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Notes

GENERAL ETHICS

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Privacy is a key ethical principle in occupational health services. Its importance is emphasised in several laws, in ethical codes of conduct as well as in the literature, yet there is only very limited empirical research on privacy in the occupational health context. Conceptual questions on privacy in the occupational health context are discussed. The baseline assumption is that, in this context, privacy cannot be approached and examined only from the employee's (an individual) vantage point but the employer's (a group) point of view must also be taken into account, and that the concept has several dimensions (physical, social, informational and psychological). Even though privacy is a basic human need, there is no universally accepted definition of the concept and no consensus on whether an organisation can have privacy in the same way as people do. Many of the challenges surrounding privacy in the context of occupational health seem to be associated with the dual loyalties of occupational health professionals towards the employee and employer and with their simultaneous duties of disseminating and protecting information (informational privacy). Privacy is thus not an absolute value, but more research is needed to understand its multidimensional nature in the context of occupational health.

Nonetheless, there is still very limited research on privacy in occupational health services.

Privacy is closely associated with the concept of confidentiality.¹⁰ Privacy refers to the right to be left alone and free from intrusion, including the right to make independent decisions based on personal beliefs, feelings or attitudes; the right to control bodily integrity; and the right to decide when and how sensitive information is shared.¹¹ Privacy is thus a more global term than confidentiality, and has four dimensions: social, psychological, physical and informational.^{10 12} Only the informational dimension relates to confidentiality.¹¹

This article discusses questions on privacy from a conceptual vantage point in the context of occupational health. It starts out with the assumption that in this context privacy has to be approached and studied from the points of view of both employee (an individual) and employer (a group) and that the concept has several dimensions.

TRIPARTITE COOPERATION

Occupational health services prevent work-related illnesses and injuries, promote health and safety at work, support the health and working capacity of employees at different stages of their careers and help the work unit as a whole function more effectively. The attainment of these goals requires tripartite cooperation among health professionals, employees and employers.

For health professionals, tripartite cooperation presents the perennial ethical difficulty of how they can fulfil the employer's expectations and still serve the interests of the employee as a patient. The combined approach (which entails preventive and ambulatory care) to the provision of occupational health services is believed to be susceptible to breaches of privacy, but, on the other hand, also provides the valuable opportunity to appreciate work-related problems, work exposures and the organisational climate.¹³ In practice, this means that health professionals have to maintain a balance between the two groups of clients, having simultaneous duties, loyalties and responsibilities towards both employees and employers.^{9 14 15} This position has been described as that of a "double agent"¹⁶ or as one requiring "dual loyalty".^{17–20}

The weight given to privacy depends on how health is valued. As far as employees and occupational health professionals are concerned, health is a value in and of itself—professionals are committed to health promotion even by virtue of their professional code of ethics. If a company values health for reasons of productivity and cost effectiveness, then an ethical

The world of work in industrial countries has seen profound and dramatic changes in the past decades. The ageing workforce,¹ organisational downsizing² and the growth of temporary employment³ have all placed new demands on the tripartite cooperation among occupational health professionals, employees and employers. Health professionals have a special role in this cooperation in the sense that they serve two groups of clients. They are constantly seeking to strike a balance between the individual good (ie, the health and working capacity of individual employees) and the common good (ie, the health and safety of the company as a whole). This places a big challenge on privacy.

Privacy is a central concept in healthcare, and the Hippocratic oath makes it obligatory for doctors to keep private the information gained as a result of the patient–doctor relationship.⁴ In occupational health services, privacy and confidentiality are basic premises in various acts, laws^{5 6} and ethical codes of conduct.⁷ They are also highly valued ethical principles among occupational health professionals.^{8 9}

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dilemma is bound to emerge.^{19–21} In practice, occupational health professionals may find themselves under pressure to breach privacy so that employers can gain access to medical information on their employees.¹⁵ On the other hand, there is also a statutory requirement of transparency: legislation and ethical codes oblige the professional to release information on any adverse health exposures, because non-interference may cause injuries and illnesses to a larger group of employees.¹⁴ Breaches of confidentiality are also legitimate in situations where there can be a serious risk to public health or serious crime.^{22–23}

WHAT IS PRIVACY?

Defining the concept

Most of the literature on the concept of privacy dates from the 1960s and 1970s and represents various academic disciplines. A broad consensus exists on the importance of privacy for human beings,^{24–26} but there is no universally accepted definition of the concept. The different dimensions of privacy—physical, social, informational and psychological—are used in defining the abstract concept from an individual's perspective.^{12–27} That a group such as an institution or organisation can have privacy in the same way as an individual does is rarely believed to be possible, although Burgoon²⁷ remarks that the privacy of a group is easier to study because the group's rules make it visible.

