional indemnity insurer, local medical council, and/or colleagues before releasing confidential information without client consent. This information should be confined to items which are essential to make decisions about health and safety and should not contain any unnecessary personal information about the person unless in breach of other laws. Such circumstances will depend upon local jurisdictions.

PRE-PLACEMENT MEDICAL EXAMINATIONS

In principle, the term 'pre-employment medical' should not be used. The intent should be to identify aspects of a job that an individual may have difficulty with or where there may be a hazard to that individual or others. Thus, it is better to describe the consultation as a 'pre-placement medical examination' before an offer of employment has been made. There are some circumstances where there may be substantial medical constraints on fitness for a position, and the medical assessment will be part of a broader recruitment process. As an example, this would be the case in emergency services or military employment.

The requirement for pre-placement medical examinations may be statutory and/or related to potential health and safety risks to the individual or others or material risks to the employer. It may also provide a baseline of health at the commencement of employment, and can provide information valuable for the management of emergency situations. Where there is ongoing health surveillance during employment, the pre-placement assessment should be consistent with subsequent assessments. The rationale for these assessments needs to be well established and accepted by all stakeholders, should be regularly reviewed to ensure that the assessments remain appropriate, and should be based on established evidence.

Employers may rely upon guidance from OEPs when deciding what service is required and OEPs may rely on such assessments to generate income or to justify their own position. OEPs must differentiate between that which is in their financial or professional interest, and that which is appropriate for the patient/client they are assessing. Recommendations must be based on evidence and good use of resources in support of clients and patients.

A detailed assessment involving a consultation with a medical practitioner may not always be necessary for certain jobs, and a simple enquiry as to whether a selected candidate has a health problem or disability for which they may need assistance may be all that is necessary.

In many cases occupational health assessments are not conducted by OEPs. Rather an OEP's role should be to establish policies, develop the relevant scope of the history, examination and investigations, clarify what qualifications are needed to conduct aspects of the assessment, make recommendations on fitness, identify in what circumstances there should be referral for further investigations and what information will be provided to whom.

AFOEM recommends following these principles with regard to pre-placement medical assessments:

- Only those professionally competent for the task should conduct the assessments. Only health professionals, and not administrative staff, should perform the assessments.
- The content of the assessment should reflect the nature of the work to be undertaken.
- All documentation used to collect health data should be suitably marked to show that the information will be held in confidence. The usual conditions relating to storage and disclosure apply.
- Reports to management should focus on capability and should not include medical or other details without the consent of the individual.

In general, applicants will be classed as 'fit for the proposed employment' or 'fit subject to defined adjustments'. It is for the prospective employer to determine whether it is reasonable to apply these adjustments and hence whether to confirm the appointment. It is unusual for an occupational health assessment to result in a decision that an individual is 'unfit for the proposed employment'. In such cases, it is usually because an applicant is unable to meet predetermined standards. OEPs involved in setting such standards should ensure that they are, as far as possible, based on capability, rather than specific medical conditions and that they are underpinned by robust evidence. Medical standards are inherently discriminatory. Those setting and applying them may well have to justify their opinions. Where pre-placement medical standards exist, they should be transparent and made available to applicants at an early stage in the recruitment process, so that they have realistic expectations of a job offer. Decisions should be evidence based.

In the course of any health assessment, the OEP may become aware of a medical condition of which the subject is unaware (e.g. glycosuria). In such a circumstance, OEPs must inform the subject of this medical condition and make reasonable attempts to ensure that he or she receives appropriate medical advice and follow up. Ideally, this should be via the subject's own treating doctor.

FITNESS FOR WORK

Pre-placement health assessments and health surveillance are covered in other sections of these guidelines.

In the context of attendance and/or performance management an OEP may be asked to assess a worker's fitness to work. The OEP should perform a competent detailed and objective evaluation which may require him or her to seek additional medical information with consent from the worker's treating health practitioners. In some circumstances there may be disparity between the treating doctors' opinions and the opinion of the OEP. In such cases it may be appropriate for the OEP to discuss the matter with the treating doctor or health professional, as they may not be aware of the particular work situation and what adjustments may be available in the workplace to facilitate work.

Control of sickness absence is a matter for management; however, prompt good quality occupational health advice is helpful in enabling managers to perform this role. Information should be appropriately conferred, in keeping with confidentiality principles. In some cases, a simple certificate of no impairment will suffice; in others, more complex and detailed information is needed: guidance on any workplace restrictions should be relevant, specific, detailed, and evidence-based. Certificates should be legible, precise, correct and not pre- or post-dated. They should be issued with the knowledge of the worker, and should comply with relevant statute and guidance.

Under most circumstances, there should be no disclosure of medical details, in which case, advice should be of an "operational" nature only and should observe confidentiality. If disclosure of a medical condition is required, then written consent for this should be obtained from the worker. Information should generally be limited to the impact of the condition on fitness for work and of work on the individual.

HAZARD AND RISK COMMUNICATION

OEPs should communicate information about workplace and environmental hazards, and their potential risks to health due to exposure to those hazards in an effective way to individuals or groups. In the group setting, this often requires joint meetings with relevant stakeholders, such as employers, unions and community representatives. The communicated information, whether in verbal or written form, should be sufficiently detailed and in an easily understandable form, to enable employers, workers and/or the public to take the necessary steps to protect their health from these hazards. The most effective communication occurs when the person presenting the information is aware of the concerns and information needs of the recipients of the information and when the information is evidence-based. It is important to remember that the OEP is usually acting in an advisory manner and should not presume to decide for others whether or not a risk to health from a workplace or environmental hazard is acceptable.

Different styles of communication are usually required for different audiences and the message should be consistent and at times culturally sensitive. Some specific guidance about communication to different audiences follows:

To individual workers

As for any medical consultation, OEPs should advise patients/clients of the facts and appropriate management steps for any medical conditions identified during a medical assessment. When commenting on relevant working conditions and workplace hazards, advice should be given on the nature and extent of any risk to health to the individual, and how to manage this.

To employers

Advice to employers about an individual worker should generally be confined to information about fitness for a job, limitations of functioning and any workplace adjustments or modifications necessary to ensure that worker's health and safety. Clinical details should not be disclosed. It is important that the employer understands that the medical examination has been conducted with the aim of providing non-clinical information and advice to the employer about fitness for the job and other workplace aspects, rather than clinical details.

