ICOH Board Working Committee on Ethics and Transparency

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INTERNATIONAL CODE OF ETHICS FOR OCCUPATIONAL HEALTH PROFESSIONALS

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Translations are to be performed in compliance with ICOH Bye Laws 17 and the ICOH Good Association Practice Guidelines. For projects aimed at translation of the Code, the ICOH President will appoint a project leader and members of a Working Group of ICOH members in good standing who share the same mother tongue. Each member of the Working Group

shall complete the Declaration of Interest Form according to Bye Laws 17. Assessments of possible conflicts of interest will be carried out by the Secretary General for preliminary analysis. The Committee on Ethics and Transparency will evaluate the Transparency Declaration Forms, as requested by the ICOH Secretary General.

Any final text is to be approved by the ICOH Board. Dissemination at national level, including printings, is encouraged. ICOH does not normally provide funding support for translations of the Code. The Translating Working Group is entitled to seek financial support from private and public bodies. Financial support for translation or dissemination is subject to the authorization of the ICOH President in accordance with ICOH Good Association Practice Guidelines.

The section entitled 'Basic Principles' summarizes the principles on which the Code of Ethics for Occupational Health Professionals is based. It can usefully be exhibited as a poster on the premises of Occupational Health Service departments and organizations.

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Preface

Occupational health and safety professionals face numerous ethical challenges in the rapidly changing world of work. The complex, and sometimes competing, responsibilities of occupational health and safety professionals in serving a multiplicity of stakeholders are increasingly and generally recognized. These stakeholders include workers, employers, contractors, client companies and their customers, public health and labour authorities, and other bodies such as social security agencies and national judiciaries. It is also increasingly recognized that occupational health and safety professionals carry out their tasks in interaction with existing health care organization; adopting a multidisciplinary approach to occupational health implies close collaboration with specialists belonging to other professions.

An important contextual factor, with an impact on occupational health practice, is ongoing globalization. The globalization process is associated with the advances of science and technology, with commercial pressures and political agreements, with decisions to increase freedom of trade across national boundaries, and with harmonization of economic policies towards the opening of trade. It involves, essentially, intensification of economic, political, social and cultural communication, and interaction and migration of people and organizations across regions and national borders. It also implies a broad sociological process, involving cross-cultural interaction and the steadily growing interdependence of regions, nations and peoples. Global competition in a market economy has become predominant in many countries, regardless of their prevailing political system. There is evidence that the effects of the recent global financial crises have added to health burdens in many countries worldwide, leading to deepening health inequalities that affect social policies and programs. Professional occupational health services, by operating close to the production of goods and services in undertakings of many different kinds, are more affected

by these trends than general medical services. This applies particularly in societies where employers may discharge and replace their work force with ease.

Purpose of the ICOH Code of Ethics

The ICOH International Code of Ethics for Occupational Health Professionals aims at providing a benchmark for standards and guidance for health professionals on their conduct in activities that involve ethical considerations or the resolution of dilemmas.

It is also intended to guide the public and clients of occupational health professionals in shaping their expectations towards the profession and its members, both nationally and internationally.

The Code provides a basis for reviewing and developing the activities of occupational health professionals, both internally and externally. It may also be adopted and implemented, wholly or in part, by national and international professional organizations in the occupational health domain.

The ICOH Code has the following more specific purposes:

- Promotion of ethical conduct and the deterrence of unethical conduct among occupational health professionals.
- Provision of a comprehensive set of standards against which to judge professional behaviour.
- Provision of guidance in situations where an occupational health professional is facing ethically difficult decisions.
- Provision of a conceptual framework for establishing the rights and responsibilities of occupational health professionals.
- Provision of a set of principles indicating the values that the occupational health professional organization stands for.
- Provision of a basis for the professional and moral development of occupational health professionals.
- Legitimization of professional norms in the realm of occupational health, and the justification of sanctions when norms are ignored or unethical conduct occurs.

- Enhancement of public trust and respect for the occupational health professions.

The Code is a guidance document that presents a set of principles relevant to professional ethics in the occupational health domain. It is not a textbook.

The Code has been written with the aims of supporting occupational health professionals in identifying relevant ethical considerations, and of helping them to make decisions that respect fundamental ethical values in bringing benefits to workers, client companies or employing organizations, and to the public. It should be recognized that, as an international professional-guidance document, the Code carries moral authority that may be taken into account in legal decisions, and may be considered for incorporation into national legislation in its entirety or in part.

The ICOH Code is relevant to many professional groups carrying out tasks and having responsibilities in undertakings and organizations, in the private as well as the public sector, on matters of safety, hygiene, health and environmental protection in relation to work. The term 'occupational health professional' refers, for the purpose of this Code, to a large target group, sharing a common vocation in pursuing an occupational health agenda. The Code covers the activities of occupational health professionals both when acting in an individual capacity and in participating in actions taken by undertakings providing services to customers and the public. The Code applies to occupational health professionals and occupational health services regardless of whether they operate in a free market subject to competition or within the framework of public health services.

More detailed guidance on a number of particular aspects of the Code can be found in national codes of ethics or in guidelines for specific professions. The ICOH Code of Ethics does not aim to cover all areas of implementation, or all aspects of the conduct of occupational health professionals, or their relationships and interactions with social partners, other professionals and the public. It is acknowledged that some practical aspects of professional ethics may be specific to professions, which implies a need for additional ethical guidance. The principles of health ethics apply directly to all health professions. However, in the arena of occupational health, a wide range of professions are involved in health issues in their professional capacity, although the relationship may be more indirect.

The principles may apply to professions such as lawyers, architects, manufacturers, designers, work analysts, work organization specialists, human resource and personnel managers, social workers, teachers in universities and institutions for vocational training, and also professionals in the mass media, all of whom have important roles and responsibilities in relation to the improvement of the working environment and of working conditions.

The ICOH International Code of Ethics represents professional values and ethical principles in occupational health. It is intended to guide all the people involved in occupational health activities and to set a reference-quality level on the basis of which their performances can be assessed. This document may be used for the elaboration of national codes of ethics, or for the purposes of training and education. It may be adopted on a voluntary basis and serve as a standard reference for defining and evaluating professional conduct. It is also designed to contribute to the development of a common set of principles for collaboration between all the stakeholders concerned, and also to promote teamwork and multidisciplinary approaches in occupational health. It further provides a framework against which to document and justify departures from recognized practice, and places a burden of responsibility on those who do not make their reasons explicit.

It should be borne in mind that professional health ethics is a realm that is omnipresent in all occupational health activities, prevention of risks to health and safety, curative activities and health promotion. Thereby, it has no distinct boundaries. It requires interaction, multidisciplinary cooperation, consultation and partnership. The ICOH Code is not to be regarded as a conclusive document, but rather as a milestone in a dynamic process of development. It needs to be regularly reviewed. This process involves the global occupational health community in its entirety and all organizations and bodies concerned with safety, health and the environment at work, including employers, workers, and their representatives.

Introduction

1. The aim of occupational health practice is to protect the lives of workers and to protect and promote workers' health and well-being throughout their working lives. This overall aim

incorporates objectives to sustain and improve work ability and skills, and to contribute to the establishment and maintenance of a safe and healthy working environment and working conditions for all. Improvements to conditions of work, health and safety of workers and adaptation of work, while taking into account their health situation and life circumstances outside work, are strategic objectives in occupational health practice. Occupational health professionals have a moral obligation to commit themselves to these objectives.

2. The field of occupational health is broad, and includes prevention and health promotion. This implies the tasks of adapting work to be in consonance with the health needs of workers and the rehabilitation of injured or handicapped workers. Tasks include provision of care and rehabilitation for all impairments arising out of employment, and medico-legal assessments of work injuries and work-related disorders, including occupational diseases.

3. Occupational health professionals should engage in matters of work organization relevant to safety and health, including health hazard identification, health risk assessment and risk management, by means of the design and choice of sound work processes, adequate health and safety equipment, appropriate work methods and procedures, and safe and healthy work practices. They should encourage workers' participation in decisions and actions concerning their own work and working conditions, and their involvement in providing feedback from experience.

4. On the basis of the moral principle of equity, occupational health professionals are obliged to assist workers in obtaining and maintaining employment, notwithstanding their health shortcomings or handicaps. It should be recognized that there are particular occupational health needs of workers, as determined by gender, age, physiological and psychological condition, social aspects, and other factors. Such needs should be met on an individual basis, with due concern for the protection of safety and health and information of a confidential nature, so as to preclude the possibility of discrimination.

