

Ethical issues among Finnish occupational physicians and nurses

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A postal survey was conducted among 200 Finnish occupational physicians and nurses on their ethical values and problems. Both groups considered 'expertise' and 'confidentiality' as the most important core values of occupational health services (OHS) corresponding with newly published national ethical guidelines for occupational physicians and nurses in Finland. Nearly all respondents had encountered ethically problematic situations in their work, but ethical problems with gene testing in the near future were not considered likely to occur. Only 41% of the nurses and 36% of the physicians had received some training in the ethics of OHS, and 76% of all respondents never used available ethical guidelines. According to the results, even if ethics play a vital role in OHS, the ability to critically evaluate one's own performance seems quite limited. This creates a need for further training and more practicable national guidelines.

Key words: Ethics; occupational health services; occupational nurses; occupational physicians; postal survey; values.

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INTRODUCTION

Ethics have always been of crucial importance in occupational health services (OHS) because they serve several customers whose rights and duties sometimes seem to clash.^{1–3} The International Commission on Occupational Health (ICOH) published ethical guidelines in 1992⁴ and, in Finland, national ethical guidelines for occupational physicians and nurses have also been published.

In Finland, 'Good Practice in Occupational Health Services' was introduced in 1994 by the Ministry of Social Affairs and Health. The principles of the good practice have been further defined in the newly published guidebook.⁵ This new concept emphasizes ethical standards along with demands for the evaluation and constant improvement of quality and effectiveness in OHS. The goal of occupational health services is to ensure a healthy and safe work environment and an able and well-functioning working population.⁶ Four models of OHS are in use: the municipal health care centre

model, the company's in-plant health service (integrated model), group services of several small- and medium-sized enterprises (joint model) and the private medical centres.

According to a national survey in 1992,⁷ there were 1,025 OH units in Finland with 1,532 full-time and part-time posts for physicians, 1,925 for nurses, 405 for occupational physiotherapists, 127 for occupational psychologists and 831 for ancillary staff. Seventy-eight per cent of the full-time physicians, 75% of the full-time nurses and 59% of the full-time physiotherapists have attended the 4-week course on OHS offered by the Finnish Institute of Occupational Health. The specialists in occupational health services occupied slightly less than a third of the posts for occupational physicians.

AIMS

The ethical issues confronting Finnish occupational nurses and physicians have never been studied before, and we are not aware of any studies on ethical questions in which both groups are included. However, the tradition of team work in the Finnish OHS made this approach most suitable. The aim of this survey was to study the ethical principles among occupational health

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physicians and nurses, the kinds of ethical problems that arise and the ways in which they are managed.

MATERIALS AND METHODS

In the spring of 1996 an anonymous postal inquiry, followed by a reminder card, was sent randomly to 200 physician members of the Finnish Association of Industrial Medicine (125 men and 75 women) and 200 members of the Finnish Association of Occupational Health Nurses (all women).

The overall response rate was 56%; 121 nurses and 103 physicians replied. One questionnaire in which the background information was lacking is included in the total analyses only. Female physicians had the highest response rate (85%), followed by nurses (60%), whereas only 31% of the male physicians returned the questionnaire (Table 1).

The age range of the nurses was 26–62 years, and that of the physicians, 30–84 years. The mean age was the same in both groups (46.8 years). All nurses were of working age. Physicians over the age of 65 years who had listed themselves as practising physicians were included in the survey. The mean duration of experience in OHS was 15.6 years with no considerable difference between the two groups.

The professional values were studied by means of a question with 32 choices of characteristics for good OHS. The respondent was asked to choose the three most suitable characteristics and to place them in rank order. The first choice received three points, the second two points and the third one point. The points given to the characteristics by all the respondents were summed up.

The equality of the customers was studied with an example in which an employee wanted to have a health examination. All the respondents received an identical question, but in half of the questionnaires (61 nurses and 53 physicians) the employee was a cleaning lady and in the other half a personnel director (60 nurses and 50 physicians).

The responses to all questions were compared between the physicians and the nurses. The question on equality was analysed by comparing the responses within the professional group. The statistical significance was calculated with the Chi-squared test.

Furthermore, to study the implementation of ethical values in practice, we presented some imaginary cases involving ethical dilemmas (Appendix 1). The respon-

dents were asked to choose one of the given alternatives that most correctly described the respondent's opinion and likely action in a similar situation.

RESULTS

According to the respondents, the two most important characteristics of good OHS chosen from a list of 32 choices were 'expertise' and 'confidentiality' (Table 2). The 10 most important characteristics in the lists of the physicians and nurses were almost identical.

OHS were primarily regarded as the right of employees by the majority (54% of physicians, 63% of nurses), whereas 44% of the physicians and 34% of the nurses saw OHS first of all as a means to enhance productivity at work. Two per cent of all respondents considered the primary function of OHS to be the minimizing of the risk of early retirement among employees.