When advising on working conditions and workplace hazards, advice should be given to the employer on the nature and extent of the risks and the means by which they can be controlled. OEPs should inform the employer in writing if, in their opinion, workplace conditions are unsafe or hazardous and can suggest measures to reduce these risks. OEPs can provide such information and advice in relation to controlling the hazard and the current approaches to interpretation of acceptability of risk, based on legal requirements on 'best practice' in similar workplaces.

To colleagues

OEPs should advise other doctors or health care professionals about the results of their medical assessment of the worker with the worker's consent, especially if there are implications for the worker's general medical care. In some situations, the worker's own primary care doctor or provider will need to follow up concerns and undertake further investigations and/or specialist referrals. Where this has implications for the worker's employment, it is important that the OEP maintains communication with the treating practitioners about the workplace environment and facilitates interaction with the workplace such as in a return to work plan.

The OEP can also communicate information about work hazards to the wider audience of medical professionals. This may include publishing in peer reviewed medical journals, via electronic forums, conference and seminar presentations, and other appropriate methods. At all times, individual information about workers should not be disclosed in such communication.

To policy makers

The OEP may have an obligation to communicate with workers' compensation, workplace health and safety and other Government departments about hazards and risks in the workplace, such as where there is a requirement for notification of occupational injuries or disease, or as the result of a Government inspection. In such circumstances the OEP should work closely with the Government representative(s), employer and union representatives and advise on appropriate courses of action to control hazards.

In the environmental health setting, the relevant policy makers are likely to be from a Department of Health, Environment Protection Authority or local Government. Similar principles apply to working with such bodies, advising about risks to local communities from environmental hazards, and measures to control such risks. When assessing such risks, the OEP needs to take into consideration the greater susceptibility of communities compared with workers, such as children, the elderly and people with co-morbid chronic diseases.

To the public

The OEP may interact with the public on an individual or group basis. Individual patients may be referred to an OEP because of concerns about environmental exposures and risks to health. The OEP should communicate the assessment results to the patient and discuss any necessary measures to reduce or manage exposure to the relevant hazard, as well as communicating this information back to the referring doctor.

The OEP may also be asked to provide information and advice about environmental hazards to the public through community groups or community meetings. This may relate, for example, to residents living in close proximity to a contaminated site or a large emission from a local factory or storage facility. In such circumstances, it is important for the OEP to maintain independence and provide factual and impartial advice. There may also be media interest in these situations and the same principles apply in communicating with that group.

The OEP may also advocate for action in addressing identified health risks to workers and/or the wider community from workplace-based hazards. Such advocacy needs to be evidence-based, and ensure that any conflicts of interest are identified and declared.

WORKSITE ASSESSMENTS

A workplace assessment is a process of gathering information about the factors that support and/or hinder the health of workers at a particular workplace. Assessments can range in scale from an individual work environment and assessment of work accident causation to a comprehensive understanding of complex set of interactions between the individual and interpersonal, organisational and physical work environments. Since Ramazzini, the assessment of work is the essential skill that separates being an OEP from the general doctor, and so requires ongoing professional development.

A planned approach is required for each type of assessment, that recognises the issues of consent, confidentiality, record keeping, the uses of assessment reports, working in teams, conflicts of interests, and conflicts that can arise, including disputes regarding suspected non-compliance. A written plan that covers such relevant issues may facilitate consent and cooperation from employers, workers and representatives.

Where possible, assessments should balance the use of workplace statistics and worker inputs with individual or team inspection.

HEALTH SURVEILLANCE/BIOLOGICAL MONITORING

Health surveillance comprises a range of activities, including pre-placement screening, statutory biological monitoring, non-work related health screening or even assessing families prior to overseas placement. Drug testing and genetic screening are covered in other sections of this document.

The occupational health objectives, methods, procedures and potential outcomes of health surveillance should be clearly defined and communicated by the OEP. The relevance and validity of the methods and procedures should be carefully considered and, on occasions, discussed with stakeholders in the process. The documentation should seek to define potential difficulties, conflicts and costs. Preference should be for adapting workplaces to workers, rather than excluding workers from work.

Surveillance must always be carried out with the informed consent of the individual worker. The issue of consent is covered in other sections of this document.

The potentially positive and negative consequences of participation in all aspects of screening and health surveillance programs should be discussed by the OEP, or staff, with the workers and other stakeholders as part of the consent process.

Any information contained in reports to third parties should be discussed with the worker prior to release, who should be given the opportunity to request corrections to what they see as misunderstandings. Disagreements should be openly acknowledged, discussed and documented. Where requested, second opinions should also be documented.

Screening and surveillance reports provided to employers and non-medical personnel should limit unnecessary medical or personal information, and should provide information limited to work or functional capacity only. The reports may include opinions on causation, possible risks, benefits and costs of rehabilitation and prognosis and may provide recommendations to the employer.

All personal test results of biological monitoring should be explained and discussed with the worker to ensure understanding of their significance. Results that could potentially identify an individual worker should be released to other people only with the written agreement of the worker.

Group data not identifying individuals may be forwarded to management and unions or those in charge of ensuring safety and health, as set out in the screening and surveillance policies and program documentation.

DRUG TESTING

The testing of workers for drugs or alcohol raises a number of legal and ethical issues. OEPs should be guided by the general ethical principles of confidentiality and recognition of the possibility of false positive tests. Failure to address these issues can lead to adverse consequences for individuals.

OEPs should familiarise themselves with the testing process, the potential pitfalls, and should be confident in the competency and security of the process. Samples should be taken by an appropriately qualified clinician and there should be a secure chain of custody. There should also be a robust system of laboratory testing, in keeping with the principles of the Australasian Medical Review Officers Association (AMROA), and the AS/NZS 4308: 2008 *Procedures for specimen collection and the detection and quantitation of drugs of abuse in urine standard*, or, if relevant, AS 4760:2006 *Procedures for specimen collection and the detection and quantitation of drugs of abuse in oral fluid*. At the time of writing, there is no Australian/New Zealand Standard for hair or sweat testing.

OEP with extra Medical Review Officer¹ qualifications are preferred in this area. The OEP should also be familiar with the employing company's drugs and alcohol policy. If no such policy exists, then testing should not proceed.