5. In the articles of this Code, the expression 'Occupational Health Professional' refers to all people who, in a professional capacity, carry out occupational safety and health tasks, provide occupational health services, or are in occupational health practice. A wide range of disciplines and professions are involved in occupational health since it implies action at the interface between work, working conditions and health, which has technical, medical, social,

cultural and legal aspects. Occupational health professionals include occupational health physicians and nurses, labour inspectors, occupational hygienists, occupational psychologists, and the specialists involved in ergonomics, in rehabilitation, in accident prevention, and in occupational health and safety research. It should be recognized that many of these professions have adopted their own ethical codes or codes of conduct, which address specific ethical issues within their professional domains. In occupational health practice, the competence of all professionals should be sought within the frame of a multidisciplinary team approach.

6. Beside occupational health professionals, as referred to in Section 5 above, a broad range of expertise representing other, not directly health-related fields of knowledge and disciplines may become involved in occupational health practice. These include chemistry, toxicology, engineering, radiation, epidemiology, environmental health, environmental protection, applied sociology, insurance, and health education Further, public health and labour authorities, and employers, workers and their representatives, have essential roles and direct responsibilities in the implementation of policies and programs.

7. The term ‘employer’ refers to any person who is responsible for the health and safety of workers in their employment by virtue of a mutually agreed relationship. The employer has legal authority to determine an undertaking’s working and production process, and also implementation of the work contract. The term ‘worker’ denotes any person who works, whether full-time, part-time or temporarily, for an employer. The term is used in a broad sense to cover all employees, including management staff and the self-employed, but does not include domestic workers in a private occupation without an employer. From an occupational health perspective, the term ‘work’ represents an activity, based on an agreement or relationship of commissioning between an employer or other body and workers, with a view to carrying out work tasks. The expression ‘competent authority’ encompasses government ministries, government departments and public agencies legally authorized to enforce regulations or other instructions, and organizations or bodies in charge of supervising their implementation.

8. The people involved in occupational safety and health have a wide range of duties and responsibilities, and there are also complex relationships between them. In general, duties

and responsibilities are defined by statutory regulations. Each employer has responsibility for the health and safety of the workers in his or her employment. The self-employed and informal sector workers constitute a special group that needs special consideration. Each profession in work life has responsibilities related to the nature of its tasks. It is important to define the role of occupational health professionals and their relationships with other professions, with the competent public authorities, and with social partners, in the light of economic, social, environmental and health policies. This calls for a clear view on the ethics of occupational health professionals and standards in their conduct. When specialists of several professions, or of the same profession, work together in a multidisciplinary team, they should seek to act on a shared set of values and an understanding of any others' obligations, mandates and professional standards.

9. The duties and rights of occupational health professionals and the conditions of operation of occupational health services, may be defined in statutory regulations. Basic requirements for sound occupational practice include the full independence of professionals, which should enable them to make judgments and give advice on the protection of workers' health and safety within an undertaking in accordance with their knowledge, experience and conscience. Occupational health professionals need to make sure that the necessary conditions are met to enable them to carry out their tasks according to good practice and to the highest professional standards. This includes adequate staffing, training and competence development, which implies the continuous updating of knowledge and skills, and support from and access to an appropriate level of senior management.

10. Further basic requirements for acceptable occupational health practice, often specified in national regulations, include unimpeded access to the workplace and to all relevant information needed for occupational health activities. Such access presupposes an ability to investigate the working environment, to make job analyses and to participate in enquiries, and the right to consult the relevant competent authority on the implementation of occupational safety and health standards in an undertaking. Special attention should be paid to ethical dilemmas arising from the simultaneous pursuit of objectives that may compete, such as the protection of employment and the protection of health, workers’ rights to information and confidentiality, and the need fully to consider the needs of workers whose health is vulnerable.

11. Professional occupational health practice should meet the aims defined by the ILO and WHO in 1950, and updated as follows by the ILO/WHO Joint Committee on Occupational Health at its 12th session in 1995:

"Occupational health should aim at: the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological capabilities; and, to summarize, the adaptation of work to man and of each man to his job."

12. It cannot be overemphasized that the central purpose of occupational health practice is the primary prevention of occupational and work-related diseases and injuries. Such practice should take place under controlled conditions and within an organized framework – preferably involving occupational health professionals – in order to ensure that it is relevant, knowledge-based, and sound from scientific, ethical and technical points of view.

13. There is an increasing awareness that a further purpose of good occupational health practice is to protect, maintain and promote workers' safety and health, well-being and work ability. This includes taking into account the family situation and dependents of workers. Occupational health practice and occupational health promotion address workers' health and their human and social needs in a comprehensive and coherent manner. They include preventive services, health promotion, curative health care, first-aid services, rehabilitation and compensation for the consequences of occupational diseases and injuries, and strategies for recuperation and reintegration back into work. Good practice in the occupational health arena implies an awareness of the importance of the close associations between occupational health, public and community health, environmental health, human resources development, quality management and product safety in any undertaking. It necessitates the seeking of contacts and partnership with other professionals acting in these domains. In the broad field of occupational health, which embraces hazard prevention and health promotion, the health of workers' families and dependents are important determinants of program success. Development of occupational safety and health

management systems, and strategic choices of clean technologies and alliances with those who produce and those who protect, are needed to make development sustainable, equitable, socially acceptable and useful, and responsive to human needs.

14. Occupational health professionals are, in their professional conduct, morally obliged to abide by the four value principles of bioethics: doing good (beneficence), harm avoidance (non-maleficence), autonomy protection, and equity-justice. These principles are outlined in Annex 1 to this Code, entitled Fundamental Principles of Ethics, by Godfrey B. Tangwa.

The moral obligation is in close alignment with a professional commitment to the overarching principles of protecting and safeguarding human dignity and fundamental human rights, and respect for the dignity of human beings in recognition that they all belong to the human community. This implies a professional obligation to respect all humans as moral equals. For occupational health professionals, it entails a moral obligation to adhere to the principle of making all professional action accountable, well-intended, well-motivated, and designed to achieve good ends or results, to avoid the infliction of harm, and to treat fellow human beings with fairness and equity. These moral principles are also in alignment with programs run by the Council for International Organizations of Medical Sciences (CIOMS), aiming at the domains of bioethics and health policy, ethics, and human values. They are also in line with the principles adopted by the World Medical Association (WMA) in the Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects, first adopted in 1964, and the WMA International Code of Medical Ethics, first adopted by the 3rd General Assembly 1949. See bibliography on the CIOMS and WMA.

Basic Principles

The first five paragraphs of the International Code of Ethics for Occupational Health Professionals summarize the principles of ethics and values that it embraces.

Purpose of Occupational Health

The purpose of occupational health is to serve the health and social well-being of workers, both individually and as a collective. Occupational health practice is to be performed according to the highest professional standards and ethical principles. Occupational health

professionals must make a public-health contribution to community and environmental health.

Duties of Occupational Health Professionals

The duties of occupational health professionals include protecting life, protecting and promoting the health, work ability and well-being of workers, and respecting the highest ethical principles in occupational health policies and programs. Integrity in professional conduct, impartiality, and protection of the confidentiality of health data and of the privacy of workers, are part of these duties.

Roles of Occupational Health Professionals

Occupational health professionals are experts who are entitled to full professional independence in the execution of their functions. They must acquire and maintain the competence necessary to fulfill their duties, and demand conditions that allow them to carry out their tasks according to the requirements of good professional practice and professional ethics.

Ethical principles

Evolution of Medical Ethics into Bioethics: The ethical dimension of occupational health professionalism has, over the years, undergone changes in response to the impacts of advances in medical, biological, technical, social, and other research domains. In the process, the role of the Hippocratic tradition in medical ethics, with its emphasis on trust, compassion, respect of autonomy and disinterestedness in an individual relationship between physician and patient, has become less dominant. This role has gradually been taken over by bioethics, with its focus on a coexisting, comprehensive relationship between human beings and the entire biosphere, including nature, with humans at the centre of a continuing questioning of scientific, technical and social progress. Bioethics is founded in reflection and questioning rather than the seeking of normative answers. It provides a comprehensive basis for ethical analyses of the dilemmas to be resolved in occupational health research and practice. This entails a broadening of scope to both encompass and go beyond the central moral principle of medicine – adhered to by physicians and health care

workers since the times of Hippocrates – of producing net benefit for the patient with as little harm as possible.

Principles of Bioethics: Ethical values and fundamental ethical principles are the cornerstones of the ethics of all health professionals. These principles are commonly embodied in the four fundamental values of bioethics:

- Doing good deeds (beneficence).
- Avoidance of harm (non-maleficence).
- Recognition and protection of the autonomy of others.
- Fairness or justice/equity.