Most respondents felt that the information from OHS to the employer is most frequently used to improve the employees' work ability and working conditions. However, according to 10% of the respondents, it is possible that information is misused to eliminate difficult employees. Twice as many thought that this never happens.

In the situation where a cleaning lady or a personnel manager asked for a comprehensive health examination without having any symptoms or known risk factors, the most frequent procedure chosen by the respondents was an invitation to a consultation. Four per cent of the respondents informed the cleaning lady and 1% the personnel manager, that no health examination would be needed. Nine per cent of the physicians would perform the health examination according to the wishes of the patient if she was a cleaning lady, and 6%, if she was the personnel manager; the corresponding figures were 11% and 23% of the nurses, respectively. The differences were not statistically significant in either group.

The respondents were asked to select the most important purposes of a pre-employment examination from a given list. Both the nurses and the physicians saw the prevention of diseases and the promotion of health, together with exclusion from certain jobs, to be the most important aims of the pre-employment examination (Table 3).

Table 2. The characteristics describing best the ethical principles of good occupational health services

<i>Characteristic</i>	<i>Points</i>	<i>% of all points</i>
Expertise	218	16
Confidentiality	171	13
Customer orientation	110	9
Quality	105	8
Justice	76	6
Neutrality	71	5
Comprehensiveness	64	5
Professional independence	58	4
Humanity	37	3
All others	329	24
Total	1,338	100

Table 1. The respondents by occupation and gender

	<i>Occupational physicians</i>		<i>Occupational nurses</i>	
	<i>Men</i>	<i>Women</i>	<i>Men</i>	<i>Women</i>
Number of mailed questionnaires	125	75	—	200
Number of returned questionnaires	39	64	—	121
Response rate	31%	85%	—	60%

Confidentiality in OHS was regarded as good by most respondents in both groups (85% of all); 18% of the physicians and 13% of the nurses thought that it was only satisfactory or even poor. Doubts had arisen, *e.g.*, because of easily readable and changeable computerized patient data. Also some concerns were expressed about the confidentiality of the diagnoses on sick leave certificates, and concerning the close co-operation between OHS and the personnel management. In the latter case, the secrecy of confidential information, especially concerning patients with many complaints or alcohol problems, was considered to be endangered. The nurses reported more often than the physicians that they had been confronted by demands to release confidential information (47% *vs.* 28%, $p = 0.005$).

The majority (65%) anticipated hardly any ethical problems in connection with gene testing in the near future; the physicians were more confident of this than the nurses (79% *vs.* 54%, $p = 0.001$). Thirty-one per cent of all respondents had no opinion, and 4% felt that ethical problems would most likely occur.

Nearly all (97%) reported situations involving ethical problems in their work, most often when the employer was reluctant to improve the working conditions, or when either the patient or the employer disagreed on assessed work ability. The use of methods lacking scientific evidence was listed as a cause for ethical considerations by 16% of the physicians and 7% of the nurses. Most respondents discussed ethical problems with a colleague in the

same unit (67%) and almost as many with other professionals in the same unit (61%). Ethical discussions with colleagues outside one's own OH unit were less frequent (reported by 29% of the respondents). More often than this, even representatives of the workplaces (41%) and safety personnel (42%) were involved in these discussions. Only 3% reported that they had never discussed ethical matters with anybody.

When asked about ethical guidelines at their work place, 55% of the respondents replied 'none' and 21% did not know. The guidelines reported by 24% of the respondents were laws, mostly concerning confidentiality, the *International Code of Ethics for Occupational Health Professionals* by ICOH, and guidelines issued by a professional association or by the Ministry of Social Affairs and Health. Some respondents listed guidelines issued by their OH unit or the company itself and the instructions in their quality manual.

Thirty-six per cent of the physicians and 41% of the nurses had received some training in the ethics of OHS, and the majority [physicians (52%), nurses (84%)] wished to receive more. The types of training most preferred were discussions in small groups and training concentrating on the practical implications of ethics. Also among the listed expectations were clarification of ethical concepts, versatile and up-to-date training in basic questions based on core values, as well as training in working with work organisations.

Because the solutions in the presented imaginary cases require an occupational physician's decision, the results presented here concentrate on the physicians' opinions. The most evident difference in the answers between the physicians and the nurses is in the first case, where the nurses are more willing to ask for the opinion of an outside expert and less willing to impose restrictions (Table 4). Otherwise, once again, the choices made by the physicians and nurses are quite similar.

In the first of the presented imaginary cases, 41% of the physicians would give both a written statement on restrictions and consult the employer on necessary procedures to protect the applicant. However, equally many (42%) would not contact the employer, but would give a written statement either on complete rejection or restrictions and leave the necessary adjustments to the employer's initiative.