- 1 Medical Review Officers (MROs) are registered medical practitioners who have knowledge and understanding of:
- substance abuse disorders and their management
 - A&OD testing procedures and methodologies
 - interpretation of test results including alternative medical explanations for laboratory confirmed test results as well issues relating to adulterated and substituted specimens
 - pharmacology of illicit drugs
 - ethical and privacy issues surrounding workplace drug and alcohol testing
 - laboratory methodology and quality control
 - legislation and recommended standards in regards to A&OD programs
 - fitness for work and other medical related safety issues

Source: Australasian Medical Review Officers Association (AMROA) website: <http://amroa.org.au/about>

Testing without documentation of issues including testing rationale, drug level cut-offs, escalation procedures and consequences may create later ethical or practical dilemmas. The OEP can offer to assist the employer to write such a policy.

HEALTH PROMOTION

When engaging in health education, health promotion, health screening and/or public health programmes, OEPs must seek the participation of both employers and workers in their design and implementation. They must protect the confidentiality of the workers' personal health data, and prevent misuse of that data.

The increasing prevalence of non-communicable diseases, including mental health problems, is a global issue. Nutrition, hydration, fatigue, stress, tobacco, alcohol and substance use interventions may be effective in reducing the risk of disease occurrence and progression. Promoting behavioural change in the work environment can deliver benefits not only to individual workers and society, but also to the employing organisation.

OEPs are well placed to promote health and wellbeing in the work environment, either at the level of the individual worker or by championing workplace schemes. Such approaches should take into account the context in which the workers operate. Workers immediately have a health advantage by being in employment in the first place.² Health promotion should acknowledge that there are many social determinants which impact on an individual's health and wellbeing (for example, socio-economic status, education level, transportation, social support), many of which are outside their direct control.

Respect for the autonomy of the individual is paramount when addressing health promotion. Discussions with individuals should set out the evidence of the proposed programme in a balanced way, using language that the worker will understand, avoiding jargon, to assist them in making their own decision about whether or not they will participate. At times the OEP must understand that there may be cultural sensitivities that need to be considered.

OEPs must avoid forcing their own views upon others or coercing workers to act in a particular way. They should disassociate themselves from spurious health arguments that some may seek to use in discriminating against workers who engage in habits of which they disapprove. Any decision to discriminate against a worker based on behaviours/lifestyle choices such as tobacco use, drug use, alcohol consumption, fitness level or physical size must be based on the legitimate inherent requirements of the role and the fact that these behaviours specifically compromise the ability or safety of the worker or their colleagues in carrying out their functions.

OEPs should try to ensure that an evidence-based approach is maintained, following published guidelines from reputable sources. For example, if complementary health services may be proposed as part of health promotion, these should be subject to the same standard of evidence. Where there is insufficient evidence of effectiveness, it should be pointed out that resources expended would be better channelled into activities of known worth. A few therapies may be considered actively harmful and OEPs must not only highlight this information to decision makers, but also work actively to prevent their introduction.

Whilst it is relatively common for employers to offer incentives to workers to encourage their participation in health promotion programmes, care should be taken to ensure that those workers choosing not to participate are not unduly disadvantaged.

Participation in health promotion programs should always be voluntary and OEPs should oppose even well-meaning compulsion on the part of employers. Emergency services and military personnel are exceptions where a high level of fitness and to some extent a loss of autonomy form part of the employment requirements.

GENETIC SCREENING

Over the past 10-15 years, there has been considerable progress in understanding the genetic makeup of the human genome and identifying people at increased risk of a wide variety of diseases which have a genetic basis. It is now possible to test for the genes associated with a large number of important medical conditions, and this development has significant implications for screening for such diseases in the general community.

At present the genetic tests that are available are used primarily in the clinical care and counselling of patients.

² Please refer to the position statements on the health benefits of GOOD work available from the RACP website for further information: <https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-occupational-environmental-medicine/health-benefits-of-good-work> [last accessed 12/04/2016]

With the rise in the number of genetic tests available, their use as pre-employment or pre-placement screening tools in the workplace or for insurance or superannuation purposes has been promoted.

One principle driving the introduction of genetic testing in the workplace may be the belief that identifying those people more susceptible to developing a disease from a certain level of exposure to a workplace hazard, and then excluding those people from that type of work, will mean that exposure levels do not need to be reduced to provide protection of those individuals. This is contrary to good OEM practice as it shifts the emphasis for reduction of risk onto the worker rather than the work environment.

There are some specific examples of those with a certain genetic make-up who may have increased susceptibility to an occupational disease, for example, individuals with the sickle cell trait who may be at increased risk for sickle cell anaemia if exposed to carbon monoxide or cyanide and testing agricultural workers exposed to organophosphate insecticides for paraoxonase-1 status, which can affect cholinesterase inhibition. Such examples are currently rare. Disease causation is usually the result of a complex pathway involving multifactorial interactions between many genes or gene sequences with variable penetration, lifestyle and behavioural factors and environmental exposures.

The availability of genetic screening tests raises many scientific and ethical issues for OEPs. These issues have been discussed in the Faculty document *Genetic Screening and Occupational Medicine - A Position Paper* (AFOM, 1995).³ OEPs who are asked for advice on whether genetic testing is suitable for introduction in a workplace should apply the same principles as for any medical test suggested as a screening tool. These include the sensitivity and specificity of the test, an acceptable positive predictive value and the need for a clear link between the genetic factor being tested and the job, either through increased susceptibility to disease or an impact on the worker's ability to undertake the job requirements. Privacy and discrimination implications are also paramount to consider. AFOEM should encourage rational community discussion and societal guidance of the scientific, ethical, social and legal considerations involved in this rapidly changing field.

TREATMENT

Treatment options must be available for all workers. Except in specific circumstances such as the military, workers have the choice of treating practitioner. The OEP may provide appropriate first aid for injury and emergency care for illness or injury arising within the workplace. If the OEP is to provide ongoing care for the work-related condition, then care needs to be taken to ensure the coordination role of the primary care physician is not usurped.

Some workers do not have a regular medical practitioner. In the case of such people requiring medical treatment it may be appropriate for the OEP to provide initial and limited primary care within his or her level of competence. Thereafter it is appropriate for the injured person to have access to an alternative treating health practitioner. This will enable cessation of the responsibility of ongoing care by the OEP, where this is appropriate and sought by the patient.

Similarly, in isolated conditions of work, such as mining operations distant from community health services, the occupational health service may have to provide medical care for non-work related conditions. In these situations the OEP should be aware of the potential for conflict of interest and loss of continuity of care with the GP.

Personal health surveillance or ongoing medical care may be undertaken at work upon advice from the treating medical practitioner. Such care may include, for example, the measurement of blood pressure, advice on weight control and help with smoking cessation. These issues are covered in more detail in the section on health promotion.

