Safety review risks injury to workers

The Association of Personal Injury Lawyers (APIL) has warned that workers could be exposed to unnecessary risk of injury if Britain’s health and safety regulations are watered down.

The not-for-profit campaign group spoke out as it responded to the Löfstedt Review which recently closed for comments.

Karl Tonks, the Vice-President of APIL, said, “Any assault on health and safety, in a bid to cut back on what is perceived to be too much regulation, is a shot at the wrong target. All that’s needed is to ensure people understand the existing rules properly and apply them with common sense.”

According to APIL, the number of workplace deaths has fallen by 73% since the Health and Safety at Work, etc Act 1974 took effect.

As part of its response to the Löfstedt Review, APIL submitted that the levels of expertise a health and safety consultant has should be officially recognised with a kitemark. APIL says this would allow employers to know whether or not they are being given the best possible advice.

Mr Tonks added, “Employers should feel confident in the knowledge that they are taking the right steps to prevent needless injury. Health and safety should not be seen as a burden, but as a way of helping to ensure that people who turn up for an honest day’s work are not unnecessarily injured. If you cut the negligence, you cut the harm to workers. Not only does it make moral sense, but it makes economic sense too.”

The Löfstedt Review of health and safety was set up to help simplify health and safety legislation and make it more effective and proportionate for the benefit of both business and the workforce. Professor Löfstedt is due to report to Employment Minister Chris Grayling later this year.

CONTENTS

1 Safety review risks injury to workers
2 News
3 Ethics in occupational health

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MANAGEMENT OF HEALTH RISKS SPECIAL REPORT
Go-ahead for RIDDOR changes

The Board of the Health and Safety Executive (HSE) has confirmed that, despite opposition from unions and some voices in the health and safety world, it will recommend changes to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) in order to increase the period for reporting injuries.

The change is the result of the HSE’s recent consultation on the RIDDOR legislation, initiated by Lord Young’s Common Sense, Common Safety report on health and safety in Britain.

The proposals were to increase the “over three days” time period after which an injury must be reported to enforcing authorities to “over seven days”.

It was argued that, among other benefits, the increased period would coincide with the point when an employee who is absent from work due to ill health or injury (connected with the work activity) must obtain a “fit note” from his or her doctor.

Following a meeting, the HSE Board says it will recommend to the Work and Pensions Secretary of State the proposed change to RIDDOR, to increase the period for reporting injuries that lead to a worker being incapacitated from over three days to over seven days.

A paper published by the HSE Board on 17 August 2011 indicated there had been “a 2:1 majority in favour of the proposed change”.

The Board said over 18,000 copies of the consultative document were downloaded, but only 776 finalised responses were received.

It is estimated that the new legislation will be in force by 6 April 2012.

Health and safety of women at work

The European Agency for Safety and Health at Work has published a new research report on emerging risks and trends in the health and safety of women in the workplace.

The report, presented recently by the Agency at the 19th World Congress on Safety and Health at Work Exhibition in Istanbul, Turkey, says that inequality both inside and outside the workplace can have an effect on the health and safety of women at work.

The publication acknowledges that progress has been made, but says “there are still gaps within the research, policy and prevention measures”.

In particular, the report points out that European occupational safety and health statistics do not cover women satisfactorily.

For example, occupational diseases continue to reflect mainly male jobs and accident recording omits sectors where women work, eg education and health care.

The report says that in Europe, a number of factors continue to impact on the safety and health of women at work including:

- occupational segregation
- gender discrimination
- family responsibilities
- women’s multiple roles and jobs
- disparity in pay
- poverty.

The research also highlights that major risk factors include:

- the type of work carried out by women
- issues faced by younger and older women
- the growth of the service sector
- violence and harassment
- increasingly diversified working time patterns.

Professor Craig A Jackson, Professor of Workplace Health Psychology at Birmingham City University, looks at the ethical issues that can confront the occupational health professional.

