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SCIENTIFIC CONTRIBUTION

Models of occupational medicine practice: an approach to understanding moral conflict in "dual obligation" doctors

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Abstract In the United Kingdom (UK), ethical guidance for doctors assumes a therapeutic setting and a normal doctor–patient relationship. However, doctors with dual obligations may not always operate on the basis of these assumptions in all aspects of their role. In this paper, the situation of UK occupational physicians is described, and a set of models to characterise their different practices is proposed. The interaction between doctor and worker in each of these models is compared with the normal doctor–patient relationship, focusing on the different levels of trust required, the possible power imbalance and the fiduciary obligations that apply. This approach highlights discrepancies between what the UK General Medical Council guidance requires and what is required of a doctor in certain roles or functions. It is suggested that using this modelling approach could also help in clarifying the sources of moral conflict for other doctors with "dual obligations" in their various roles.

Keywords Occupational medicine models · Occupational physician · Doctor–patient relationship · Dual obligation · Moral conflict · Fiduciary obligations

Introduction

In 2009, the United Kingdom (UK) General Medical Council (GMC) updated its guidance to doctors on confidentiality,[1] with supplementary guidance,[2] including a section entitled "Disclosing information for insurance, employment and similar purposes",[3] which clearly applied to doctors with "dual obligations",[4] including occupational physicians (OPs). One of the requirements was for the doctor to "offer to show your patient, or give them a copy of, any report you write about them for employment or insurance purposes before it is sent".[5] This provoked great consternation amongst OPs. Most had been used to offering a copy of their report to the worker at the same time as to the employer or pension fund manager. Having to offer the report to the worker before the commissioning party however, could have significant implications to the way they practised. The UK Faculty (FOM) and the Society (SOM) of Occupational Medicine issued a joint statement which reflected this unease[6]: "Publication of this (GMC) guidance has caused widespread concern among OPs about the practical difficulties associated with compliance and unintended consequences relating to the impact that it may have on the perceived impartiality of reports".[7] In practice,

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[1] GMC (2009a).

[2] GMC (2009b).

[3] p 22–26.

[4] The GMC (2009b) p 24 state that "dual obligations arise when a doctor works for or is contracted (such as) by a patient's employer, an insurance company, an agency assessing a claimant's entitlement to benefits, the armed forces". The British Medical Association (BMA) (British Medical Association 2012) p 649 describes these as "situations where doctors have clear obligations to a third party that can be in tension to the obligation to the patient".

[5] p 23.

[6] For example, an applicant who had been found not to meet the medical criteria for an early pension release due to ill-health, could simply refuse consent for this report to be released, and seek a more favourable opinion at a later date from a different physician.

[7] FOM, SOM (2010).

OPs and occupational health (OH) providers have since changed their processes and consent forms to address this.[8] However, I suggest that there is a more fundamental reason why such ethical guidance does not sit comfortably with OM practice. I aim to show that the very nature of the doctor–patient relationship (DPR) is sufficiently different in OM practice compared with the therapeutic setting, for the same ethical rules to be at times incongruent in the former context.

To achieve this aim, I will describe OM as it is practised in the UK, and propose a set of models distinguishing the different OP roles and facilitating clearer comparisons between the OP situation and the normal therapeutic DPR.

OM in the UK

OM is that branch of medicine that deals with the effects of work on health, and of health on work.[9] In the past, an OP[10] would have been mainly concerned with the effects of toxic hazards in the workplace on the health of workers, but as work environments in the UK and other developed countries have become increasingly better controlled and safer,[11] the emphasis has shifted to assessing whether workers meet the appropriate medical standards for their occupation, that is, their fitness for work. A UK survey reveals that 75 % of OP working time is spent on attendance and absence assessments (Suff 2007). Thus the majority of an OP's time is spent in consultations to which the worker would have been referred by his manager for advice on fitness for work, and in a number of these cases, whether the worker would meet a pension scheme's criteria for early retirement on the grounds of ill-health[12] (IHR).

There are several other features of OM in the UK which may have a bearing on the OPW interaction. Firstly, in the UK, OH departments do not provide treatment services, except for first aid. Secondly, although the National Health Service (NHS) provides this treatment service, it specifically does not provide a National *Occupational* Health Service, so OH is largely *not* state funded.[13] Thirdly, although OH is mainly employer funded, there is no legal obligation on employers to fund this,[14] which is a different situation to that in some other European countries.[15] Lastly, there has also been a growing trend for OH services to be outsourced from in-house services to external commercial providers.[16] These background factors in UK OH provision may also contribute to some of the particular tensions that can arise between employers, OH professionals, and workers. However, before I describe the OP-worker (OPW) interaction in this context, the normal doctor–patient relationship will first be discussed, as this may clarify any differences between the two types of interaction.