Key elements of the concept of privacy as seen from the individual's point of view are control, inaccessibility and withdrawal. The physical and social dimensions of privacy are often defined by the term control—that is, the ability of people to control their bodily integrity or personal space and social contacts.^{12–25–27} Control includes social power and freedom of choice.²⁴ Loss of control may have adverse consequences, leading to helplessness and a sense that our actions and efforts have no effect.²⁸

The term inaccessibility is sometimes used to describe informational privacy. The different zones of privacy include different kinds of information, the most sensitive of which lie at the very core of the inner zone.²⁹ For an outsider to gain permission to visit this inner zone, he or she will need to enjoy the person's complete trust and confidence.^{28–30–31} Informational privacy relates to the concept of confidentiality.¹⁰

The term withdrawal is used to describe psychological privacy. Withdrawal seems to be necessary for a person's psychoemotional well-being.^{24–25–32–34} Withdrawal offers emotional release in times of loss, shock and sorrow,¹⁸ a time-out to restore our self-esteem after bruising contact with the world around,³² and an opportunity for self-evaluation.²⁴

The privacy of a group has been discussed in terms of organisational privacy. A group (eg, an organisation or a labour union) needs the right to decide when and to what extent its acts and decisions should be made public. A group is similar to an individual in that it has its own purpose, internal rules and procedures. The lack of privacy for certain core secrets can threaten the independence or autonomous life of an organisation, much as it does that of a person.²⁴ Velecky³⁵ emphasises that a group enjoys privacy when it has its meetings in private, but nevertheless does not use the group as a unit in defining the concept.

Basic assumptions of privacy

Seen from the individual's point of view, privacy seems to include certain basic assumptions. Privacy ties in firmly with concrete situations, is subjective in nature and entails an ongoing dynamic process with the world around.^{12–24–25–30–32} To some extent, the basic assumptions about group privacy seem to be tied up with each person's membership of a group and

how he or she follows the rules the group has set for itself.^{24–33–35}

Privacy is associated with concrete situations. In healthcare, privacy pertains to all caring, but some activities seem to require particular attention. Patients expect their privacy to be respected during intimate-care actions, when they undress, when they are washed or when they go to the toilet.^{30–36} Irrelevant touching is regarded as offensive, but if the patient feels respected, touching can be experienced as pleasant.³⁷ Mothers on maternity wards³⁸ and elderly patients who require care and stay long periods in hospitals³⁹ seem to need more time for themselves. During chemotherapy, patients do not want to be stared at⁴⁰ and in end of life care they want the company of only a few people.⁴¹ Patients do not want other patients to see their personal medical documents³⁴ nor do they want the results of their laboratory tests to be discussed within other people's hearing.⁴²

Subjectivity in privacy implies that privacy means different things to different people at different times and in different places. Desired privacy is a subjective statement of an ideal level of interaction with others, of how much or how little contact is desired at any given moment.²⁵ During a person's life span, the content and degree of privacy varies according to subjective life experiences.²⁴

The dynamic process in privacy means that the person constantly seeks an optimum balance in privacy: neither too much nor too little privacy is right.^{24–25–32} Every time we allow someone to penetrate our privacy, we lose part of our personal defence. On the other hand, if we have the courage to expose ourselves, it becomes possible to construct successful relationships.²⁸

Individual psychoemotional development requires both privacy and participation. The group in which people participate may be a family, workplace community or government. Membership of this group is achieved by obeying its rules. People wanting to benefit from this membership must be prepared to accept a measure of transparency with regard to their privacy and also that in some cases the best interests of others take precedence over their own. In healthcare—in the treatment of communicable diseases, for instance—the person's privacy is subservient to the common good, but in this case the intrusion is not ill intentioned.^{24–33–35}

Situations where intrusions of privacy may be coloured by unethical intentions do exist, however. Furthermore, privacy is closely connected with power, which an organisation may use to further its own goals at the expense of serving its members.⁴³ Westin²⁴ points out that society must intervene in unethical actions and in bringing its members back to participatory responsibility. Byrne²⁹ also warns against allowing the right to privacy to become an inviolate protector of harmful behaviour, referring to sexual harassment in the workplace. In occupational health services, respect of privacy is based on the perception that health professionals are able to meet the requirements of legislation and ethical standards in professional conduct and will not misuse the power society confers on them.²⁰