It is often said in occupational health circles that working as a workplace doctor, nurse, psychologist or health advisor is quite unique in that the “patient” is not the client, and that the first and main allegiance of the practitioner is to the worker, and not the organisation who employs the practitioner. This duality emphasises the wide range of ethical issues that can be encountered in the fields of occupational health practice or research. In many senses, such pressures of dual loyalties are no different from those faced by medical practitioners assessing disability claimants. However, while the essential duality of allegiance is common, the specific expression of this duality is often peculiar to the occupational health setting, and raises ethical conflicts that are not generic but particular to the occupational health domain. Moreover, it is important to remember that ethics does not provide an absolute set of rules but rather a set of principles to guide choices about appropriate behaviours. There are no right or wrong answers, rather answers that should be justifiable in a moral framework.

This article illustrates ethical issues that are commonly encountered in clinical work — as opposed to occupational health research, and it is hoped to go beyond the traditional codes of conduct developed by practitioners and professional bodies in dealing with patients or clients. “Beneficence, autonomy and justice” are the three words uttered most by those working in medical, nursing and health-related occupations when asked to identify what is meant by ethical practice. Going beyond that superficial understanding may help practitioners and those in occupational health who are charged with preserving and promoting the heath of workers.

Basic principles

To summarise the main principles of ethics developed by the International Code of Ethics for Occupational Health Professionals prepared by the International Commission on Occupational Health (ICOH), occupational health practice must be performed according to the highest professional standards and ethical principles, occupational health professionals must serve the health and social well-being of the workers, individually and collectively, and they must also contribute to environmental and community health.

The obligations of occupational health professionals include protecting the life and the health of the worker, respecting human dignity and promoting the highest ethical principles in occupational health policies and programmes. Integrity in professional conduct, impartiality and the protection of the confidentiality of health data, and of the privacy of workers, form part of these. Occupational health professionals are experts who must enjoy full professional independence in the execution of their functions. They must acquire and maintain the competence necessary for their duties and require conditions which allow them to carry out their tasks according to good practice and professional ethics.

Ethics and ethicality in occupational health still comprises a relatively small area. Despite the high potential for workplace conflict to pose difficult ethical dilemmas, training in ethics for occupational practitioners is generally poor, and awareness of international codes on ethics in occupational health can be limited. The business of “ethicality” — helping individuals, practitioners and organisations keep in accordance with the accepted principles of right and wrong that may govern the conduct of a profession — is productive and thriving. Corporate governance is one aspect of organisational life that has not only accepted ethics and ethical practice as a necessity, but has actively embraced the core principles of ethicality in reminding everyone of how business is done. Corporate ethics is
seen as something that is required and vital, in order to prevent organisations from undertaking activities that may prove to be harmful to others and ultimately the organisation. Organisational psychologists have said that corporate ethical practices are vital, as individual members of such organisations may not always apply their own personal ethical standards when faced with peer-pressures, moral decisions, or company goals that may contradict their own. A possible explanation for why there seems to be little evidence of personal ethical awareness or development for many in the workplace could be the sentiment that for many, ethics is simply knowing “what’s right and what’s wrong”. Many practitioners who work in occupational health or the newer areas of well-being and lifestyle guidance may consider further thought about personal and professional ethicality as being unnecessary — as surely everybody knows when something is “unethical”. There is a view that anyone who feels they may need to explore and reflect on their own ethicality should probably not be working in a health-related profession.