In addition to and notwithstanding the recommendations of this Code, the four fundamental principles above are applicable in all situations and contexts where human beings act and interact with others. They carry a general validity and are binding on occupational health professionals in their moral valuations and rationality. *Non-maleficence,* or the avoidance of harm, represents the minimalist, lowest level of these principles. To knowingly and willingly do avoidable harm is always wrong, and morality, no less than rationality, demands that, in our dealings with others, we do not harm them. It is ethically imperative that all professional occupational health action is well-intentioned and motivated at achieving good/worthy aims/ends. That is what is meant by *beneficence*. In dealing with others, we are morally obliged to treat them with fairness and equity, the way we ourselves would like to be treated if we were in their place and they were in ours. This is implied by the principle of *justice*. Neither justice nor beneficence nor non-maleficence would, however, be possible without the recognition, acceptance and respect of others as moral equals. This lies at the heart of the principle, *respect of autonomy*.

The fundamental principles of Bioethics are essential points of departure in ethical analyses. They are broadly accepted as possessing cross-cultural validity and being practically applicable. See Annex 1 to this Code, entitled “Fundamental Principles of Ethics” by Godfrey B. Tangwa.

Duties and Obligations of Occupational Health Professionals

1. Aims and Advisory Role

The primary objectives of occupational health practice are to protect the lives and safeguard and promote the health and well-being of workers, to promote a safe and healthy working environment, and to protect the work ability of workers and the security of their employment. In pursuing these objectives, occupational health professionals must use validated methods of occupational health risk assessment and health promotion, propose effective preventive measures, and follow up their implementation.

Occupational health professionals are obliged to provide competent advice and recommendations to employers and to workers in respect of their responsibilities in the field of occupational safety and health and the protection and promotion of health at work.

Occupational health professionals should maintain direct contact with the occupational safety and health representatives of employers and workers, with the safety and health committees of undertakings, and with all the other structures in the workplace that may be related to workplace health and its promotion.

2. Knowledge and Expertise

Occupational health professionals are obliged to be familiar with the work, the work processes, the working environment and the working conditions in the undertakings they serve. They are obliged to remain well-informed, in terms of scientific and technical knowledge, on the prevention, treatment and rehabilitation of work-related injury and illness, including the identification of occupational hazards and health-promoting factors. They must be aware of the limits of their competence in evaluating workers' health or the working environment. It is, thus, a moral obligation of occupational health professionals continually to update and develop their professional competence in these respects. This also applies to knowledge of effective means to eliminate or minimize occupational health and safety risks and to promote health. As the emphasis should be on primary prevention, expressed in terms of policies, work design, choice of clean technologies, engineering control measures, and adapting work organizations and workplaces to workers, occupational health

professionals must regularly visit their workplaces in order to make independent professional observations and assessments, and to consult both workers and management on the work and working conditions.

3. Development of Policies and Programs

An occupational health and safety policy is an essential component of any organizational strategy to protect and promote the health and work ability of employees. The task of occupational health professionals is to advise the management of undertakings and workers, and their representatives, on the factors at work that may adversely affect workers' health, and also on the factors that may promote it. Such a policy should be based on identification of workplace health hazards and assessment of the risks involved, aiming at their prevention. Occupational health professionals must contribute to the formulation and implementation of any policy. The implementation of a health and safety policy must include programs for the promotion of health and work ability, and health education that targets both management and workers.

Proposals for policies and programs made by occupational health professionals must be based on up-to-date scientific and technical knowledge and conform to best occupational health practice. Occupational health professionals are obliged to ensure that they possess the required skills, acquiring them if needed, in order to be able to offer advice on prevention programs. Such skills should include, where appropriate, measures for the monitoring and management of occupational safety and health hazards and, in case of failure, for minimizing their consequences. All occupational health programs should be delivered by professionals with appropriate competencies. The quality and effectiveness of programs should be continually audited, and the results used to facilitate ongoing quality improvement.

4. Emphasis on prevention and prompt action

Where health risk assessment identifies the need for prompt action in order to prevent an injurious exposure, special attention must be paid to the implementation of simple and cost-effective measures that can be implemented quickly and easily. The overarching principle should be the protection of life and well-being. Further evaluation is often needed to assess

whether such promptly taken measures are effective, or whether a more complete solution must be sought. If there is uncertainty about the existence or severity of an occupational hazard, prudent and reasoned precautionary action should always be taken. Where there are uncertainties or differing opinions concerning the nature of the hazards involved, occupational health professionals must be transparent in their assessments to all concerned, so as to avoid ambiguity in communicating their opinions and to enable consultation with other professionals as necessary. All interventions should be evaluated and revised if proved necessary.

5. Follow-Up of Remedial Actions

Occupational health professionals must balance their duties, as members of organizational teams, against those of the medical experts who provide services to individuals. The challenge is to aim for the best achievable impact on health and well-being of all personnel, while paying particular attention to the particular needs of workers who are diseased, handicapped or vulnerable in any other respect. While there is a need to accept certain organizational constraints in the implementation of a health and safety policy or a preventive occupational health program, there is an overriding duty to ensure that all reasonable measures are undertaken to protect and promote the health and safety of workers. Such measures must be implemented within reasonable time scales proportionate to the assessment of risks and needs for health protection. Should occupational health professionals become aware of failures to implement required health and safety measures, they must inform the senior manager responsible, setting out – in appropriate language so as to ensure that the message is understood – what actions should be taken and the risk assessments underlying any recommendations. Any advice for action should be evidence-informed and documented, taking into account best-available scientific data and social imperatives, such as those in statutory or mandatory requirements.

When a failure to take action on the part of an undertaking makes it necessary for occupational health professionals to inform workers and their representatives of their concerns and, as necessary, the competent authorities, measures may need to be taken to protect the professionals from retaliation. In such situations, it is advisable for any occupational health professional involved to seek the counsel of experienced senior

colleagues and relevant professional organizations, or to contact an appropriate public agency.

6. Safety and Health Information

An effective health and safety culture requires workers to be enabled and empowered to protect and promote their own occupational health and safety and working conditions, including general health, and also those of their fellow workers. Workers must be informed about the risks in their places of work. They need to know how to work and behave in the best interests of their own health and safety, and what to do in the event of an accident, hazardous exposure or untoward incident. Occupational health professionals have a key role in communicating about risks at work and their management. In so doing they must take into account and cope with language barriers, differences in capacity to understand the complexities of health information, cross-cultural cleavages and other diversities among audiences of workers that impact on the effectiveness of communication and understanding. They must interpret and explain scientific and health-related information in such a way that it can be understood by a wide variety of audiences; the information needs to be understandable, clear and credible. Methods of assessing risk and uncertainty should be transparent. Occupational health professionals must collaborate with the employer, and the workers and their representatives, to ensure that adequate information and training on health and safety at work is conveyed to management personnel and workers. In situations where there are significant difficulties in communicating due, for example, to cross-cultural obstacles, the calling-in of intermediary organizations or experts should be considered to assist in the process of communication.

7. Commercial Secrets

Occupational health professionals have a duty not to reveal any industrial or commercial secrets of which they may become aware in the exercise of their activities. However, they are not to withhold information that is necessary to protect the safety and health of workers or of the community. When needed, occupational health professionals should consult the competent authority in charge of supervising the implementation of the relevant legislation or, alternatively, seek counsel with legal specialists in the health and safety arena or senior professional colleagues.

8. Health Surveillance

The occupational health objectives, methods and procedures of workers' health surveillance need to be clearly defined, and priority given to adaptation of workplaces to workers. The workers must be informed in this respect. The relevance and validity of the methods and procedures employed should be consistent with best-available scientific evidence and recognized good professional practice.

Occupational health surveillance involving health examinations of personnel should be implemented on the basis of the free, voluntary, non-coerced and informed consent of those examined. See also Article 14 (below) on informed consent. There may be an exception to this general principle with regard to the health surveillance of work programs that have been set up pursuant to statute; employers and other authorized bodies are required to make such programs available, and workers are obliged to submit themselves to medical examinations. It is, however, not an ethical justification for a program or a policy just for it to be legally required. Irrespective of the motives for medical examinations, occupational health professionals must clarify the objectives, methods, uses of results and implications of screening and health surveillance programs in advance of implementation as part of the informed consent process. Health surveillance should be performed by occupational health professionals authorized by a competent authority, or follow the competence requirements of nationally recognized good practice.

9. Health Examinations – Communication of Information

Information resulting from health examinations in health surveillance is of a confidential nature and must not be disclosed to employers or others unless:

- disclosure is required by law, or
- the examined workers give their informed consent to disclosure, or
- disclosure is warranted in the public interest to protect individuals or society from assessed risks of serious harm.

The determination of medical fitness for a given job by occupational health professionals, where required, is to be based on adequate knowledge of job demands and of the

workplace, and also on an assessment of the health of the worker. Workers are to be informed of their right to withdraw their informed consent, and also of their right to challenge the conclusions drawn by occupational health professionals concerning their fitness to work. An appeals procedure should be established in this respect.

Workers are entitled to see their personal occupational health records and workplace occupational health monitoring data. Exemptions from this right to access can only be granted by statute. See also the Code, Article 21.

