Study of business ethics in occupational medicine

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Abstract

Objective—To investigate the views of specialists in occupational medicine about business ethics in occupational medicine.

Method—A qualitative study with face to face focus groups and successive reviews of the draft consensus was undertaken of all accredited specialists in occupational medicine who were members of the south Wales and west of England group of the Society of Occupational Medicine, and of all regional specialty advisers and deputies from the Faculty of Occupational Medicine.

Results—There was widespread agreement for the need of a code of business ethics. In all, during the four draft stages of preparing a consensus, 72% (28/39) of members of the south Wales and west of England group of the Society of Occupational Medicine, and 31% (20/64) of regional specialty advisers and deputies provided detailed comment for inclusion in it.

Conclusions—Consensus of their views was reached among study participants for issues of business ethics involving advertising, competence, qualifications, fees, commitment, changes in provider contracts, regulation, and supervision of trainees. It provides a basis for further debate.

(*Occup Environ Med* 1997;54:351-356)

Keywords: business; ethics; research

The present Chief Medical Officer for England has pointed out "the increasingly important part which ethical issues play in health and health care".¹ A recent editorial in *Occupational Medicine* noted that: "as we rush headlong towards the new millenium", time should be taken to review and discuss the ethical principles and core values which are critical to the workforce of tomorrow.²

Medical ethics is indeed, a live and changing concept.³ The Faculty of Occupational Medicine, Royal College of Physicians, London, (FOM) has reported that: "attitudes and behaviour in society are changing rapidly and for physicians working in industry and commerce the changes tend to be quicker and more radical than elsewhere. Ethics, as a code of conduct, must take account of these changing attitudes and also of legal standards. The

need for special consideration of ethical standards in occupational medicine arises largely because doctors may find themselves in a position where there are conflicts of interest and loyalty derived from the different roles they are required to play".⁴ In 1995, the FOM Ethics Committee identified three areas of current pre-eminent ethical concern:

- The freedom of doctors to serve industry without necessarily following standards of practice commensurate with those of a specialist in occupational medicine
- The concern that some professional colleagues question the impartial basis of actions of occupational physicians
- The issue of business ethics and lingering concerns about advertising, competition, etiquette, and professional standing.⁵

It has been argued that the shift from a professional to a business ethic is partly responsible for radically altering the medical profession worldwide,⁶ and that a business which allows anything to conflict with its compelling obligation to maximise profit will soon have the matter resolved by predatory or merely prudent competitors.⁷ Nevertheless, the conflicts between treating medicine as a business and as a profession, and of the utilitarian foundations of economics and duties inherent in professional medical ethics, are recognised.⁸ Tensions between the forces of business and the practice of medicine have for example, been explored previously for ethics in cardiopulmonary medicine.⁹

Within this framework, the General Medical Council (GMC) recently issued guidance on good medical practice.¹⁰ It encourages doctors to provide factual information about their professional qualifications and services which must be legal, decent, honest, and truthful, and conform with the other requirements of the British Code of Advertising Practice. But they note that the advertising of doctors' services must be subject to additional restriction to ensure that the public is not misled or put at risk in any way.¹¹ The GMC guidance noted that: "advertising material should contain only factual information and must not include any statement which could reasonably be regarded as misleading or disparaging of the services provided by other doctors, whether directly or by implication. No claim of superiority should be made either for the services offered for a particular doctor's personal qualities, professional qualifications, experience, or skills".¹¹ Doctors who offer occupational health services were specifically mentioned. The GMC noted that: "specialists

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Accepted 20 November 1996

may keep their professional and managerial colleagues (and the public) informed of the services they offer and of their practice arrangements including details of fees and charges. Material circulated in this way should not, however, disparage, directly or by implication, the services provided by other doctors, nor should it claim superiority for the specialist's personal qualities, qualifications, experience, or skills".¹¹ The British Medical Association (BMA) has published similar advice.¹²

Despite this guidance for medical practitioners who offer occupational health services, problems persist.⁵ In October 1993, for example, a planning meeting for the South Western Region Subcommittee in Occupational Medicine received comments that problems associated with the ethics of business practices in occupational medicine were being experienced. Participants expressed interest in the preparation of a code of business ethics for medical practitioners working with industry. This study is a contribution to the debate about business ethics.