Table 3. Distribution of the preferred purposes of the pre-employment examination

Purpose of the examination	% (n = 225)
To exclude persons with disease attacks from accident-prone jobs	91
To exclude from jobs hazardous to health	90
To get information as a basis for health promotion	88
To exclude physically unfit persons	84
To give information on OHS	76
To give information on improving working conditions	62
To exclude persons susceptible to cancer in jobs with carcinogenic substances	60
To screen for occult diseases	48
To exclude drug users	46

Table 4. Distribution of answers to the presented imaginary cases

	Case 1		Case 2		Case 3	
	Physicians (%)	Nurses (%)	Physicians (%)	Nurses (%)	Physicians (%)	Nurses (%)
Choice 1	14	4	23	15	22	20
Choice 2	2	13	37	48	37	36
Choice 3	5	5	0	0	0	0
Choice 4	28	10	17	17	6	12
Choice 5	41	50	20	20	5	7
Choice 6	11	18	—	—	0	0
Choice 7	—	—	—	—	9	1
Choice 8	—	—	—	—	21	24
n	103	121	101	121	103	121

In the second case, 23% of the physicians would recommend absolute rejection. However, 54% would give the applicant an opportunity to start working, 37% providing that he quits smoking and 17% would recommend appointment unconditionally (regardless of smoking and the consequent increased risk of cancer).

Most of the responses in the third case were divided between two of the given choices. Thirty-seven per cent of the physicians would send the statement on the patient's work ability to the employer after having informed him of this procedure, whereas 22% would rely on the patient and give the statement to him to take to the employer.

CONCLUSIONS

The three most popular core values (expertise, confidentiality and customer orientation) are in concordance with the principles of *Good Practice in Occupational Health Services*.⁵ However, 'effectiveness' and 'efficiency', also established principles in the guidebook, were not among the 10 most important characteristics. Even though more than a third of all respondents seemed to consider the economic advantage for the company to be more important than the personal benefits for the employee as the main task of OHS, neither 'economy' nor 'profitability' were rated among the 10 most important guiding values. This is surprising, as more and more often OH personnel are required to show the outcome of their processes in the form of monetary value. Being asked to choose only three values, the respondents had to leave out choices that they might have considered important. At this point, personal values linked closely to contacts with patients seem to be preferred to values describing the OHS system as a whole.

Enhancing the profitability of enterprises as the main task of OHS is quite surprising because this is not one of the tasks stipulated in the Occupational Health Services Act or in the good practice. Some respondents have related in personal discussions that by improving the working conditions and the work ability of the employees, the profitability of enterprises can be enhanced, and that is why they chose this alternative. However, ethical problems usually arise only in case of conflict of interests. Therefore, one can only wonder whose side these respondents choose.

Unexpectedly, the physicians and nurses had very similar ethical principles, even though their training and tasks in OHS can be very different. This conclusion is supported by the findings that hardly any ethical conflicts with other professional groups were reported by either group and that ethical dilemmas are mostly managed inside the OH units.

Confidentiality in the OHS was mostly considered to be at a satisfactory level. Despite this, continuous improvement is important, because some respondents had their suspicions of lapses in confidentiality. Although the nurses were more often confronted with demands to break confidentiality, this didn't affect their trust in confidentiality in general. When interpreting the answers, one

has to bear in mind that a postal inquiry doesn't necessarily give a reliable picture of the reality, but describes only the opinions of the respondents.

The answers may be distorted by the assumed 'ideal' answers that the respondents want to give even though these might not reflect their own opinions. The question on equality in OHS is interesting because the respondents didn't know that there were two kinds of questions, and thus were not aware of the aim of the question. These professions were chosen, because OHS usually operate in close co-operation with or even under the administration of a personnel manager, whose status is regarded to be quite different from that of a cleaning lady. The possibility of inequality remains in the factual process of health examination, despite the fact that the announced reaction to a request from a cleaning lady and a personnel manager were so similar.

The study groups were selected from professional associations because professionals identifying themselves as occupational health nurses or occupational health physicians are usually members of these associations. The occupational nurses and physicians working in public health care centres were under-represented, and those working in single enterprises' own OH units were over-represented, compared with the national distribution.⁷ The low response rate among the male physicians is surprising and may have distorted the results. Especially the concordance concerning the core values of the nurses and the physicians might have diminished with more answers from male physicians, since most of the respondents in both groups were women.

The majority of the respondents did not expect ethical problems in connection with gene testing contradicting the discussions in the literature.^{8,9} In view of the fact that so many respondents wanted to exclude persons susceptible to cancer in jobs with carcinogenic substances, and to screen occult diseases in pre-employment examinations, gene tests capable of showing susceptibility to cancer or other diseases might already have a market in OHS today. Clearly the respondents are not yet sufficiently informed about the possible applications and ethical dilemmas of gene testing. Another ethical issue for debate is drug testing, as almost a half of the respondents supported the exclusion of drug users in pre-employment examinations, and drug testing has lately received more attention in Finnish companies.