The results of the examinations prescribed by national laws or regulations are to be conveyed to management only in terms of judgments of fitness for the envisaged work or of limitations necessary from a health point of view in assignments to tasks or in exposures to occupational hazards. In providing such information, the emphasis should be on proposals to adapt tasks and working conditions to the abilities of the worker.

General information on work fitness or workplace health, or on the potential or probable health effects of work hazards, may be provided to an employer on condition of informed consent of the worker concerned, and – in so far as necessary – to guarantee protection of the worker's health. See also the Code, Article 21

11. Danger to a Third Party

Where the health condition of the worker and the nature of the tasks performed are such that they are likely to endanger the safety of others, the occupational health professional has a moral obligation to take action to prevent such danger. Appropriate action is first to inform the worker concerned and the employer of the situation. In the case of a seriously hazardous situation, if so required by national regulations, the competent authority may also have to be informed of the measures necessary to safeguard other persons. In providing advice in such situations, the occupational health professional should seek to reconcile employment of the worker concerned with the safety and health needs of others involved.

12. Biological Monitoring

Biological tests and other medical examinations should be chosen for their validity and relevance to protection of the health of the worker concerned, with due regard to their

sensitivity, their specificity, and their predictive value. Occupational health professionals should not use screening tests or investigations that are not reliable, or that do not have an appropriate predictive value in relation to the requirements of their work assignment. Preference is to be given to non-invasive methods and to examinations that do not involve any danger to the health of the worker. An invasive investigation, or an examination that entails a risk to the health of the worker concerned, may only be recommended after an evaluation of the benefits to the worker and the risks involved. Such investigations are subject to the worker's informed consent and are to be performed to the highest professional standards. They are, in principle, not justified in relation to insurance claims. As regards the use, storage and disposal of samples of biological material (blood, urine, body fluids, etc.), see Article 14 in this Code, under the heading 'Research and Contribution to Scientific Knowledge'.

13. Health Promotion

When engaging in health education, health promotion, the promotion of work ability, and health screening and public health programs, occupational health professionals are obliged to seek the participation of both employers and workers in their design, content and implementation. The professionals have a duty to protect the confidentiality of the personal health data of workers, and prevent their misuse. They are obliged to provide information generated in health surveillance programs to workers for advice on health promotion and promotion of work ability. In so doing, their aim should be to achieve full understanding by workers of their state of health, and how it is related to their work tasks and working conditions.

14. Research and Contribution to Scientific Knowledge

Occupational health professionals who participate in research involving human subjects are obliged to protect the health, integrity and human rights of the subjects in the conduct of research and in communicating its results. This implies adherence to the principles embodied in the 'World Medical Assembly Declaration in Helsinki on Ethical Principles for Medical Research Involving Human Subjects' adopted in 1964 (latest revision 2008), the Council of International Organizations for Medical Sciences' (CIOMS) 'International Ethical

Guidelines for Biomedical Research Involving Human Subjects 2002' and 'Guidelines for Epidemiological Studies 2009' with particular regard to:

Institutional independent review of study proposal and ethical review

- Research must have ethical justification and scientific validity. It must conform to generally accepted scientific principles, be based on a thorough knowledge of the pertinent scientific literature, and adhere to the professional standards defined by recognized scientific societies.
- A study design and/or a research protocol must be submitted for review of scientific merit and ethical acceptability by an independent and competent ethical review committee, or an equivalent independent research body, whenever the proposed research implies a health risk or discomfort to study subjects.
- The investigator is responsible for ensuring that the materials submitted for an independent ethical review include a declaration of any potential conflicts of interest affecting the study. Authors have ethical obligations with regard to the publication of the results of their research. Authors also have a duty to make publicly available the results of their research, and are accountable for the completeness and accuracy of their reports. Sources of funding, institutional affiliations and conflicts of interest should be declared in any publication. Reimbursement or any form of financial compensation to study participants should be declared.

Procedures for ascertaining full, voluntary, non-coerced and explicit informed consent of the subjects involved

- The investigator must obtain the written voluntary informed consent of the subjects to participate in research, providing detailed information on: the aims and methods (procedures, duration) of the research; the expected benefits of the research to the individual, the community or society at large; and, any potential risk, discomfort, disadvantage or inconvenience to the worker that the research may entail. Informed consent is also to encompass: intended storage and future use of collected data; the institutional affiliations of the researchers; and, the sources of funding and any possible conflicts of interest arising in the planning and course of the study. The

potential subject must be informed of the right to refuse to participate in the study, or to withdraw consent to participate at any time without reprisal. Informed consent has to be renewed if there are any significant changes in the conditions or procedures of the research, or if new information becomes available that might affect the willingness of subjects to continue to participate. In the case of long-term studies, consent should be renewed at pre-determined intervals even if there are no changes to the design or objectives of the research. Ascertainment of informed consent is to be seen as a process in which the two options of acceptance and rejection of researchers' proposals for participation are à priori to be seen as equals, since neither is coerced. Insurance arrangements should be made to protect study participants and researchers against the risks of undesired effects or consequences arising from the research while it is being carried out.

Assurance of adequate security of all data collected in a research undertaking and protection against unauthorized access to confidential health and personal information on subjects involved in the study

- Every precaution must be taken to guarantee protection of the privacy of research participants and the confidentiality of their personal information, and also to minimize the impact of the study on their physical, mental and social integrity.
- Participants should be told the limits, legal or other, to the investigator's ability to safeguard confidentiality and the possible consequences of breaches of confidentiality.
- When seeking the informed consent of study participants in collecting and storing human biological samples and related data, such as health or employment records, for long-term epidemiological research, the investigator is obliged to inform study participants about the envisaged use of all the data and biological material collected, and to provide a time-plan for their storage and destruction. It is necessary to clarify who will have access to the samples and the foreseeable uses of the samples, whether they are restricted to an already fully defined study or extend to a number of wholly or partially undefined studies. It is equally necessary to clarify the intended

purpose of data use, whether only for research, basic or applied, or for commercial or other purposes.

Occupational health professionals conducting or participating in research must plan and carry out their activities on a sound scientific basis with full professional independence and in compliance with published professional ethical guidance including implementation of the independent review procedures referred to above.

15. The Public Health Role of Occupational Health Professionals

Occupational health professionals must be aware of their public health role with regard to the needs to protect the entire population and the environment in a community. This role implies a moral obligation to initiate and participate, as appropriate, in identifying conflicts of interest, assessing public health risks, informing for the promotion of transparency, and advising for the purpose of prevention of the occupational and environmental hazards that may result from operations or processes in an undertaking.

In their public health role, occupational health professionals are under a moral obligation to counteract inequalities in health in the populations they serve and to seek means for their correction.

16. Moral Obligation to Report

Occupational health professionals have a moral obligation to report objectively to the scientific community, and also to the public health, occupational safety and health agencies and labour authorities, on new or suspected occupational hazards or on observations that indicate increasing ill-health among workers attributable to workplace conditions. This also includes a duty to report new and relevant preventive methods.

Occupational health professionals should promote the proper reporting of occupational injuries and work-related diseases to the competent authority according to national laws and regulations.

17. Conditions for Execution of Functions – Competence, Integrity and Impartiality

Occupational health professionals must ensure that they have the necessary skills, sustained by ongoing competence development, to enable them to fulfil the roles for which they are employed or contracted. The primary concern is the safety and health of workers. Competent occupational health professionals should have the ability, and be provided with the necessary resources, to assess and evaluate the effects of the working environment on health and to advise on adapting working environment and arrangements to promote health, work ability and employability. Occupational health professionals must recognize the bipartite, sometimes multipartite, relationships that may exist between themselves, workers, managers and other third parties, such as human resource managers, workers' representatives, safety officials and primary/secondary care physicians. Advice given by occupational health professionals should carefully balance scientific, technical, medical and organizational information so as to promote optimal working arrangements in an impartial manner. In so doing, they should protect their own integrity and that of their specialty, since these are critically important for the necessary trust of all involved in the workplace.

18. Workers' Health – the Prime Concern

Occupational health professionals have an obligation to act, as a matter of primary concern, in the interest of protecting the life, health and safety of workers. They act under a professional obligation to base their judgments on scientific knowledge and technical competence and to call upon specialized expert advice as necessary. Occupational health professionals must refrain from any judgment, advice or activity that may endanger trust in their integrity and impartiality.

19. Professional Independence

Occupational health professionals are obliged to seek and maintain professional independence. They should not allow their judgment to be influenced by any competing or conflicting interest when advising an employer or a worker, or their representatives, with regard to any occupational safety or health matter.

Occupational health professionals should draft a written "Declaration of Interests", setting out any and all possible influences that might impair the independent exercise of their professional duties, and make the declaration accessible to all persons concerned.