Additionally, the prophylaxis of biological hazards in the working environment, such as tuberculosis, Q fever or Hepatitis B, may be addressed by immunisation programs. Travel medicine consultations may also include appropriate vaccinations and prophylaxis e.g. malaria precautions. It is good practice, with appropriate consent from the worker, to inform their primary care practitioner, for continuity of medical records purposes.

OEPs will often become involved in the ongoing management and rehabilitation of non-compensable ill or injured persons when they return to work. The medical management and/or rehabilitation of ill or injured individuals in the workplace would, as an ideal, be undertaken with full cooperation of the worker and the medical practitioners involved in the primary management of the worker. In specific circumstances this may not be achieved; the OEP practitioner, assuming appropriate consent is given, should endeavour to continue to keep the treating medical practitioner(s) updated.

³ The Australasian Faculty of Occupational and Environmental Medicine (AFOEM) of The Royal Australasian College of Physicians (RACP) (1995), *Genetic Screening & Occupational Medicine – A position Paper*. Available online: <https://www.racp.edu.au/docs/default-source/default-document-library/afom-position-paper-genetic-screening.pdf> [last accessed 22/09/15]

WORKERS COMPENSATION AND VOCATIONAL REHABILITATION

Workers compensation schemes often have structures available specifically to support injured workers to return to work. OEPs have an important role in these structures, and should familiarise themselves with them, because there are a number of state, federal, and country-specific differences. While respecting the wishes of their patient, OEPs should provide objective information about capabilities of the patient, suitable duties and restrictions to rehabilitation coordinators, insurers and management and encourage their patients to cooperate with rehabilitation processes. This may require the OEP to seek consent to disclose information to these third parties. OEPs are directed to AFOEM documents regarding 'The Health Benefits of Good Work'.⁴

MEDICO LEGAL ASSESSMENTS

Independent Medical Examinations for the purpose of workers compensation or other medico-legal matters are not part of the traditional doctor-patient relationship. These examinations are frequently requested by a third party, often a lawyer, pension scheme or insurance company, rather than the patient themselves. During these medical examinations, the doctor typically does not offer advice or prescribe treatment. In medico-legal assessments on behalf of third parties, it is not the role of the OEP to initiate treatment (except for immediate emergency treatment) or to refer the patient/client to other practitioners. If the assessing OEP believes such treatment or referral is necessary, he or she should make this recommendation to the party who referred the patient/client and/or to his or her usual treating doctor, and make clear that there is no OEP-examinee treating relationship established.

These examinations may be further complicated by patient/client anxiety about adverse findings, mistrust and potential prejudices and the tension of an adversarial legal system. It is common for doctors and examinees (claimants) to feel that these assessments are unsatisfactory.

These assessments do not fit easily into the standard ethical framework because of the altered doctor-patient relationship and the fact that the different parties may have different priorities and values. Under these circumstances, the usual constructs of confidentiality, objectivity, and evidence-based medicine continue to apply; examinees should be made aware of the purpose of the consultation and of the destination of the eventual report.

Each of the parties involved in medico-legal assessments (requestors, claimants and doctors) should treat the others with respect and ensure that they are given clear and accurate information. Ethical guidelines have been prepared by the Australian Medical Association (AMA),⁵ the Medical Board of Australia⁶ and the Medical Council of New Zealand.⁷

OEPs, if conducting assessments, should confirm their adherence to the relevant court jurisdiction's rules on the provision of expert evidence and provide clear, evidence-based comment. The Independent Medical Examiner should be aware that their primary duty is to the court, to provide impartial medical opinion based on best available evidence. If there is a potential conflict of interest, the OEP should carefully consider the implications of embarking on assessment; they may choose to discuss possible conflicts with their legal advisors.

CASE CONFERENCING

Case conferencing is materially different to a consultation between an OEP and a patient/client. The case conference is intended to progress the care of the patient/client by engaging a range of participants. The OEP should confirm the relevance of attendance of all parties to the case conference, and that suitable confidentiality is agreed before medical details are discussed. The same principles as apply to medical records are relevant – the information discussed should be on a "need to know" basis. In general, clinical specifics should not be discussed

4 These documents are available from the RACP website: <https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-occupational-environmental-medicine/health-benefits-of-good-work> [last accessed 12/04/2016]

5 Australian Medical Association (2010), *Ethical Guidelines for Conducting Independent Medical Assessments 2010*. Available online: https://ama.com.au/sites/default/files/documents/Ethical_Guidelines_for_Conducting_Independent_Medical_Assessments.pdf [last accessed 03/05/16]

6 Medical Board of Australian (2014), *Good medical practice: a code of conduct for doctors in Australia*. Available online: <http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx> [last accessed 22/06/15]

7 Medical Council of New Zealand (2010), *Non-treating doctors performing medical assessments of patients for third parties*. Available online: <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Non-treating-doctors.pdf> [last accessed 28/01/2016]

in the case conference, limiting the discussion to how the consequence of the medical condition can be managed in the workplace. Case Conferencing is covered in more detail in the AFOEM publication, *Vocational Rehabilitation Case Conferencing*, published in 2013.⁸

RELATIONSHIPS WITH OTHERS

The multiple roles of OEPs create diverse and complex relationships with other physicians and nurses, OHS providers, management, unions, insurers, lawyers, Governments and others, such as physiotherapists and occupational therapists.

Other doctors

All personal medical information obtained by the OEP should be made available to the attending medical practitioner when requested by the worker. At times, it may be necessary for information to be passed from the OEP to a medical practitioner or, conversely, in the other direction. Any such transfer of information must be with the written consent of the worker.

OEPs may also need to discuss the working conditions of a worker with that person's treating doctor. OEPs in private or consultant practice may see patients on referral from other doctors. OEPs should try to see these referrals promptly and provide clear, timely reports to the referring doctor. They should not take over the clinical management of the worker unless specifically asked to do so for a particular condition or relevance to the worker's job.

Nurses

OEPs should give due professional consideration to occupational health nurses who should be sufficiently informed concerning work-related health matters, to allow them to carry out their responsibilities. The occupational health nurse and other staff of the occupational health service share the responsibility for medical record confidentiality. OEPs should discuss ethical issues with occupational health nurses, especially where the OEP is part-time or sessional, and the occupational health nurse has management responsibility for the occupational health service.

Other OHS Providers

The establishment and maintenance of a healthy workplace is often a team effort and the OEP is one member of the team. Exchange of information is essential if the team is to be effective. The OEP may disclose general, relevant (but not personal) health and safety information to the occupational hygienist, safety officer, other health and safety providers and/or occupational health and safety committee. The OEP should maintain confidentiality of health data, ensuring that individuals cannot be identified without their consent.