PRIVACY PROBLEMS IN OCCUPATIONAL HEALTH PRACTICE

Occupational health services are liable to various privacy challenges. Occupational health professionals have two simultaneous clients and many of the problems surrounding privacy seem to stem from this dual role.^{18–20} Professionals themselves consider their position to be highly demanding,⁴⁴ and occupational health services have not gained the unreserved trust and confidence of employees, who remain suspicious about the impartiality of doctors.⁴⁵ This obviously undermines their trust in occupational health services in

general.⁴² Professionals admit that ethical misconduct does occur,⁴⁶ they do not have sufficient competence in ethics⁸ and they need more training in business ethics.⁴⁷

Many of the ethical challenges related to privacy derive from the requirement that professionals identify employees “who are susceptible” or at “high-risk”—that is, employees who are believed to be at risk of certain occupational injuries or diseases. Traditionally, these evaluations include pre-employment and periodic examinations and health assessments for exposure to suspected occupational hazards.¹⁷ More recently, health assessments also include screenings for substance misuse or for infectious agents such as HIV,^{48 49} genetic screenings to determine employee predisposition to occupational diseases⁵⁰ and return-to-work evaluations.^{14 15}

Privacy problems arise from the dual loyalty of occupational health professionals and also from every contact with each employee. A certain amount of privacy is enough for one, but too much for another.^{12 25 30} The desire for privacy also varies according to how much the person benefits from the membership of the particular group.^{23 35} Employees seem to be prepared to accept a certain measure of transparency about their health (eg, “voluntary” drug tests) so long as, in return, they can have a secure livelihood and a safe working environment.

The inclusion of the aspect of organisational privacy complicates the ethical aspect of the problem. Although there is no theoretical agreement on whether an institution may have privacy in the same way as an individual employee, in practice this certainly seems to be the case. For ethical reasons alone, professionals have an obligation not to disclose industrial and commercial secrets if they become aware of them.⁷ The concept of organisational privacy is gaining increasing importance today, as employers are looking to occupational health services to contribute to their business management—for example, they expect to gain a return on their investment in employee health in the shape of increased productivity^{19 44}—and health professionals must be prepared to prove their cost effectiveness to the employer who is footing the bill.^{21 47 51} Mutual understanding is not always seen here: employers have become more aggressive in pressurising professionals to release sensitive information⁵² and in using them as a “tool of management”.⁵¹

The main dimension of privacy in the context of occupational health seems to be informational privacy—that is, the question of how privileged information should be handled. Occupational health professionals should, however, also pay attention to the physical, psychological and social dimensions of privacy. Research in hospital settings clearly testifies to the importance of this multidimensional approach to privacy.^{30 36 38 39 41}

The question on privacy raises both legal and ethical concerns, and both approaches have been applied in seeking adequate ways of resolving problematic situations. The bottom line in legislation is that no information that relates to a patient’s health can be used unless authorised by either the patient or someone acting on the patient’s behalf. It is no easy task to define what exactly constitutes a high-standard occupational health service in terms of privacy. Legislation is only an ethical minimum⁵³ and therefore cannot be applied to all situations and dimensions of privacy. Occupational healthcare is much more than just a technical exercise regulated by rules and norms. According to Tilton,⁹ ethics and ethical codes have a higher status than legislation because they deal with what is right and what is wrong, and do not vary according to temporal and regional standards and customs. In practice, however, both sets of standards—that is, laws and codes of ethics—must be interpreted before they can be applied to real-life situations. Obviously, ethical problems on privacy in tripartite cooperation can never be

totally resolved, but this does not detract from its importance. On the contrary, the fundamental tenet of privacy in occupational health service requires ever greater attention and research on account of its inherent complexity.

CONCLUSIONS

Research on privacy in the context of occupational health services is scarce. Most of the existing literature deals with issues from a theoretical perspective. The following conclusions may be drawn from our review.

1. Some consensus has been reached on the basic assumptions on an individual’s privacy.
2. No theoretical agreement has been reached on whether an institution may have privacy.
3. In the context of occupational health, privacy has to be approached and studied from the individual’s point of view and also from the employer’s or organisation’s point of view.
4. In occupational health services, privacy problems tie in closely with the dual loyalties of professionals to employees and employers.

This review has highlighted some interesting areas for further research, with a need to study

1. privacy and its various dimensions in the occupational health context;
2. the conceptions of professionals, employees and employers on the maintenance of privacy in tripartite cooperation; and
3. ethical competence of occupational health professionals on privacy.

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