Professional independence is a fundamental pre-condition for ethical conduct and for impartiality, and thereby for the trust of employers, workers, clients, client undertakings, and the public. It is, in principle, however, constrained by the following dependencies:

- Dependence on being professionally competent and evidence-informed on current professional knowledge and recognized professional practices.
- Dependence on working relationships with specialized health professional colleagues.
- Dependence on working relationships with other health professions.
- Dependence on relationships with customer/client/patient systems.
- Dependence on being a member of organization acting on a health market.
- Dependence on being in paid employment or commissioned to provide professional services.

Thus, the professional independence of occupational health professionals can be envisaged as the exercise of independent judgment in carrying out tasks, while being aware of the above-mentioned dependencies. It also entails awareness of potential conflicts of interest between stakeholders, and of the importance of competent ethical analyses and impartiality in seeking optimal solutions in workplace hazard prevention and health promotion.

20. Equity, Non-discrimination and Communication

Occupational health professionals have a moral obligation to build a relationship of trust, confidence and equity with all people to whom they provide occupational health services, to treat all clients in an equitable manner, and to combat discrimination based on age, gender, belief, colour, culture, health condition, disability, race, lifestyle, religion, sexual orientation, or social or economic status. Occupational health professionals must establish and maintain open channels of communication among themselves, and with workers´ representatives and senior managers responsible for decisions at the highest level in any undertaking, about the conditions and organization of work, and the working environment.

21. Contracts of Employment of Occupational Health Professionals

In preparation of agreements or contracts for specialist services, occupational health professionals should explore the needs and expectations of clients and client organizations for compatibility with professional standards, guidelines and codes of ethics. It is recommended that a contract should be drafted with the employer or commissioning party for clarification of the occupational health professionals' duties and accountabilities in situations that can be foreseen. Occupational health professionals must not accept conditions of practice that do not allow performance of their tasks according to recognized standards and principles of ethics. Contracts of employment should contain guidance on legal, contractual and ethical aspects, and on the management of conflict, with particular attention being given to the protection of confidential information. Occupational health professionals should ensure that their contract of employment or service does not contain provisions limiting their professional independence. In case of doubt about the terms of their contract, legal advice is recommended, and also consultation with health professional bodies and competent authorities, as appropriate.

22. Records

Occupational health professionals are obliged to collect sufficient and adequate data and information for the purpose of carrying out their tasks in identifying and, as appropriate, monitoring occupational health problems in their undertaking with a view to hazard prevention and health promotion, and to keep records with an appropriate degree of confidentiality. Maintaining secure, accurate, legible and up-to-date records is a fundamental professional competence. Records are kept to facilitate the monitoring of the health of workers and to identify occupational health problems in the undertaking. Occupational health records may be paper-based or electronic. They will usually refer to some or all of the following data or data sources:

- Results of surveillance of the working environment.
- Personal data, such as employment history.
- Occupational health data.
- Exposure monitoring.
- Physiological monitoring – by, for example, lung function testing and audiometry.
- Biological exposure or effect monitoring – exposure to specific agents, e.g. lead.

- Preventive actions, e.g. vaccination.
- Assessments of fitness to work.
- Assessment and monitoring of rehabilitation back to work.
- Fitness certificates.

Workers are entitled to see their personal occupational health records and workplace occupational health monitoring data. Exemptions from this right to access are only to be granted by statute.

23. Medical Confidentiality and Data Security

Protecting medical confidentiality and data security are essential to developing and maintaining trust between workers and occupational health professionals. The protection of, and access to, personal or medical information held is governed by national laws or codes of ethics in many countries. Information must be kept in secure settings, and access restricted to designated members of an occupational health team. Professional occupational health organizations should have a data protection policy identifying the data controller. Careful consideration should be given to the storage of information to ensure that it remains accessible for designated periods of time. Clinical occupational health information should be held separately from non-clinical safety information, such as fitness to carry out a specific work activity, by occupational health services. This implies a need to assign a special status to such information in that, although the resources used to record information belong to the undertaking concerned, data security is the responsibility of the occupational health professional – commonly an occupational physician or an occupational nurse. Confidential medical information must not be released by occupational health professionals without the informed written consent of workers unless they are instructed to do so in a court order.

Access to medical files, and their transmission and release, are governed by national laws, or regulations on medical data where they exist, and relevant national codes of ethics for health professionals and medical practitioners. The information contained in these files must only be used for occupational health purposes. Occupational health professionals must inform workers about how their personal health information is recorded and used, and under which circumstances and conditions it may be shared with others.

24. Collective and Individual Health Data – Access and Use

It is permissible and desirable for collective health information, provided that there is no possibility of identification of individual persons, to be communicated to managers and workers' representatives in order to assist in fulfilling duties to protect health and safety. An example is the provision of reports to an undertaking's health and safety committee. It is important to ensure that, even without obvious means of identification, it is not possible to identify workers from such reports. For example, reference to specific activities involving only a small number of workers may effectively negate the anonymity of a report.

Access to medical files, and their transmission and release, are governed by national laws or regulations on medical data where they exist, and also on relevant national codes of ethics for health professionals and medical practitioners. The information contained in these files must only be used for occupational health purposes.

Occupational health professionals must not seek personal information that is not relevant to the protection, maintenance or promotion of workers' health in relation to work or to the overall health of the workforce. They represent, by virtue of their ground training, a large variety of different academic disciplines. Effective prevention of health hazards at work and health promotion may be achieved only if all the professional competencies needed are brought together in joint and integrated action. Close collaboration with the other health professionals involved is a moral obligation for occupational health professionals, in the spirit of mutual respect for and sharing of the fundamental ethical values underlying this Code. If partners in such collaboration are not bound by other professional codes, the ICOH Code should be proposed for ethical guidance on joint activities. Occupational health professionals may, if necessary for the management of a workplace hazard, and conditional on informed consent from the worker concerned, provide individual health information, as appropriate, to the other occupational health professionals involved (hygienists, ergonomists, psychologists, etc.). On informed consent, see Article 14 above. Occupational health professionals may seek further medical information or data from the worker's personal physician, or from other sources, with the worker's informed consent, for the purpose of protecting, maintaining or promoting the health of the worker concerned.

25. Combating Abuse of Occupational Health Data

Occupational health professionals are under a moral obligation to collaborate with other health professionals in the protection of the confidentiality of health and medical data concerning workers. They have a duty to identify, assess and indicate to those concerned any procedures or practices that are, in their professional judgment, contrary to the principles of ethics embodied in this Code, and inform the competent authority when necessary. This concerns, in particular, instances of misuse or abuse of occupational health data, concealing or withholding findings, violating medical confidentiality, or inadequate protection of records, in particular with regard to information placed on computers.

26. Relationships with Social Partners

Occupational health professionals are obliged to enhance the awareness of employers, workers and their representatives, and also the competent authorities, of their moral obligations to engage in ongoing professional competence development, to fulfil their need for full professional independence, and to commit to the protection of health and human dignity. This entails protection of the confidentiality of individual health information, protection of vulnerable groups of workers, and protection of any special needs, such as those attributable to maternity. These are fundamental requirements for establishing the trust of the public in professional occupational health practice.

27. Accountability

An essential component of occupational health professional conduct is a commitment to seek the best solutions to challenges of occupational health, while taking into account the context of the situation at hand, action taken by important others, and adherence to public, professional and personal values. Professional conduct entails taking responsible action and making judgments, for which the occupational health professional is accountable. Occupational health professionals should be prepared to justify their actions and judgments on the basis of reflected ethical analysis.

28. Conflicts of Interest

When competing interests interfere with occupational health professional judgments, workers' health and public health may be harmed. In order to prevent this from happening,

occupational health professionals have a duty to ensure ethical conduct regarding conflicts of interest by identifying, acknowledging and appropriately addressing any secondary interests that might distort the integrity of their judgments or be perceived do so. A conflict of interest may be limited to specific issues or events, but may also be more comprehensive in scope and of a long-lasting or permanent nature. On either of such scenarios, the occupational health professional must ensure that harm does not accrue as a result of such a conflict.

29. Promoting Ethics and Professional Auditing

Occupational health professionals must seek the support and collaboration of employers, workers and their undertakings, and also of competent authorities and other national and international organizations (WHO, ILO, CIOMS, among others) and professional communities for achieving the highest standards of ethics in occupational health practice.

Occupational health professionals must institute a program of professional audit of their activities to ensure that appropriate standards have been set, that they are being met, that deficiencies, if any, are detected and corrected, and that steps are taken to ensure continuous improvement of professional performance.

Occupational health professionals should seek to join and establish professional networks for forums for the exchange of experiences, and for competence development with regard to both professional skills and competence in the identification and management of ethical dilemmas.