Management

The relationship between management and the OEP may be beset with ethical difficulties. Management may employ the OEP directly, or as a consultant or contractor. In such circumstances the worker/employer relationship may make it hard for the OEP to be an impartial adviser.

While doctors generally agree that there is an ethical imperative to put the interests of the patient first, in some occupational and environmental health situations it may be that neither management nor workers are 'patients' in the strict sense. This may occur, for example, where advice is needed about the introduction of a new technology or potential hazard into the workplace. In such circumstances, the OEP should take a precautionary approach to ensure the health and safety of all those whose health could be impacted by new technologies, work hazards and so on.

In general, except where there is conflict with other ethical principles, OEPs should respect the corporate private information of their employers/clients and take care not to divulge them deliberately or inadvertently when consulting to other companies. Similarly, OEPs should not use data belonging to a company without that company's knowledge and permission.

The OEP should clarify with the employer the professional ethical obligations and principles, especially as they

⁸ The Australasian Faculty of Occupational and Environmental Medicine (AFOEM) of The Royal Australasian College of Physicians (RACP) (2013), *Vocational Rehabilitation Case Conferencing*. Available online: <http://www.racp.edu.au/docs/default-source/pdfs/racp-vocational-rehabilitation-case-conferencing07fe4cafbbb261c2b08bff00001c3177.pdf?sfvrsn=0> [last accessed 22/09/15]

relate to confidentiality and disclosure, preferably before ethically-challenging work starts. Consideration should be given to having this made explicit in the OEP's employment or consultancy contract.

At times, management may oppose or wish to modify recommendations advised by the OEP. In such cases of conflict that cannot easily be resolved, it is useful to review the general ethical principles and to establish clearly whose needs should be served, and how best to achieve that. There may be situations where the OEP should choose to oppose management decisions. In such circumstances discussions with peers, medical indemnity organisations or professional associations are advisable.

Worker representatives and other workers

OEPs should be prepared to discuss occupational and environmental health issues with unions and worker health and safety representatives. They should be prepared to explain the rationale for their advice on occupational and environmental health and safety.

OEPs should not comment on the health of individuals to any third parties without the express permission of the person concerned.

Government agencies

Within their normal course of work, OEPs may be called upon to report information, cooperate in data collection or otherwise assist Governments and other regulatory bodies in achieving regulatory/statutory requirements or other legitimate goals in occupational and environmental health and safety.

Such interaction should be achieved in a manner consistent with the principles set out herein, relating to disclosure of information relevant to the health and wellbeing of individual workers and the workforce more generally.

All doctors, including OEPs, are under legal obligation to report certain diseases or conditions (for example, high lead levels, infectious tuberculosis, and so on). Where this is necessary, the OEP should ensure that the worker, employer, union representatives and other relevant stakeholders understand the regulatory requirements, so it does not undermine confidence in the OEP's work.

The general public

The OEP has a responsibility to the wider community. At times it may be that the public interest may need to be put ahead of the interests of an individual. In such situations, decisions should be made openly and those affected should be told what is proposed, or what will be done.

OEPs are increasingly drawn into public debates, especially on issues of occupational and environmental health and safety, public and environmental health. In such public debates, OEPs should state clearly their affiliations and any potential conflicts of interest in the issue. They should limit their input to evidence based facts and offer impartial advice. The health of individuals should not be discussed.

One special example relating to the public is organising and/or addressing meetings on controversial topics. OEPs who are involved in such activities should avoid being used to endorse the promotion of hazardous materials or situations or giving credibility to issues where scientific evidence is misrepresented or not balanced. OEPs have a responsibility to present scientific facts and to state clearly their interests in the topic.

TELEHEALTH⁹

'Telehealth, in the context of the Australian and New Zealand healthcare setting, can be defined as the use of videoconferencing technologies to conduct a medical consultation where audio and visual information is exchanged in real time. Telehealth can be conducted between a specialist and patient in the presence of their general practitioner or other health worker, or can be conducted with no medical support at the patient end.'¹⁰

In providing telehealth, the same good medical practice principles as for face-to-face consultations apply. OEPs should be confident that there is sufficient confidentiality when undertaking consultations via videoconference. They should also acknowledge and bear in mind some of the drawbacks inherent to telehealth consultations. For

9 Further information on Telehealth can be found on the RACP Telehealth Website: www.RACPTelehealth.com.au and on the Australian College of Rural and Remote Medicine (ACRRM) eHealth Website: <http://www.ehealth.acrrm.org.au/>

10 RACP Telehealth Guidelines and Practical Tips 2013. Available online: <http://www.racptelehealth.com.au/guidelines/> [last accessed 24/06/15]

example, OEPs should be aware that not all providers of internet communication are secure and confidential and that there may be limitations to the technology.

The decision to use telehealth needs to incorporate the following factors:¹¹

- Clinical: continuity of care, shared care, and the best model of care for the individual.
- Practical: availability of appropriate technology and patient-end support.
- The quality of the technology at the remote site will play a significant role in the information gained during the clinical consultation.
- Patients' needs: ability of the patient to travel, and their family, work and cultural situation. Physicians should also consider the patient's capacity to participate. For example, additional assistance may need to be arranged for a video consultation with patients with vision or hearing impairments.

As outlined in the RACP's *Telehealth Guidelines and Practical Tips*, 'subspecialists should accept referrals in a manner that supports a generalist model of care, such as accepting patients who have been initially assessed by a regional general physician. In accepting referrals for telehealth, specialists should consider whether timely, in-person specialist consultation services are available for the patient in their region.'¹²

Seeking patient consent

'Physicians should be satisfied that patients have consented to participate in the telehealth consultation. In cases where the patient is not competent and does not have the capacity to give consent, consent should be obtained in the same way as in a face-to-face consultation. The physician or patient end practitioner may have to arrange for consent to be given by a family member or friend who has the requisite legal authority (for example, enduring guardianship) to give consent on the patient's behalf.'

*In cases where a recording is to be used for education or assessment purposes, the patient should be informed of this and give consent to how the recording is to be used. A patient's verbal consent to the recording of the consultation, and how the recording is to be used, should be given at the start of the telehealth consultation and recorded.'*¹³

Telehealth consultations are subject to the same criteria as the principles of case conferencing, and electronic medical records.

If remote physical "examination" is conducted, the examiner should be considered to be an extension of the OEP; as such, the OEP should be confident as to their competency to conduct such evaluations.