Research ethics

There is much more to be written on research ethics than can be covered here. However, a broad appreciation of the ethical frameworks set down by the Helsinki declaration, and how it overlaps the ethical standards of clinical work, is worthwhile. Adopted by the 18th World Medical Assembly in Helsinki in 1964 and subsequently amended on several occasions, this sets out guidance for physicians on biomedical research involving human subjects. The most relevant points can be summarised as follows: researchers need to secure an independent ethical review and subsequent approval; research proposals should be evaluated to be sure of sound scientific design; the research team needs to be competent in its fields and duties; any research objectives that pose theoretical risks to participants must be justified; allow for a careful assessment of risks and benefits for participants; have consideration and respect for the privacy and integrity of all participants; avoid research in which potential hazards cannot be predicted or avoided; ensure meaningful and accurate publication of results in responsible journals; provide full details to allow informed consent from participants; place no pressure or duress on individuals to take part; make provisions when participants are incompetent or unable to give informed consent, so that assent can be secured; provide a clear statement of ethical considerations in the research protocol.

In terms of research ethics committees that can grant review and approval for research projects, there are three main areas for consideration. If the research involves participants who are accessed/recruited into the study as a virtue of being an NHS patient/or NHS staff, then a Local NHS Research Ethics Committee will need to be sought via the National Research Ethics Service (NRES) electronic process. If the research involves military personnel in any of the armed services, then the project would need to be reviewed by the MoD Military Research Ethics Committee. If the research involves prisoners or staff working in the HMP estate, then application needs to be made through the HMP Research Ethics Committee if the project involves more than one single prison establishment. If a single prison establishment is used, then ethical approval can be granted independently by the HMP establishment in question.

Practice guidance

Much of the literature and guidance for practitioners focuses on actions directed toward “ethical” purposes in isolation away from the rest of a physician’s clinical activities. Ethical practice should be no different from efficient proficient practice. For decades, medics, and health professions aligned with them, have had their personal accrediting and professional bodies that sensitively dictated how to practise with the utmost ethicality. Many, of course, have suggested that such
ethical guidance and codes of conduct are essentially there to protect the practitioner as much as the patient and client. There are many potential ethical issues in most contemporary working environments; many have been brought about by changes in societal attitudes, cultural beliefs or organisational thinking. Such ethical evolution can be argued to be even more pronounced for those individuals whose jobs focus on keeping many other people, environments, or organisations “healthy” while working. No doubt the greatest source of ethical issues for those working in occupational health could arguably be that of emerging technologies, and this is demonstrated by case study 1.

Case study 1
Sick worker fired over Facebook

In 2009, a woman lost her job after her employers saw she was using the online social networking site Facebook when she claimed she was too ill to use a computer. After suffering a migraine at work, she had said she needed to go home and lie in a darkened room. Her employer claimed that their discovery of her using Facebook removed their trust in her and prompted their sacking of her. The employee said she had been using the Facebook network from her smartphone while in bed ill and that she did not believe the company’s assertion that “a colleague had inadvertently noticed her using Facebook” and alleged the company had been spying on her. She claimed the company had invented a fictitious Facebook persona who became “friends” with the woman on the website, thereby allowing the company to spy on her and monitor her activity. The company had not denied the creation of the online “friend” and stated that they followed a simple logic: that those who are well enough to use Facebook with a migraine are well enough to work with a migraine.

For many theorists, the notional ideas of ethics boil down to the fundamentals of freedom and well-being. Most of the work done by occupational health practitioners is directed toward these objectives. With individual or organisational interventions, there is the responsibility to recommend suitable policies and procedures, and even therapeutic and treatment regimes that are evidence-based and reliable. It is vital for workers to understand, and perhaps consent to, investigations and treatments, and the same understanding should be afforded to organisations and workplaces.

In primary prevention, the occupational health professionals should promote freedom and well-being by helping to remove or lower hazardous occupational exposure limits to a level that suitably informed management can operate within.

Secondary prevention would involve the occupational health professional recommending suitable screening procedures or tools that are proven to be valid, reliable and useful. Any recommendations for tertiary prevention would also need to be of scientific or demonstrable worth.

Personal behaviour
An interesting and contentious area of practice ethics involves practitioners’ personal behaviour in their workplaces, and how this may enhance (or otherwise) freedom and well-being. Personality styles, communication skills, attitudes to colleagues and patients/clients could be overbearing, objectified or generally demeaning.