Method

Qualitative methods were used in this study for two reasons. Firstly, it has been reported that their benefits are greatest when the subject of study cannot be controlled and is poorly defined.¹³ Secondly, they can be usefully applied to investigate the functioning of a professional body and its code of ethics.¹⁴ Such methods are appropriate to open up a new area of study or to identify and conceptualise salient issues; they depend not upon numerical but conceptual analysis and interpretation.¹⁵

Most qualitative studies are restricted to a small sample size because qualitative data are more cumbersome to manipulate and analyse than quantitative data.¹⁵ The focus group method (a form of face to face group interview that capitalises on communication between research participants to generate data),^{15 16} was selected as the most appropriate for this study as the issues could be explored in dialogue and the method can "generate a significant body of rich textual data".¹⁷ It is commonly regarded as an exploratory method and considered particularly useful where investigators wish to establish quickly the range of perspectives on an issue of importance among different groups.¹⁵ Each face to face focus group discussion was based on a written draft consensus of views reached at that time.

The first stage of this study was undertaken in November 1993. A letter was sent to all 27 accredited specialists in occupational medicine who were members of the south Wales and west of England group of the Society of Occupational Medicine, (SOM) and working in the South Western Region, England. Their comments were invited on:

- Ways in which medical practitioners have offered occupational health services to companies
- Difficulties for managers attempting to

identify competence from qualifications

- Levels of fees for the standards of service given
- The supervision of training posts.

These four topics were identified in focus group discussion by six members of the South Western Region group of the Subcommittee in Occupational Medicine as key areas of business ethics in need of study. A draft document, "*The Faculty and ethical matters*", was prepared from the responses. The 22 written and three oral comments were evenly divided between the four topic areas, equally distributed among respondents, and all provided substantial material. The draft was sent for comment in January 1994 to the larger group of all 39 accredited specialists in occupational medicine belonging at the time to the south Wales and west of England group of the SOM, and in April 1994 to the 42 regional specialty advisers in occupational medicine and their deputies with one of the investigators (RP) as focus group facilitator for the 38 participants. It was also discussed in April 1994 at the six monthly FOM meeting of regional specialty advisers and their deputies. Received comments were incorporated into the draft at each of these three steps. In October 1995, revised GMC guidance was published.^{10 11} It included material relevant for business ethics. This material was added to the draft text which in April 1996 was sent for any further comment to all 51 accredited specialists in occupational medicine who were at the time the south Wales and west of England group of the SOM, and to all 64 accredited specialists who in March 1996 were on the FOM circulation list for the six monthly regional specialty advisers' meetings. This list included members of the Academic Committee and FOM Board. The text was also discussed, again in a focus group, by 35 participants at the regional specialty advisers's meeting on 18 April 1996 and by the 10 FOM Ethics Committee members the same day.

At each stage of the study the four researchers collated the comments received and revised the findings for further scrutiny by colleagues. Although each of them has held or presently holds an FOM or SOM executive position, this summary of the findings does not necessarily reflect the FOM or SOM viewpoint.

Results

The table shows the response rates to the invitation to comment on four key areas of business ethics and each successive draft consensus of views.

Of the 26 total responses to the second and third drafts, 24 (92%) were for points of detail and wording, and two (8%) were with additional material. Comments at the three focus groups were widespread, widely held, and focused on phraseology and emphasis of the points. In the comments received there was widespread experience of organisations with existing occupational health services being approached by external service providers.

Table 1 Response rates to each step in preparation of a consensus statement for business ethics in occupational medicine

Sequence of steps	Time	Group of respondents	Response rates (n (%))
Invitation to comment on areas for study	November 1993	Accredited specialists in south west England	25/27 (93)
First draft of consensus	January 1994	Accredited specialists in south west England and south Wales	10/39 (26)*
Second draft of consensus	April 1994	FOM RSA's† and deputies	14/42 (33)
Third draft of consensus	April 1996	(a) Accredited specialists in south west England and south Wales	0/51 (0)
		(b) FOM RSA's† and deputies, members of FOM Academic Committee and FOM Board	12/64 (19)

*Includes 7/12 (58%) people in south Wales not previously circulated and 3/27 (11%) in south west England previously circulated in November 1993.

†Faculty of Occupational Medicine regional speciality advisers.