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Annexes

Annex 1: Fundamental Principles of Ethics

Godfrey B. Tangwa

Introduction

Four moral principles, describable as 'fundamental', have been widely discussed in the contemporary ethics literature. These principles are respect for autonomy, beneficence, non-maleficence, and justice or fairness. While these principles are couched in the language and idioms of the industrialized Western world, where they have been most discussed and debated, they have cross-cultural relevance and applicability, even if they are not everywhere conceived or expressed in the same terms. The principles are also relevant to, and applicable in, all fields of human endeavour and activity, irrespective of context, situation or perspective. They are particularly important for professionals in any domain because their specialized knowledge and skills greatly increase their capacity for doing both good and bad.

What is Ethics?

An easy description of ethics is that it is an articulate field of study that deals with the morality of human actions and behaviours. Morality consists in judgments of human acts, actions or behaviours as right or wrong, as good or bad. Ethics can also be defined as the study of the fundamental principles of morality and their applications in actual concrete situations. The terms 'ethics' and 'morality' are often used interchangeably, but the concept of morality is much broader than that of ethics. Even before we start dealing with or studying ethics, or articulately discussing ethical problems, we already have a sense of morality, and we have made many moral judgments without necessarily consciously and explicitly reflecting on the principles underlying them. Human beings everywhere seem to have a sense of moral intuition from which they immediately can judge some acts or actions or behaviours as right or wrong, good or bad. Ethics presupposes that we already have a sense of morality, and consists partly but importantly in articulate reflection on the general principles underlying our moral judgments and intuitions.

Ethics is a normative discipline because it seeks to study or to lay down the norms of acceptable human conduct or behaviour. Systematic moral reasoning, or articulate ethical reflection, can be applied to any issue in any domain of human activity. Ethics is therefore inescapable since it is pervasive and important in all domains where human beings operate or act, or simply live their lives. Ethics is, of course, particularly important for professionals and other people with special skills (Pellegrino 2002, pp. 378-384), because their specialized

knowledge, expertise and endowments increase their capacity to do good or bad. In traditional societies, the conduct, behaviours and actions of professionals are typically regulated by sundry taboos and ritual restrictions, and in modern societies by written codes and ceremonial oaths.

Natural Allies and Companions of Ethics

The natural allies or road companions, to use a common metaphor, of ethics are law, human rights theory and practice, civics, religion, and the customs, taboos and traditions of communities or societies. All the above are necessarily mingled and interwoven with ethics, but ethics is separable from each and all of them. Ethics is, moreover, rationally more compelling than any of its road companions. For example, no law, custom, or cultural or religious practice is justifiable if it is unethical, i.e. if it can rightly be judged as morally wrong or bad, because, in a sense, all these road companions are meant to serve morality, and morality is more important than all of them. As Rebecca Cook and colleagues have rightly pointed out (Cook et al., p. 90):

"*…law aims to serve the ethical principle of justice. Accordingly, it is not an ethical justification of a policy simply that it is legal. It is not even an ethical justification that a democratic government of a country had a popular mandate to introduce or support the particular law, and that it has been upheld by a country's most significant court according to the country's constitution. These features alone, while legally and politically significant, do not show that the law is ethical*".

Ethics is, however, limited to acts, actions and behaviours that are free, purposive and intentional, and liable to impact on other creatures. Un-free or externally compelled acts/actions are not voluntary or responsible acts/actions, and cannot therefore be qualified as morally right or wrong. It can also be argued that acts/actions that have no possibility of affecting other creatures are not relevant to ethical appraisal. That is why it is plausible to argue that, if only a single individual existed in the universe, s/he would have no need for ethics or morality, as anything s/he chose to do would be right, or rather neither right nor wrong. If you were the only creature in the world, you could act and behave in any way you liked without bothering about morality, except perhaps to the extent that you believe

another superior being such as God exists, and expects you to behave in certain ways rather than in others.

Natural Challengers of Ethics

The natural challengers, adversaries or enemies of ethics are amoralism and egoism. An amoralist is someone who sees no reason why s/he should do what is morally right or avoid what is morally wrong, especially as doing what is morally right does not always pay off personally, whereas immorality is often personally beneficial. The defiant question 'Why should I be moral?' is one that is very difficult to answer satisfactorily. It is a challenge objectively to justify morality because morality is something that is both objective and subjective. If someone truly does not have any moral intuitions, and feels no need at all to be moral, there may be no third-party arguments that would be convincing to him/her. It is doubtful whether it is possible for a human being to be completely destitute of a sense of empathy and sympathy, i.e. a sense of identification with and kindred feeling towards, at least, other human beings, if not other non-human creatures; if that were truly possible, such a person might be called an amoralist.

Egoism or selfishness may be related to, but cannot be justified by, the fact that humans are necessarily egocentric beings. Egocentrism simply means that each human being is self-centered, and cannot perceive and appreciate the world other than from his/her own point of view. This need not, but sometimes does, lead to egoism or selfishness. The disputable theory of psychological egoism is that human beings are, by nature, selfish and self-seeking in everything they do. According to psychological egoism, therefore, human beings are naturally selfish and cannot help being selfish. But to the extent that human beings are capable of genuine altruism (concern for others) and selfless love, the theory of psychological egoism is false. Some human beings do sometimes make sacrifices, even of their lives, for others. How would this be possible if psychological egoism were true? Morality is not possible without altruism, empathy and sympathetic impartiality, and it can be argued that they are also part and parcel of human nature.

What is Culture?

Culture is basically a way of life of a group of people, underpinned by adaptation to a common environment or ecological niche, a common worldview, similar ways of thinking and acting and doing, similar attitudes and expectations, and similar ideas, beliefs and practices, etc. There is a remarkable diversity and variety in the human cultures of the world and in the ecological niches in which cultures and individuals flourish. This diversity, an observable fact, is similar to the equally remarkable diversity of the biological world, of the different species that populate the earth. Cultures and sub-cultures are like concentric circles (Tangwa 1992, pp. 138-143), and there is no human being who does not fall within at least more than one such circle; the nuclear family or, more ideally, the extended family in its African conception, might, in fact, be regarded as delimiting the smallest of such cultural circles. Thus, like biological diversity, cultural diversity is an observable fact, something that is there for us to notice, recognize and appreciate.

Unlike culture, morality is grounded on human rationality and common biological nature, and on basic human needs (for food, shelter, clothing, self-expression, etc.), which – being common to all irrespective of culture – may be regarded as defining what it is to be human. For this reason, divergence of moral opinion, both within and across cultures, is a descriptive fact that falls short of the prescriptive ideal. Moral imperatives are necessarily universal. That it is morally wrong to kill, steal or lie, that truthfulness, honesty, kindness and reliability are good in themselves, are universal imperatives not limited to any particular people or culture. But moral thinking and particular practices may differ from culture to culture, and even from person to person within the same culture. This is because of environmental constraints, existential pressures and human limitations, which include the impossibility of perceiving from more than a single point of view, the impossibility of being an experiential participant in all human existential situations, and their couplings with human ego-centrism and fallibility. It is for this reason that some human practices or behaviours, such as homosexuality, polygamy, circumcision, pedophilia, prostitution, abortion, capital punishment, rape, etc., are controversial; they are considered by some, or at times, as morally wrong and by others, or at other times, as permissible. In discussing such issues, personal or cultural prejudices are likely to induce a perception of self-evident rightness or wrongness, where in fact the case may not be so clear. We therefore always need both

critical self-awareness and sympathetic understanding when dealing with issues concerned with self and others.

No Human Culture is Perfect

Human ego-centrism, coupled with ethnocentrism (the tendency to be too firmly implanted within one's ethnic group, thereby allowing it to define all of one's perceptions and relations with all outside groups), naturally leads individuals to perceive their own culture as *the* culture, but critical observation and reflection can help to correct any such mistaken perception. Professor Michael Novak in his book, *The Experience of Nothingness* (Novak 1970, p.16), remarks that every culture differs from others according to the 'constellation of myths' that shapes its attention, attitudes and practices. In his view, it is impossible for any one culture to perceive human experience in a universal, direct way.

"...[E]ach culture selects from the overwhelming experience of being human certain salient particulars. One culture differs from another in the meaning it attaches to various kinds of experience, in its image of the accomplished man, in the stories by which it structures its perceptions.

Of course, men are not fully aware that their own values are shaped by myths. Myths are what men in other cultures believe in; in our own culture we deal with reality. In brief, the word 'myth' has a different meaning depending upon whether one speaks of other cultures or of one's own. When we speak of others, a myth is a set of stories, images and symbols by which human perceptions, attitudes, values and actions are given shape and significance. When we speak of our own culture, the ordinary sense of reality performs the same function. In order to identify the myths of one's own culture, therefore, it suffices to ask: What constitutes my culture's sense of reality?"