STORAGE AND USE OF MEDICAL RECORDS

Medical records are important documents because they relate to the ongoing medical care of the individual and they may be important in compensation or legal proceedings.

- Good medical records are important for the management of individual patient/client, and to help the OEP in any subsequent medico-legal proceedings. For this purpose, OEPs are strongly encouraged to take and maintain full, factual and contemporaneous notes.
- Records should be clear, accurate, and legible, with minimal abbreviation. OEPs should remember that their medical records may be used as evidence in legal proceedings and may be read in court. They should not make inappropriate or gratuitous comments in the records.
- Each entry should be signed and dated.
- Each page should have at least two personal identifiers.
- Any deletions/corrections should be dated and signed.
- Paper records should be stored securely and confidentially; if appropriate a notes tracking system should be put in place.

11 RACP Telehealth Guidelines and Practical Tips 2013. Available online: <http://www.racptelehealth.com.au/guidelines/> [last accessed 24/06/15]

12 RACP Telehealth Guidelines and Practical Tips 2013. Available online: <http://www.racptelehealth.com.au/guidelines/> [last accessed 24/06/15]

13 RACP Telehealth Guidelines and Practical Tips 2013. Available online: <http://www.racptelehealth.com.au/guidelines/> [last accessed 24/06/15]

The legal ownership of medical records has been addressed by the courts. In Australia, the individual does not own their records; they are the property of the treating medical practitioner, however individuals can request copies of their medical records, in accordance with the Privacy Act (1998). In New Zealand, The Privacy Act (1993), the Health Information Privacy Code (1994) and the Health (Retention of Health Information) Regulations 1996 apply.¹⁴ The Medical Council of New Zealand also makes clear that medical information belongs to the patient; however the record itself belongs to the doctor.¹⁵

Additionally, legislation requires employers to keep medical records and to maintain them for a certain time. In Australia, states vary in their legislative approach to retention – defaults ranging from 7-15 years; OEPs should familiarise themselves with their state requirements.¹⁶ The Medical Council of New Zealand recommends, by default, a period of 10 years from the last entry.

In specific circumstances, medical records may need to be kept for longer. OEPs should familiarise themselves with Australian Legislation¹⁷ which can, in the case of asbestos, dictate that medical records should be kept up to 80 years after the date of the claim. In New Zealand, the Medical Council of New Zealand states that in the case of “other problems likely to persist in the long term”, records are kept for longer; the duration is unspecified.¹⁸

In general, when OEPs are employed, they should assume the records belong to them and take charge of them unless directed to do otherwise by a court. If an OEP leaves employment, it is their responsibility to formally hand over records to their successor (if relevant), or to maintain control of these records. In the case of an outsourced occupational health service, the situation is less clear, and in case of uncertainty, OEPs are advised to discuss the issue with their medical indemnity insurer.

Access to the records must be strictly controlled. Other employees of the OEM service who need access to records must observe strict confidentiality, and access should be on a “need to know” basis. When an OEP’s attendance is only part-time, the occupational health nurse, if employed, will have the responsibility for maintaining confidentiality of the medical records. OEPs should ensure that they have the authority to fulfil this responsibility in their organisation.

Electronic records are becoming increasingly the norm: an “auditable” trail is recommended. Ideally, IT records should be on an access-controlled server, or “standalone”. Any data transferred to a third party should be encrypted. If paper records are to be destroyed, then this should be performed effectively by shredding. Care should be taken that paper records that may be needed in the future (for example, for legal/regulatory matters) are not inadvertently destroyed.

Access by any other persons, whether medically qualified or not, including HR personnel and managers should not be granted except with the worker’s informed and signed consent. All staff working in OEM services should have training in confidentiality, and must abide by the ethical code of their professional organisation. Non-clinical staff should sign a confidentiality agreement as a condition of employment. Access to their own medical records may be requested by individuals. This is supported by legislation in Australia and New Zealand.¹⁹ Usually OEPs should respond positively to any such request or provide the individual with a reason why this is not possible. It may be inappropriate to permit access under some specific circumstances: examples include information unrelated to the health of that person (for example, third party medical information), or if disclosure of the information would result in a serious imminent threat to life, health and safety of the individual or others, or poses a serious threat to public health or safety. If the OEP is concerned or the situation is unclear, they should discuss the matter with their medical indemnity insurer.

14 New Zealand Parliamentary Counsel Office/Te Tari Tohutohu Parameta, *Health (Retention of Health Information) Regulations 1996*. Available online: <http://www.legislation.govt.nz/regulation/public/1996/0343/latest/whole.html> [last accessed on 18/01/16]

15 Medical Council of New Zealand (1998), *The maintenance and retention of patient records*. Available online: <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Maintenance-and-retention-of-records.pdf> [last accessed 19/01/16]

16 Australian Government, Department of Health, *Personally Controlled Electronic Health Record System: Legislation Issues Paper. Appendix 4: State/territory general medical record retention requirements. State/territory general medical record retention requirements*. Available online: http://www.privatehealthcareaustralia.org.au/wp-content/uploads/PCEHR_Legislation-Issues-Paper2.pdf [last accessed 03/05/16]

17 Australian Government, National Archives of Australia (2011), *Records Authority 2010/00322036, Comcare: Asbestos Related Compensation Claims & Workers’ Compensation Claim Management*. Available online: <http://www.naa.gov.au/naaresources/ra/2010-00322036.pdf> [last accessed on 19/01/16]

18 Medical Council of New Zealand (1998), *The maintenance and retention of patient records*. Available online: <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Maintenance-and-retention-of-records.pdf> [last accessed 19/01/16]

19 See references 14 to 18 above.

PERFORMANCE MANAGEMENT

Performance management is an activity to ensure that goals are being met and enable improvement. Performance management for OEPs can be used as an appraisal system to demonstrate that their practice is safe, up to date and that they are fit to practice. It can also be a process by which managers, other stakeholders and OEPs work together to plan, monitor and review work objectives and the OEP's overall contribution to an organisation.

All OEPs need to maintain their competence to deliver safe and appropriate care. This requires them to develop, update and enhance their knowledge, skills and performance on an ongoing basis via the AFOEM/RACP Continuing Professional Development (CPD) program, the registration renewal requirements of the Australian Medical Board and the recertification requirements of the Medical Council of New Zealand. OEPs need to commit to the principle of continuing education and maintenance of specialist knowledge, in an environment of progressive discovery and changing practice. When OEPs declare high standards of practice, such declarations must be honest, transparent and subject to scrutiny by stakeholders and professional bodies.