There was also general concern that these approaches did not always allow comparisons of quality. Respondents agreed that:

- Guidance on business ethics and related matters as well as that of the GMC is necessary
- This guidance should appropriately come from the FOM
- Doctors should not lay claim to a level of competence and experience in occupational medicine which they did not possess
- It was not clear how guidance on business ethics could be conveyed to doctors practising occupational medicine who are neither FOM or SOM members nor trainees
- There is a need for widespread debate about business ethics in occupational medicine.

The following consensus of views among respondents was agreed.

The business environment and contractual obligations of commercial, industrial, and service undertakings are changing. At least in the United Kingdom, markets in care of health and illness, separation of purchasers and providers, and questions of professional deregulation have emerged. Market forces now often determine the types and levels of services to be given. New business arrangements and opportunities are emerging for many physicians with responsibilities for people at work. Physicians working in occupational health must ensure that the highest standards of professional ethics are upheld in this new approach to their business practice. Advertising, competence, qualifications, fees, commitment changes in provider contracts, regulation, and supervision of trainees all need to be considered.

ADVERTISING AND ALL MEDICAL PRACTITIONERS WITH RESPONSIBILITY FOR PEOPLE AT WORK

In 1990, the GMC relaxed its rules on advertising. A Monopolies and Mergers Commission report criticised the rules for stopping general practitioners making their services more widely known.¹⁸ It is now well recognised that employers require advice about their occupational health needs. It is ethically acceptable to respond to such requests and for a doctor to provide factual

information about a service he or she can provide. However:

(1) A doctor must satisfy him or herself that the advertising is accurate and truthful. Strident campaigns are undesirable. It is unacceptable for a doctor publicly to discuss his or her own ability in a particular field in such a way as to imply that his or her expertise is superior to that of other doctors. Also, doctors employed by an occupational health provider who are allotted to a particular customer should not use their position to gain personal advantage by—for instance, offering the same service independently at a lower rate. A doctor who is approached by the customer in these circumstances should refer the matter to their employer, the provider of the service (Aldridge J, personal communication).

(2) Any concern about possible incompetencies of a medical practitioner with responsibility for people at work or apparent deficiencies in services he or she is responsible for, should be discussed first with a senior experienced colleague, and then if needs be, with the senior medical manager of the employing firm, regional specialty advisors, Regional Postgraduate Medical Dean, or GMC. Although the GMC has responsibility for issues involving proved incompetence, colleagues should be able to offer educational advice and support where necessary.

(3) Businesses offering an occupational health service to an organisation cannot always contact that organisation to find if an occupational health physician, occupational health nurse, or other occupational health practitioner is in post. If doing so, it is essential that GMC and BMA guidance on canvassing or advertising is followed. Any advertising or marketing material that is generally distributed should include a comment to indicate that if an organisation already has an occupational health service it may not wish to take up the offer being put forward, or may wish to take up only an element of it such as a screening service or well person clinic. In accordance with BMA guidance,¹⁹ courtesy must be shown at all times to those physicians or nurses who are or may be in post.

(4) Accredited specialists in occupational medicine can give guidance to organisations on matching occupational health needs to appropriate levels of content and service. Although fees may be charged for guidance, all doctors giving such advice must do so on the basis of objective assessment. The overriding objective in giving such advice must be to meet the occupational health needs of the patient or client and include practical solutions, balanced for cost and benefit. Fees charged by occupational physicians should be commensurate with the levels and content of service being provided. The BMA and the SOM publish guidance appropriate for some services.

QUESTIONS OF COMPETENCE AND QUALIFICATIONS

It is essential that difficulties are not created for company managers when they are trying to

distinguish between competence and qualifications.

(1) Physicians in possession of the Membership of the Faculty of Occupational Medicine (MFOM), accredited in occupational medicine with the Joint Committee on Higher Medical Training of the Royal Colleges of Physicians (JCHMT), or in possession of a Certificate of Completion of Specialist Training (CCST) in accordance with the EU Directive, should use the term, "specialist"; those without such qualifications should not.

(2) The term "consultant occupational physician" is only acceptable when used by those offering occupational health or medicine advice and who fulfil the criteria in (1) of a specialist.