Culture is like a congenitally tinted pair of spectacles through which we look at reality. We inevitably impose our particular cultural tint on everything we perceive, but critical awareness can lead us to the realization that 'objective reality' is multi-coloured. It is very important always to try to see or imagine things from the point of view and perspective of the other. No human culture or community is perfect, although some may be more advanced or better-off in some respects than others. There may be activities/skills at which

any one culture is 'better' than all the others, but a culture in general cannot be described as being 'superior' or 'inferior' to another on that basis. In Cameroon, for example, it would be generally agreed that, while both the Oku people and the Nso' people engage in wood-carving, the former by far excel the latter in this activity; but it cannot on that account be said that the Oku culture is superior to Nso' culture. To say that one culture qua culture is 'better' or 'superior' to another is like saying that a donkey is better than or superior to a horse. A donkey qua donkey cannot be superior or inferior to a horse qua horse because a donkey is not a horse, nor vice-versa; they are two different creatures with very different evolutions, aims and purposes.

Cultures qua cultures can be said to be equal in the same sense in which human beings are equal, in spite of great differences in their individual and individuating attributes and characteristics. We could qualify such equality as 'moral' equality, not to be confused with other senses of equality. From most other points of view, human beings are rather demonstrably unequal, but in spite of their un-equality in those respects, they are all equally human, for which reason they should always be treated with fairness and equity. All human cultures are, however, perfectible, because none is perfect; and none can be perfect, given that human beings, the creators of culture, are imperfect beings.

The limitations of cultures are directly related to the limitations of human beings who, both as individuals and as communities, are the creators of culture. Human limitations, especially human fallibility, are impossible of complete eradication, in spite of the very strong impulse, present to varying degrees within all individuals and all cultures, to strive for certainty and infallibility under the invincible impulse and optical illusion that they can be achieved. Such an impulse euphemistically may be described as 'the desire to be God'. However, human limitations need not be a hindrance to striving for perfection or to making clearly recognizable moral or cultural progress.

The Basic/Fundamental Principles of Ethics

A principle is a general rule or formula that applies to many particular cases/instances. It is a standard of reference, and is necessarily universal rather than particular. It is abstract rather than concrete. Of course, the pre-conditions for and fundamental principles of morality ought to be the same for all societies and all cultures, because these are based on human

beings being rational and social beings, imbued with some sense of morality that underlies ethical thinking. Those who study the peculiarities of different societies, such as social scientists, might often end up with an exaggerated highlighting of the differences, resulting in moral relativism, and fail to realize, for example, that the *mores* of the various societies are derivable from principles or considerations that are common to them all.

Acceptance of the moral equality of all human beings is perhaps the first pre-condition for morality. Where this initial moral equality is denied some human beings, acts will be carried out – such as colonizing, enslaving or massacring – which come across as highly immoral, like a slap in the face, thereby indicating that human moral equality is a moral imperative imposed by human reason itself. Other fundamental moral principles have been widely discussed in the moral literature of the Western world, notably, respect for the autonomy of others, beneficence, non-maleficence and justice. In simple terms, these principles have to do with respect for all other humans as moral equals, making sure that our actions are well-intended/motivated and calculated to achieve good ends or results, avoiding the infliction of harm, and treating others with fairness and equity (Beauchamp and Childress, 2001).

Autonomy

The word *autonomy* comes from two Greek words: *nomos* ('rule') and *autos ('self'),* giving it the literal meaning of 'self-rule' or 'self-governance'. Autonomy implies an individual who is master of himself/herself and can act, make free choices and take decisions without the constraint of another. The principle of autonomy therefore implies both the freedom of each individual to act and the obligation of others to respect that freedom. The principle is thus alternatively described as 'respect for autonomy' or simply 'respect for others'. The necessary pre-conditions for autonomy are competence (the capacity to be a moral agent) and liberty or freedom. Individual autonomy may be diminished or completely absent, as in the case of minors, aged people with diminishing mental capacities, the mentally handicapped or incapacitated persons, prisoners, etc. The principle of autonomy can be said to be the first, though not necessarily the most important, of the fundamental principles of ethics. It is based on the moral imperative of respect for other human persons as moral equals. Such respect demands treating them as 'ends' in themselves and never merely as 'means' to any other end, treating them with consideration, giving due regard to their point

of view, and respecting their well-considered choices. Without supposing autonomy in others, societal ethics would be a non-starter. Personal autonomy and freedom are ethically limited by the autonomy and freedom of other persons; that is why, in every society/community, discussion, compromise and legislation are indispensable to harmonious living.

The principle of autonomy accords very well with an individualistic perspective of life and may be overemphasized in discourse within individualistic cultures like Western culture, and de-emphasized in communal cultures where the community is usually given precedence over the individual. But it is equally important in all cultures, including communal cultures like African culture, in which individuality, as distinguished from individualism, is also highly respected. It is quite possible for a culture to be communal in the sense of recognizing or affirming the superiority of the community over the individual, while at the same time recognizing the uniqueness and importance or individuality of each person. The recognition of such individuality in African culture can be seen during naming, initiation and burial ceremonies. In all such ritual ceremonies, it is the individual strictly before God, the ancestors and his/her destiny.

Justice

Justice is *fairness* or *desert* or *entitlement;* it implies giving to each his/her due. Justice requires that 'equals be treated equally and un-equals unequally', unless there is a reasonable justification for treating them differently. The general moral idea or intuition underlying the principle of justice is that which states: '*Do unto others as you would have them do unto you if you were in their place and they in yours'*. According to John Rawls (Rawls 1999, p. 3):

"Justice is the first virtue of social institutions, as truth is of systems of thought. A theory, however elegant and economical, must be rejected or revised, if it is untrue; likewise, laws and institutions, no matter how efficient and well-arranged, must be reformed or abolished if they are unjust."

An untrue theory, no matter how attractive, must be rejected; an unjust system or procedure, no matter how convenient or profitable, must be reformed. Society/community

is a collaborative venture, and distributive justice is concerned with the fair distribution of the goods, benefits, advantages, etc. that result from collaborative ventures. However, morality/ethics not only includes but also goes beyond strict justice. Philanthropy and supererogatory acts/actions are also part and parcel of morality. Philanthropy is helping others in need without getting or expecting anything in return, and a supererogatory action is a good action that benefits another person but that is in no way obligatory or required, and can be neglected without incurring any blame. That is why Rawls also argues for a procedural principle according to which inequitable distribution of goods in any society is justifiable only if it is to the advantage of the least favoured or least privileged members of that society.

Beneficence and Non-Maleficence

The principles of beneficence and non-maleficence are best considered together. They are like two sides of one and the same coin, although each is distinct and important in its own right. Some ethical theorists, following the example of the *Belmont Report* (1979), tend to omit non-maleficence from the list of fundamental ethical principles, but such omission is highly questionable. In simple terms, beneficence means *doing good* and non-maleficence means *avoiding evil/harm*. They are complimentary ethical principles, the one imposing affirmative duties and the other negative ones. However, not all achievable good is ethically mandatory; as stated above, some good is *supererogatory (*i.e. desirable or commendable, but not obligatory); direct harm, however, ought always to be avoided. If you give the needy beggar money, you have done something good and commendable or praiseworthy; but, if you do not give the beggar money, you have done no harm and nothing wrong. But, of course, it not only is good but also highly recommendable and praiseworthy to help the beggar and others in need. In practice, of course, and especially for the professional, there will be many acts/actions that are situated at the interface or borderline between strict duty and voluntariness or philanthropy. A colleague of mine recently provided me with a good example, where in the theatre one night the director urgently asked the audience if a medical doctor was present who could help render emergency first aid. Another colleague of mine, who is a medical doctor, once ran across a pregnant woman in labour while doing his early morning jogging exercise. In such cases, only professional conscience and/or a stipulated code of conduct helps to determine whether it is a case of duty or supererogation.

Some people consider non-maleficence to be the most basic of all the cardinal principles of ethics because it lays down a minimalist condition for ethical correctness, as if to say: 'even if you do no good, at least do no harm'. Many medical professionals seem to have realized the moral rock-bottom nature of non-maleficence, and have adopted it as their motto, as in the expression '*primum non nocere'* – first (above all) do no harm! In African conceptions, doing harm and other types of evil attract calamity and other misfortunes, not only on the agent of the action but on his/her relations and community; by contrast, doing good is not expected necessarily to attract any benefit.

However, it is not always enough that we have done no harm; sometimes even without doing any harm, we do wrong; take the man who climbed up a cola-nut tree and hid behind its leafy branches so he could peep at naked ladies when they were bathing in the shade behind the house. He did them no harm, as he argued in his defence when he was caught, but he certainly did them wrong. In the borderline or grey-area cases between strict duty and philanthropy/supererogation, most people would agree that failure to help would be wrong and professionally below expectation, even if no direct harm was done.