The excluding nature of pre-employment examinations seemed not to cause any ethical problems, despite the fact that the role of pre-employment examinations has been strongly criticized in the literature.^{2,10,11} Adapting the work environment to the capabilities of the applicant, and thus preventing work-related disorders must be given priority, instead of using the prediction of sick leaves or early retirement as criteria for exclusion. Apart from their excluding nature, most respondents also found pre-employment examinations important as a source of information to promote the health and well-being of the employees and to improve the work environment.

Despite the fact that all respondents had received the guidelines of their own professional association, and the physicians had also received the guideline published by

ICOH translated into Finnish, only a minority reported to have any available guidelines to help them. The same situation has been found earlier among British, Dutch and Singapore physicians.¹² Apparently merely sending the ethical guidelines is not enough, but further training and room for exchange of opinions is required to arouse more interest in using the available ethical literature. The guidelines may also be on such a general level that they don't succeed in supporting the OH professionals in their ethically challenging situations.

The presented cases, including ethical dilemmas, help to evaluate the ethical principles implemented in practice. Even if no definitely correct practices can be set, the variation in the preferred choices is interesting, as it was greater inside the professional group than between the groups. Lack of agreement among occupational physicians on ethical solutions has been noticeable also in an earlier study.¹²

In cases 1 and 2, the conclusions of the pre-employment examination can be totally opposite depending on the physician. The disabled applicant in case number one had a good possibility of getting the job, but 14% of the physicians would have recommended his rejection on medical grounds. In case number two, the possibility of rejection was higher, 23%, even though almost as many physicians (17%) did not even consider this possibility.

In case number three, the difference in the answers reflects the balancing between the patient's right to confidentiality and his co-workers' right to safety at work. Considering that the danger caused by impaired vision was great, could the patient be trusted and the statement given only to him, thus respecting his right to either disclose or withhold information on his health status? Of the physicians, 23% preferred this alternative, whereas 37% wanted to ensure that the statement was given directly to the employer.

The ethical problem emerging from the imaginary cases is the variation in practices due to lack of a scientific basis for many decisions made in OHS. This problem, however, was seldom brought up by the respondents. Most alarmingly, as these examples show, lack of knowledge can lead to situations where the rights of either workers or employers and co-workers can be endangered. More guidance as well as research is needed, especially in the field of preventive measures in OHS.

Another kind of study approach would be more suitable for probing deeper into ethical standards, policies and practices in OHS. However, the present study revealed some interesting details in the ethics of the care givers in Finnish OHS. Because of the lack of training in occupational health ethics and the poor use of available guidelines, the ability to critically assess one's own work seemed to be rather limited. Improvement in this field is a challenge that has to be tackled before high-quality good practice in occupational health services can be fully achieved.

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APPENDIX 1. THE IMAGINARY CASES PRESENTED TO THE RESPONDENTS

Case 1

In a pre-employment examination, the applicant has a disease that, according to your opinion, impairs his ability to work. The person himself wants to get the job in spite of the disease. What would you do?

1. You give him a written statement in which you consider him unsuitable for the job.
2. You ask for an outside expert's opinion *e.g.*, from the Institute of Occupational Health
3. You propose a probation and a new examination later.
4. You give a written statement on the restrictions at work.
5. You give a written statement on the restrictions at work and consult the employer about the safety procedures at the work place
6. Some other solution, what?

Case 2

At an asbestos factory, a 50-year-old smoker comes to the pre-employment examination. What would you do?

1. You consider him unsuitable for work with exposure to asbestos because of his smoking.
2. You give him permission to start working provided that he quits smoking. You advise him to attend a counselling group under your supervision.

3. You give a rejecting statement directly to the employer without disclosing the reason to the applicant because you don't want to alarm him with the increased risk for cancer.
4. You give a positive statement, because smoking and the extra risk caused by it at work is his personal matter.
5. Some other solution, what?

Case 3

The eyesight of a worker is impaired because of an eye disease. He has always wanted to keep this to himself and not even his closest workmates know about his eye disease. However, you think that the disease has deteriorated

and that the other workers are in great danger because of it. The worker considers himself to be fully able to work. What do you do?

1. You give the worker a statement with your own opinion to give to the employer.
2. You send the statement directly to the employer after you have told the worker about this.
3. You don't do anything.
4. You put the worker under special surveillance.
5. You discuss the situation with the employer.
6. You give a hint to the employer in a suitable situation.
7. You let the worker prepare himself for your suggestion while he is on a long sick leave.
8. Some other solution, what?