(3) Physicians who do not have the qualifications in (1) may call themselves medical advisers but should not describe themselves as occupational physicians unless they have at least a minimum level of competence in occupational medicine as indicated by possession of an FOM qualification or equivalent. The FOM distinguishes between different levels of competence by awarding Associateship of the Faculty of Occupational Medicine (AFOM), the Diploma in Occupational Medicine, and previous attendance of an introductory course in occupational medicine.^{19 20} Physicians in possession of the AFOM sometimes use the term "associate occupational physician"; those with the diploma are sometimes described as "diplomates".

COMMITMENT

Occupational physicians have a continuous commitment to companies not only during the period that they are contracted, but also beyond that time for issues of commercial and clinical confidentiality. On ending an appointment, the medical records should be handed over to another doctor or nurse. If there is no successor or the organisation is to be closed, the occupational physician retains responsibility for ensuring the safe keeping of these records.⁴

CHANGES OF OCCUPATIONAL HEALTH PROVIDER

There has been a tendency for some organisations to move away from traditional in house occupational health services and to obtain services under contract from external providers. Contracts are renewed periodically and as a result, an existing contractor may be replaced. Two ethical points arise (Aldridge J, personal communication).

(1) The outgoing provider should not be obstructive to the new contractor and should make reasonable efforts to facilitate the change-over.

(2) Before agreeing to the transfer of the confidential occupational health records, the outgoing provider should be satisfied that the new contractors are professionally competent and have arrangements to store and safeguard the records appropriately. The management should arrange for all affected employees to be informed of the impending change, given

details of the new service and the date from which it will be effective. Included should be the statement that all relevant records will be transferred to the confidential files of the new provider by a given date and that any employee who is concerned about the transfer of their own records should be given the opportunity to discuss the matter with the outgoing physician and possibly withhold permission before the change is made. In the event of an objection the records remain a responsibility of the outgoing provider.

REGULATING AUTHORITIES

In respect of trainees, issues of medical ethics and personal behaviour applied by physicians in any commercial, industrial, or service business undertakings are matters for the JCHMT, the FOM, and the GMC. For accredited specialists, they are the responsibilities of the FOM and the GMC.

SUPERVISION OF TRAINING POSTS AND OTHER WORK OF TRAINEES

The Regional Subcommittee in Occupational Medicine reporting to the Regional Postgraduate Medical Dean, should ensure that each trainee is adequately supervised, that communication between trainees and supervisors is facilitated, and that any problems arising in the training schedule are discussed with the Regional Medical Postgraduate Dean. Three points follow.

(1) These guidelines in ethics apply to trainees undergoing specialist training under the auspices of the FOM and JCHMT. Any trainee seeking employment should state that they are in training. If they are adequately supervised then a firm should have no concern about the quality of service.

(2) Supervisors should be fully aware of the scope, content, and nature of all the work undertaken by their trainees. So that the supervisor can integrate all the training needs and help the trainee to become competent in all areas, the trainee must undertake to disclose all their occupational medicine and closely related activities to the supervisor before the training programme is agreed and during it.

(3) Trainees must be full time unless a part time commitment has been agreed for good well founded reasons. This commitment and changes in sessional employment during the training programme must be agreed with the FOM and the JCHMT, and through the supervisor, regional specialty advisors, and Regional Subcommittee in Occupational Medicine reporting to the Regional Postgraduate Medical Dean. This is particularly important when more than one employer is involved with an individual trainee, when an employer undertakes contracting in of services, or when an employer may otherwise vary the terms of employment. Using some sessional work for training purposes but not others is not acceptable. Under the rules of full time and flexible NHS training schemes, trainees should not undertake additional paid employment in, for example, locum sessions.

Discussion

It has been reasoned that "to the extent that medicine fails in maintaining its professional standards of public service and personal care, it is vulnerable to the criticism of self-serving commercialism".²¹ The Institute of Business Ethics has reasoned that: "every substantial business operating in the United Kingdom should have its own Code of Business Ethics".²² Recent changes in the business environment of commercial, industrial, and service undertakings are reflected in the way that occupational health care is now provided, sought, offered, and evaluated. Competition has emerged and is based on issues of quality, price, advertising, research and development, and service.²³ Ethical questions in the advertising and marketing of services by professions have arisen.²¹