Scope and Applicability of Moral Principles

The pre-condition for morality and the four fundamental principles of ethics are, in a loose and general sense, equally relevant to and important across all cultures, in all fields of human endeavour and activity, and within all possible human contexts and perspectives. In practice, they function as a team or single value set, completing and balancing each other, in such a manner that one cannot be singled out as being more or less important than any other, and none can claim to be absolute, since any of them can be violated, given a sufficient ethical justification. For these reasons, synthetic minds might tend to view them as all hanging from one single stem, whereas analytic minds may regard them as analyzable into various branches. In any case, one ethical principle, in a particular context and existential situation, can take precedence over another, or one ethical norm or rule can countermand another, as when, for example, one were to violate confidentiality or break a promise to save a human life. By contrast, a non-ethical reason can never justify the violation of an ethical principle, norm or rule.

From these fundamental principles, many other derivative principles can and have been formulated to help morality along. Some such procedural principles are metaphorical, others mythical, and still others simply practical. Examples of some of such derivative principles and metaphors, in my view, include: human rights, human dignity, human solidarity, sacredness of human life, 'created in God's image and likeness', etc. But, beyond myths and metaphors, which harmlessly and quite usefully (from the moral perspective), can be taken literally, critical reflection should suggest to us that (staying on the metaphoric plane) the chameleon is not without chameleonic dignity, nor the aloe vera plant without aloeveric dignity. Every creature and every existing thing have their own intrinsic value and inner reasons, even if unknown to human beings, for being there. The focus and emphasis on human beings can therefore only be justified from the point of view of *moral agency*, not from that of morality as such. Some moral 'patients', being non-human, non-rational or incompetent, have no conceivable moral obligations at all, whereas moral agents bear the whole weight of responsibility for whatsoever they choose or refrain from choosing to do or act upon.

The four principles, in the terms, language and idioms I have stated them are, of course, very much a paradigm of the industrialized Western world, where their relevance and urgent applicability have been made abundantly manifest by various activities that have violated or run the risk of violating them, such as human enslavement, colonization and medical experimentation on humans. They, nevertheless, remain equally important even where they seem to be lying dormant for want of any perception of urgent risk or hazard, the discussion of which would surely have brought them to the fore. The industrialized Western world should be credited for the coinage of the very convenient terms and idioms in which these principles are discussed today. But the fundamental principles themselves are not absent in any human culture, even if they are not thought of or understood in the same terms. The salient point about these principles is not that they are four in number – the BIG FOUR – as some people refer to them (I suggest below that within my own natal culture they can be reduced to two adages), but rather that they are clearly overarching as well as necessarily plastic in their applicability, leaving ample room for cultural perspective, situational context and existential pressure to impinge on them.

Reflecting on my own natal culture, the Nso' culture of the grassy highlands of Bamenda in the North Western region of Cameroon, I can say that these principles are captured in and

derivable from two guiding adages: the one that states that 'a human being is a human being simply by being a human being', and the other that states that 'the essence of a human being is having a good heart (will)'. The first of these adages implies that a human being, irrespective of his/her descriptive and particularistic attributes, is autonomous and of inestimable worth and must therefore be treated with due consideration and equity by other human beings (respect for intrinsic value, autonomy and justice). The second adage implies that a human being is less than a human being if s/he does not shun evil, including avoidance of harm, or if s/he is not imbued with good purposes and intentions (beneficence and non-maleficence).

These principles are what make living in communities or societies as human beings possible and harmonious. They may not be 'discovered' for some time or theoretically nailed onto an analytic frame, but they are there alright, implicitly wrapped up in social norms, traditions and practices.

Moral/ethical rules are different from all other rules. They are general, applying to a wide variety of particular cases and instances. They may be expressed in, mixed/mingled with, or reflected in laws, societal customs, cultural practices, taboos, etiquettes, etc. They are perceived as universal and timeless, not as timely or context-bound. They are anchored in simple rationality, not specialized knowledge. They are uncompromising in their demands; they transcend laws, politics, economics, customs, social practices and even cultures. For example, any law, custom or social practice that is unethical must be rejected, whereas no particular action or practice can ethically be justified simply by stating that it is the law, custom or social practice. A morally bad law, custom or social practice must be rejected.

However, moral/ethical norms are not absolute or exception-less. The moral rule that we may not kill can, for example, justifiably be violated in self-defence against an assailant bent on killing. Moral rules or norms need plastic firmness and flexibility, not cast-iron rigidity; they do not have application *in abstracto.* To apply them is to place them in particular, contextual situations, and they are then like water. Water poured into a container immediately assumes the shape and colour of the vessel without ceasing essentially to be water (Tangwa 2004, p. 67). Thus, what is of critical importance is for every person, every culture and every part of the world, every specialized profession, to reflect on the

applicability of these principles in their own particular context and situation, and to draw from them appropriate practical rules of procedure. There is no doubt, for example, that the Hippocratic Oath intuitively captures some of the basic elements of the ethics of therapeutic medical practice but, in our age and time, Hippocratic ethics is evidently insufficient and incapable of providing clear guidance for diagnostic and preventive medicine, let alone for emerging contentious issues, such as those arising from stem cell therapies, technologically assisted reproduction, biobanks, etc. Ethical reflection/deliberation is necessarily a perennial and continuous human imperative; and nowhere is this more evident than within professional occupational ethics, with its daily ethical dilemmas and perplexities.

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Annex 2. History of the ICOH Code of Ethics

The 1992 Code

The ICOH International Code of Ethics for Occupational Health Professionals was first published in English and French in 1992, reprinted in 1994 and 1996, and re-published following review in 2002. Since then, the Code has been translated into Spanish, Portuguese, Japanese, Italian, Chinese and Greek.

The preparation of an International Code of Ethics for Occupational Health Professionals was first discussed by the Board of the ICOH at its Congress in Sydney in 1987. A code text was drafted and distributed in a series of consultations during 1990 and 1991. The Code of Ethics for Occupational Health Professionals was adopted by the ICOH Board in November 1991. It was henceforth referred to as the ICOH 1992 Code of Ethics.

The 2002 Code

After adoption of the 1992 Code, the ICOH Board convened a Working Group for review of the Code in a project to be coordinated and chaired by George T. Coppée (Belgium). The review project came to involve, as well as G.T. Coppée as chair, the following ICOH members and consultants: P.H. Grandjean (Denmark) from 1992 to 1997, G. Schaecke (Germany), W.M. Coombs (South-Africa), Ron. J.L. Baudouin (Canada), A. David (Czech Republic), and M.S. Frankel (USA).

From 1998 onwards, the following ICOH members were involved: T. Guidotti (USA), J. Jeyaratnam (Singapore), T. Kalhoule (Burkina Faso), K.Kogi (Japan), M. Lesage (Canada), M.I. Mikheev (Russian Federation), T. Nilstun (Sweden), S. Niu (China), T. Norseth (Norway), I. Obadia (Canada), C.G. Ohlson (Sweden), C.L. Soskolne (Canada), B. Terracini (ltaly), K. van Damme (Belgium), and P. Westerholm; and from 2000 onwards: C-F Caillard (France).

The updated draft version of the ICOH International Code of Ethics was presented to the ICOH Board in 2000, circulated and reviewed within the ICOH during 2001, and adopted by the Board of the ICOH on 12 March, 2002.

Both the 1992 and 2002 versions of the ICOH International Code of Ethics laid down general principles of ethics in occupational health. In essence, these are still valid. Despite this, the ICOH Board anticipated a need to update the Code, with a view to strengthening the

relevance of its contents in all contexts where occupational health is practiced. The ICOH Code needs to be regularly reinterpreted, using terminology in current use, so as to address the issues of occupational health ethics that continuously arise in public and professional debates.

The ICOH Board decided in 2008 to review the 2002 Code, and commissioned the Working Committee on Ethics and Transparency of the Board to perform the task at a Board meeting on March 26, 2009 in Cape Town, South Africa.

The 2012 Code

The Working Committee – initially consisting of ICOH Board members Peter Westerholm, Sweden (Committee Chairman), Giovanni Costa (Italy), Michel Guillemin (Switzerland), John Harrison (UK) and John Howard (US) – was expanded to a Working Group, named the Code Review Group, by affiliating ICOH members Jean-Francois Caillard (France), Sergio Iavicoli (ICOH Secretary General). ICOH members Julietta Rodriguez-Guzman (Colombia), Seichi Horie (Japan), Leslie London (Republic of South Africa) and Professor Godfrey B. Tangwa (Cameroon) were affiliated to the group for contacts with occupational health professional networks in Latin America, Asia and Africa.

A task group was constituted to address Ethical Code issues related to cultural context on the African continent, with members Godfrey B. Tangwa (Cameroon), Leslie London (Republic of South Africa), Reginald B. Matchaba-Hove (Zimbabwe), Aceme Nyika (Zimbabwe), Nhlanhla MKhize (Republic of South Africa), and Remigius N. Nwabueze (Nigeria). Godfrey B. Tangwa (Cameroon) was commissioned to author a memorandum on 'Fundamental Principles of Ethics', with a view to providing a supporting, supplementary document to the revised Code.