Record keeping
Occupational health records include all forms of clinical records maintained by occupational health services, such as pre-employment health screening, routine medical assessments, or assessments undertaken while giving advice. The requirement to keep good records concerning client work (either individual or organisations) is dictated and recommended by
professional governance and or by individual employers of the occupational health professional (if applicable). Such guidelines are influenced by the need to comply with many legislative branches — including data protection, freedom of information, and patients’ rights. It is vital to routinely record, store, allow effective retrieval, and permit inspection of records, not just for governance reasons, but also to protect the practitioner and client from any claims or complaints. Such records should not be confused with health records, which may include job history or exposure details, eg non-clinical data. Health records may be relevant to specific health and safety legislation for controlled substances and should therefore be kept separate from clinical records.

Records, if written, should be legible. Use of abbreviations should be kept to a minimum and only commonly-known abbreviations should be used. The records should be clearly dated and signed, with a date on every page of the written records and page numbers. Deletions or amendments should also be dated and signed. Occupational health (OH) service providers or an in-house OH department should not hold clinical records of its own departmental staff. If an occupational health issue relating to a member of staff arises, another occupational health service should be used. The objective is to maintain correct employer/employee relationships, maintain confidentiality of its own staff members and avoid real or perceived conflicts of interest.

Word-processed electronic notes are clearly the norm in most workplaces, but practitioners may also make use of handwritten notes, diagrams and hard copies of results or printouts from other professionals, or even audio and video recordings. All need to be stored securely, and just because the usefulness or convenience of one medium over another may make such a medium the preferred “note-format” of choice, equal care has to be given to store data contained on all note formats used. “Sensitive personal data” means personal data containing details of information on racial or ethnic origin; political opinions; religious beliefs; trade union membership; physical or mental health conditions; sex life or sexual orientation; or criminal records or recorded offences;

Case study 2

Inappropriate pre-employment screening tool

In 2010, a large police constabulary in the UK uncovered a problem with the physical assessment test used for screening potential police officers. It was an indoor obstacle course, in which the candidate encountered eight obstacles on the circuit, such as a balance beam or a horizontal jump. The circuit had to be completed three times within a time limit. Should any obstacle be failed, the candidate had to re-take it until successfully completed. The time limit was identical for males and females — 3 minutes and 45 seconds — and was described as “gender neutral”. On inspection of the data, it appeared that only 8% of males failed the test, while 40% of females failed. In addition, a total of 75% of all candidates passed the test, and of those who passed, 49% were either overweight or obese (as measured using the BMI). The physical test was inadequate as a screening tool, in that it did not screen out enough candidates, with too many who passed being overweight or obese, and it unfairly discriminated against females.

The occupational psychologist who evaluated this data had an ethical duty to recommend that the constabulary drastically modify the test, or replace it with a different test. Sanctioning the constabulary in its desire to retain use of the test would have been unethical.

Duties and obligations

The following list of activities is based on the recommendations made by the ICOH code of ethics for occupational health professionals, after periodic review and evaluation.
Aims and advisory role

The occupational health practitioner (OHP) must safeguard and promote the health of workers and promote a safe and healthful working environment. He or she must use validated methods of risk evaluation and follow-up. OHPs should provide competent and honest advice to employers and workers and they should maintain direct contact with safety and health committees, if they exist. In advertising services and assistance, practitioners must appropriately advise colleagues and others of services they are competent to deliver.

Knowledge and expertise

Practitioners must improve their own professional knowledge and communicate health hazard details in sensible and effective ways to those theoretically and potentially affected. They must seek consultation from other professionals concerning individual workers or workplaces whenever needed. They must become familiar with the fitness requirements, environment and range of hazards involved in the work that is done, and the health and safety aspects of the operations concerned. They must use best scientific practice, including objectivity and integrity.