Associated with these changes, it has been suggested that clarification of entitlement to use the title specialist or consultant, regardless of qualification, is needed to avoid an erosion in standards and confusion of responsibilities.²⁴ In May 1996, the FOM and SOM issued guidance to employers on qualifications and the assessment of experience and expertise in occupational medicine.²⁰ The importance of competence and its relevance to legal liability also needs to be fully appreciated by all concerned. In occupational medicine, the implications of misguided advice may extend beyond the boundaries experienced in clinical practice. Compensation for personal injury arising from foreseeable risks may depend on the standard of advice provided by medical practitioners to employers. Case law, that tests what might reasonably be expected of any person in a given set of circumstances, suggests that practitioners will often require specialist knowledge as they will not always be judged by the commonly accepted test of medical negligence. A failure to recognise the need for appropriate professional qualifications may therefore render doctors and employers open to actions they will subsequently regret. Among other things, criminal prosecution by the Health and Safety Executive may follow. Fines imposed by a successful criminal prosecution will not be covered by professional indemnity.

These emerging issues suggest that aspects of personal responsibility and professionalism need again to be reinforced, and ethical guidelines given for the business practice of occupational medicine. In this study the response rates reduced as each successive step was taken to reach a consensus statement (table 1). Nevertheless, the need for a statement on business ethics and the content and wording of the draft consensus were endorsed by each focus group. The increasingly poor response rates to successive drafts were therefore interpreted as increasing agreement with the consensus of views.

The statement agreed by participants in this study provides a basis for further debate. This debate is needed as, for example, ethics are becoming a concern of health service managers.²⁵ Furthermore, as suggested recently for clinical guidelines,²⁶ preparation and adherence to a code of business ethics may help to ensure

that allegations of medical negligence are avoided. The FOM was also, in its standing orders: "founded in 1978 to advance occupational medical knowledge, develop education and training in the specialty and ensure the highest standards of professional competence and ethical integrity".⁴

Membership of a college is also regarded as evidence of having met certain professional standards of knowledge and competence.²⁷ Such membership needs to remain closely linked with core values for the medical profession. The BMA recently identified these as including the "ancient virtues of competence, integrity, confidentiality, compassion, and commitment practised with an enquiring and impartial mind".²⁸ Yet, in present times, whereas the professions as a whole have fought to retain the right to self regulation, core values have come under increasing threat. Four main influences seem to be at work.

(1) The public, partly fed by media coverage of unfortunate occurrences, is becoming more critical of the medical profession and demanding visibly higher standards of competence.

(2) There is an ever increasing explosion of change in technologies affecting almost every aspect of life, leading to heightened expectations and to which all the professions, not just medicine, must respond.

(3) Formalised systems of quality control are now perceived to be an integral part of any professional or industrial activity.

(4) In an increasingly changing world, many of the traditional and separate activities in medical, nursing, and paramedical health practice, are being questioned.

For these reasons, and the integrity of occupational physicians and the speciality of occupational medicine, it is essential that all physicians in occupational health practice continue to maintain the highest standards and ensure impartiality as professional advisers.⁴ Towards this aim, it has been noted that ethics and professionalism are interdependent,²⁹ and that all codes of professional ethics can be encompassed by the word "etiquette".³⁰ Professionalism implies:

- Acquiring and maintaining a recognised level of competence in specific skills
- Having a sense of dedication and purpose
- Accepting and managing responsibility
- Maintaining a great deal of autonomy
- Accepting accountability for one's actions, and for the actions of people managed and supervised
- Willingness to collaborate and work effectively with a wide range of other people
- Adhering to an ethical code of conduct
- Practice at all times with personal integrity and for the public benefit.

It is hoped that the findings of this study can be used as a basis for further debate about core values, professionalism, professional standards, and business ethics in occupational medicine.

This study could not have been undertaken without the help of many colleagues. We are particularly indebted to: members of the south Wales and west of England group of the Society of Occupational Medicine, the FOM regional speciality advisers and their deputies, members of the SOM Council, FOM Board and FOM Ethics Committee, Dr John Aldridge, Chairman of

the FOM Ethics Committee, Dr Alexander Macara, Chairman of Council of the BMA, Dr Ewan Macdonald, formerly Dean of the FOM, and Professor Richard West, Regional Postgraduate Medical Dean, South Western Region, England.

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