ETHICAL CONDUCT IN RESEARCH

Research is an important part of the training of OEPs with each trainee required to undertake a piece of research and present a research report during his or her pathway to Fellowship. Post Fellowship, many members of AFOEM continue to be involved in research. In research matters, the OEP is bound by ethical considerations common to all medical and health research, but there are some specific ethical considerations related to research undertaken in a workplace setting. Further information regarding the ethical conduct of human research is available from the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research (2007) (Updated May 2015).²⁰

The Australian National Statement²¹ and the Health Research Council of New Zealand's HRC *Guidance Notes on Research Ethics (Guidance Notes)*²² set out clear guidelines regarding the values and principles of ethical conduct in medical and health research, risks and benefits of undertaking the research, informed consent, guidance on ethical research methods, measures to recruit participants and the special needs of potentially vulnerable participants, processes of research governance and ethical review. It is important that all who are involved in human medical or health research are familiar with the latest version of national requirements, which are updated regularly.

Another important consideration in undertaking human medical and health research is to ensure compliance with the relevant Privacy and/or Health Records (or similar) Acts. For example, the Australian National and State Privacy Acts contain several privacy principles which guide the appropriate collection, use, storage and disclosure of personal information, while the Health Records Acts create a framework to protect the privacy of individuals' health information and regulates the collection and handling of health information.

Sometimes, health research may infringe on one or more of the Privacy Principles. The Privacy Acts are not intended to create a barrier to undertaking such research, and there are provisions within the Acts and also the NHMRC National Statement whereby an Ethics Committee can approve an infringement of a Privacy Principle(s), such as approving a waiver of individual consent, where the outcomes of the research are considered to be a high public interest and/or the scientific integrity and/or feasibility of undertaking the research would be compromised if all Privacy Principles were adhered to.

While the National Statement provides clear guidance on the general principles of important aspects of ethical conduct in research, it is important that researchers be aware of what is considered good practice in undertaking human medical or health research, which should be used to meet the National Statement requirements. One useful resource is 'A Guide to Good Research Practice', published by the School of Public Health & Preventive

20 National Health and Medical Research Council (NHMRC) (2007), National Statement on Ethical Conduct in Human Research (Updated May 2015). Available online: <https://www.nhmrc.gov.au/book/national-statement-ethical-conduct-human-research> [last accessed 22/09/15]

21 National Health and Medical Research Council (NHMRC) (2007), National Statement on Ethical Conduct in Human Research (Updated May 2015). Available online: <https://www.nhmrc.gov.au/book/national-statement-ethical-conduct-human-research> [last accessed 22/09/15]

22 Health Research Council of New Zealand (2014), HRC Guidance Notes on Research Ethics (Guidance Notes). Available online: http://www.hrc.govt.nz/sites/default/files/HRC%20Guidance%20Notes%20on%20Research%20Ethics%20-%20November%202014_0.pdf [last accessed 19/01/16]

Medicine at Monash University.²³ There are some particular aspects of conducting research in workplaces which require specific mention. These include:

- Researchers must gain the co-operation and endorsement of workers and management in all research undertaken in the workplace. A research advisory committee, involving representatives of all relevant stakeholders, is one way of ensuring stakeholder engagement and support.
- At all times workers should retain the right to refuse participation in the research and any consent must be truly informed consent. In a workplace, there is the possibility of workers thinking they need to participate, as non-participation may impact on their continued employment. This may particularly apply to more vulnerable workers, such as apprentices, those from non-English speaking backgrounds and those in more precarious work arrangements. This must be clearly explained in the explanatory statement for the study.
- It is important that any information collected from workers as part of a research project is kept separate from other health information on the worker held in the workplace.
- Any abnormal health results for a worker identified during the research need to be conveyed to the worker and his or her treating practitioner with the worker's consent. The worker's personal medical information should not be made available to the management at the workplace.
- The group results of research conducted in the workplace should be reported back to the workers, members of an advisory committee. The initial plan should identify other relevant stakeholders, such as workers' compensation authorities and other Government departments.
- Where the results from the research have important implications for hazard control or other aspects related to the workplace, it is important that the OEP brings to the attention of the employer the nature of the problem, as well as recommendations for necessary changes.

An OEP undertaking clinical or epidemiological research in the occupational and environmental setting, either by himself/herself or as part of a research team, must obtain approval for the research from a recognised human research ethics committee(s) before starting the research. Relevant ethics committees can be found in universities, hospitals, Government departments or can operate in a private capacity. Even research which may be considered 'low risk' may require ethics committee approval. Once ethics committee approval has been given, any significant modifications to the research protocol will need to go back to the relevant ethics committee for final approval.

ETHICS FOR INSTITUTIONS AND COMPANIES

The OEP needs to influence the ethics of the organisation they work for or with, to harmonise with the principles expressed in this document. They need to seek the support and cooperation of employers, workers, worker's representatives and their own organisations, as well as relevant authorities and professional organisations in adopting and implementing high standards of ethics in their practice. There should be a program of audit of activities in their organisation to ensure appropriate standards have been set and are conformed with, and deficiencies are detected and corrected.

WHISTLEBLOWING

Whistleblowing refers to the disclosure by current or former members or contractors of an organisation, of illegal, immoral or illegitimate practices, to persons or organisations which may be able to effect corrective action.

For the OEP issues which may be subject to whistleblowing may include:

- Occupational health and safety issues, e.g. failure to comply with statutory requirements, for example, lead results or control of noise;
- Product liability, e.g. production of goods that may cause accidents or illness; or,
- Unauthorised discharges to the environment or improper disposal of wastes.

Before bringing any issues to the attention of management or other stakeholders, the OEP should ensure that he or she has robust evidence based on credible information. Initially the OEP should discuss the identified problem(s)

²³ Monash School of Public Health and Preventive Medicine (June 2012), *Medicine, Nursing and Health Sciences: A guide to good research practice* (5th Edition). Available online: <http://www.med.monash.edu.au/assets/docs/sphpm/sphpm-grp-guide-v-5.pdf> [last accessed 22/06/15]

with management at the highest level pointing out the issues and stressing his or her own ethical and perhaps legal responsibilities in bringing these issues to attention.

If there is no action on the part of management once the issues have been reported, the OEP may be obliged to inform the relevant Government department and/or resign from the organisation.

Before raising their concerns publicly the OEP should ask for advice from his or her professional body and/or medical indemnity organisation.