Developments of policies and programmes

Risk assessments of hazards must lead to the establishment of an occupational health and safety policy, and a programme of prevention, adapted to the needs of the workplace. OHPs must propose policies and solutions based on the best scientific and technical knowledge.

Transparency

OHPs should communicate clearly to workers any significant observations about their health or well-being and advise further investigation or treatment when required. When doubts exist, e.g. about safety or certainty of actions, they must exercise caution. Practitioners must be transparent in their assessments and admit any uncertainty.

Follow-up of remedial actions

In cases of refusal or unwillingness by employers to take adequate steps to remove any undue risk or to remedy a situation that presents evidence of danger to health and safety, the OHP must make his or her concern known as rapidly as possible in a clear written (report) format to the appropriate senior manager, stressing the need to take into account scientific knowledge and applying relevant standards of health protection. Emphasising exposure limits and reminding employers of their obligations to protect health should be done as part of this report. Workers involved in such concerns, and any relevant competent agency, should be informed.

Safety and health information

Occupational health practitioners need to foster and maintain good relationships with personnel, professionals and agencies. They must co-operate with employers, the workers and their representatives to ensure adequate information and training are circulated. Practitioners must provide information about uncertain scientific areas and known hazards.

Commercial secrets

Responsible practitioners are obliged not to reveal industrial or commercial secrets of which they may become aware in the course of their duties. However, they must not withhold information that is necessary to protect the safety and health of workers or of the larger community. When needed, the practitioner must consult the competent authority in charge of any specific legislation.

Health surveillance

Occupational health objectives, methods and the procedures of health surveillance must be clearly defined, with priority given to adaptation of workplaces to workers who receive related information. The relevance and validity of the surveillance methods must be assessed and established. Health surveillance must be conducted with the informed consent.
Ethics in occupational health (cont’d)

of the workers. Potentially positive and negative consequences of participation must be discussed as part of the consent process. **Information to the workers**

Results of investigations carried out in the framework of health surveillance must be explained to workers. Determination of fitness to work must be based on good knowledge of general and specific job demands and assessments of workers. Workers must be informed of their opportunity to challenge the conclusions once they receive them, and an appeals procedure must be established for this. **Information to employers**

Ethical practitioners should acknowledge that employers are entitled to advice and opinion about the fitness of individuals in relation to work, but not diagnostic or specific details. Practitioners must retain confidentiality about patients, releasing information only when required by law or by overriding public health considerations, or to other professionals at the request of the individual according to traditional ethical practice. **Danger to third parties**

Where the health conditions of the worker and the nature of the tasks performed are likely to endanger the safety of others, the worker must be informed. In the case of hazardous situations, management and the competent authority must be informed of any measures necessary to safeguard other persons. Practitioners must try to reconcile the employment of workers with the safety or health of others endangered by the worker. **Health promotion**

When engaging in health education and promotion, practitioners must seek the participation of employers and workers. They must also protect the confidentiality of personal health data of the workers involved. **Protection of community and environment**

Practitioners must be aware of their role in relation to the protection of the wider community and environment. They must initiate and participate in identifying – assessing advertising for services – and advising, for the purpose of prevention of occupational and environmental hazards. **Contribution to scientific knowledge**

Practitioners should inform and assist the scientific community through research endeavours and awareness of gaps in knowledge. They must report to the scientific community as well as the wider public on new or suspected occupational hazards. Those involved in research must carry it out to the highest standards and sound scientific basis, and follow guidance given by independent committees on research ethics. **Conclusion**

The ICOH concludes: “Ethics ... has no clear end boundaries and requires interactions, multidisciplinary co-operation, consultations and participation. The process may turn out to be more important than its ultimate outcome. A code of ethics for occupational health professionals should never be considered as final, but as a milestone of a dynamic process involving the occupational health community as a whole ... and other agencies concerned with safety, health and the environment, including employers’ and workers’ organisations.”