IMPAIRED PRACTITIONERS²⁴

OEPs have an obligation to recognise their own incapacity, whether from illness or chemical dependency and to take steps to ensure that others are not harmed thereby.²⁵ This is separate from recognition of a lack of skill or currency that should limit an OEP's scope of practice.

An affected OEP may not recognise his or her impairment. There is thus a difficulty for colleagues who become aware of the situation and who have a responsibility to ensure that patients and others are not put at risk.

Fitness to practice medicine is the responsibility of the Medical Board of Australia and the New Zealand Medical Council. OEPs who are concerned about their colleagues should consult with other colleagues, the Doctors Health Advisory Service, the Australian Medical Board or New Zealand Medical Council in confidence.

OEPs may consult with other health professionals to assess fitness for duties. It is important that the OEP is not influenced by professional kinship and impartially assesses fitness, seeking the best outcome for all concerned: the individual, employer, the health system and the impaired practitioner's patients.

A decision to refer an impaired practitioner to the regulator can be fraught. In many jurisdictions, there is a duty to report. This can impede a relationship with the physician as a patient, particularly where it is a therapeutic relationship.

OEPs should be promoting healthy and safe workplaces. This applies every bit as much to their own workplace, whether it is in a private clinic, in a large industrial company, a regulator or the myriad of other locations an OEP might work. OEPs are in a unique position as they have the appropriate training and experience to identify workplaces which do not foster a good working environment and can advocate for improvements.

STEWARDSHIP OF HEALTHCARE RESOURCES

OEPs work, as do all health professionals, in a resource-constrained environment. Inappropriate use of resources may place the patient at risk of harm, either through the procedure itself, or a finding that then may or may not require further investigation and possible treatment, with associated anxiety, lost time and productivity. Investigations with high false positives need to be very carefully assessed, and practicing "defensive medicine", to try to avoid "missing something" at any cost, should be avoided.

OEPs should adhere to best practice and evidence-based medicine in determining a course of action. In doing so, they should be mindful of opportunity costs, where the resources invested in the management of a particular case will not be available for other uses.

This concept is described as parsimonious care. Physicians have a responsibility to practice effective and efficient health care and to use health care resources responsibly. Parsimonious care that utilises the most efficient means to effectively diagnose a condition and treat a patient respects the need to use resources wisely.

Parsimonious medicine care is not rationing. The goal of medical parsimony is to provide the care necessary for the patient's good- not to reduce resource use- although it may have the welcome side effect of preserving resources. It is this difference in intent and action that helps provide a foundation for the ethical distinction between parsimonious medicine and rationing.

²⁴ For further information about impaired practitioners, please refer to the <http://www.medicalboard.gov.au/> and <https://www.mcnz.org.nz/>

²⁵ Further information on this issue is provided in the RACP's *Health of Doctors Position Statement* (May 2013). Available online: <http://www.racp.edu.au/docs/default-source/advocacy-library/pa-pos-health-of-doctors-2013.pdf> [last accessed 22/06/15]

TRAINING

OEPs should contribute to the information for workers, on occupational and environmental hazards to which they may have been exposed, in an objective and understandable manner, and try to ensure there is no suppression of relevant information. The diversity in workplaces due to education, culture, generation, language, and so on, must be considered and suitably addressed. In the training, the level of evidence and certainty of various hazards and methods of control should be discussed with workers, employers and worker representatives.

In training OEPs, there needs to be assurance that the trainee is not exploited for use as “cheap labour”. A breadth of experience to assist the trainee to eventually achieve competent functioning at a consultant level is essential.

There are times when a conflict of interest may arise when an employer is also the supervisor of a trainee. The trainee may be reluctant to reveal shortcomings or challenge processes if there is a perception that he or she may be penalised. Employers, supervisors and trainees should be aware of such potential conflicts of interest before entering into an employer/employee relationship. If such conflict arises, the trainee should be informed of methods to redress conflict that are available within AFOEM and the RACP. Many OEP trainees will work in a variety of workplaces, including in competitor clinics. The intellectual property of the employer must be respected by not transferring information, processes, documentation, items and so on, from one provider to another.

Medical training presents an opportunity to increase healthy practices, awareness of warning signs, and strategies to manage stress. These may translate into lifelong protective habits and promote resilience. Continuing professional development also provides an opportunity to engage with doctors around the issue of maintaining their own health.²⁶ Thus, it is an important part of any ethical dimension of the training of OEPs to address these issues.

²⁶ For further information on this issue, please refer to the RACP's Position Statement: Health of Doctors 2013. Available online: <http://www.racp.edu.au/docs/default-source/advocacy-library/pa-pos-health-of-doctors-2013.pdf> [last accessed 19/01/16]

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- The Australian College of Rural and Remote Medicine (ACRRM) eHealth website: <http://www.ehealth.acrrm.org.au/>

ENDNOTES FOR GLOSSARY

- i Oxford Dictionaries: <http://www.oxforddictionaries.com/definition/english/should> [last accessed 3/09/15]
- ii Oxford Dictionaries: <http://www.oxforddictionaries.com/definition/english/must> [last accessed 3/09/15]
- iii Adapted from Medical Dictionary: <http://medical-dictionary.thefreedictionary.com/therapeutic+relationship> [last accessed 19/01/16]

ABOUT THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

The RACP trains, educates and advocates on behalf of more than 14,950 physicians – often referred to as medical specialists – and 6,533 trainees, across Australia and New Zealand. The College represents more than 34 medical specialities including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

The Australasian Faculty of Occupational and Environmental Medicine (AFOEM) is a Faculty of the Royal Australasian College of Physicians (RACP) that connects and represents Occupational and Environmental Medicine Fellows and trainees in Australia and New Zealand.

We are committed to establishing and maintaining a high standard of training and practice in Occupational and Environmental Medicine in Australia and New Zealand through the training and continuing professional development of our members and advocating on their behalf to shape the future of healthcare.

Occupational Medicine takes a preventative approach to health and safety in the workplace by looking at how a work environment can affect a person's health, and how a person's health can affect their work. Environmental Medicine is primarily concerned with the human health impacts of industrial practices on the broader environment outside of the industrial site.

Occupational and Environmental Physicians (OEPs) provide specialist knowledge to ensure a healthy, productive workforce and connect a workplace with the diverse range of health services necessary to optimise the health and wellbeing of employees. OEPs work with governments, regulators, employers, workers and other health professionals to ensure positive health outcomes for workers and employers.



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