The normal doctor–patient relationship (DPR)

Trust is said to be "intrinsic"[17] to the DPR.[18] O'Neill (2002) has described the DPR as a "paradigm of a relationship of trust … It is a professional relationship that is supposed to be disinterested, long-lasting, intimate and trusting".[19] Similarly, Brazier and Lobjoit (1999) have commented: "Patients trust doctors, nurses and other health professionals with intimate details of their lives which they may even conceal from their families".[20]

Although this paper aims to highlight the differences between OM and all therapeutic medicine, rather than specifically between OM and general practice,[21] the importance of the DPR in the GP context has been described as its "central distinguishing feature" by Rogers

[8] For example, most consent forms for disclosure of a report now offer the opportunity for the worker to read it 2 to 5 days prior to sending to the employer.

[9] It is also part of the wider discipline of OH, which also includes nurses and physiotherapists, as well as ergonomists and occupational hygienists.

[10] An OP is a registered medical practitioner who has undertaken specialist training and qualifications in OM.

[11] For example, in Centre for Workforce Intelligence (2011): "Industry has changed from a manufacturing to a service majority over the last 20 years and this trend may continue. The main hazards have changed from dust, heat, noise and vibration to workplace pressure".

[12] For example a survey reported in Ballard (2011) found that 17 % of OPs list "dealing with IHRs" amongst their top three priorities (p 22).

[13] FOM (2010a) p 7.

[14] However, there is a statutory requirement for health surveillance of workers working with certain chemicals, or exposed to certain physical or biological hazards, for example, The Control of Substances Hazardous to Health Regulations 2002 SI 2002/267, and The Control of Vibration at Work Regulations 2005 SI 2005/1093.

[15] See for example: WHO Regional Office for Europe (2002) at p 3.

[16] See for example in: FOM (2010a) p 3 para 4.

[17] For example, De Zulueta (2007) p 14.

[18] However, many authors point out that there is not a "single" DPR, and have proposed various models to describe the different types of DPR. See for example Szasz and Hollender (1956) and Emanuel and Emanuel (1992).

[19] p 17.

[20] p 187.

[21] Also known as Family Medicine (FM), but "General Practice" is more commonly used in the UK. A definition of GP/FM by WONCA (2011), the World Organisation of Family Medicine, describes GPs as "personal doctors" (at p 8). In the UK, the GP is usually the first point of medical contact for most patients, other than for accidents and some emergencies, refers to specialist or other health services where appropriate, and maintains a long term relationship with his patients.

and Braunack-Mayer (2009),[22] so the differences in the nature of the relationships may be more obvious between OM and GP. They also suggest that "trust in one area need not extend to trust in other areas. A patient may trust the goodwill of their GP in terms of confidentiality, affability, honesty and the like, but may not trust their competence in some clinical areas."[23] Likewise, O'Neill (2002) felt that she "might trust (her) GP to diagnose and prescribe for a sore throat, but not for a heart attack."[24] She also pointed out that polls show that doctors and judges are far more trusted than politicians and journalists.[25] Patient trust also appears to be the salient feature of the DPR on which the regulatory authorities, in the UK at least, base their ethical guidance to doctors: "Patients must be able to trust doctors with their lives and health."[26]

Although there may be different degrees of trust involved in different contexts, and trust may be situation- or condition-specific (such as the diagnosis of a sore throat rather than of a heart attack) there seems to be little doubt that trust is an essential component of the normal DPR.

The central role of trust in the DPR has led some authors to advocate that this relationship is subject to a fiduciary principle.[27] However, although trust is a requirement for a fiduciary relationship, it is not in itself sufficient grounds to claim that a relationship is fiduciary in nature. The duties imposed on the fiduciary to the beneficiary or vulnerable party are largely due to the power imbalance between the two parties. Such a power imbalance is said by Kennedy (1996)[28] to be evident in the DPR:

"The doctor–patient relationship has special, perhaps unique, features. Principal among these is the very significant disequilibrium of power between the two parties. The patient is uniquely vulnerable, being not only ignorant of the expertise constituted by the practice of medicine but also, in most cases, ill and anxious or anxious about possibly being ill. By contrast, the doctor has expert knowledge."

Brody (1992) has drawn attention to the importance of the doctor's *power* in the therapeutic relationship, breaking this power down[29] to Aesculapian power (deriving from the medical knowledge and skills), social power (doctors generally coming from socially and educationally privileged backgrounds), and charismatic power (he postulated that many drawn to medicine would have this). The Law Commission (1992) has summarised the duties that arise in fiduciary relationships,[30] and Bartlett (1997)[31] amended these for the doctor–patient context:

1. Fiduciaries must avoid conflicts of interest, or indeed even possible conflicts of interest, with the vulnerable party. (The "no conflict" rule).
2. Fiduciaries must not profit from their position without prior disclosure to and authorisation from the vulnerable party. (The "no profit" rule).
3. The fiduciary owes a duty of undivided loyalty to the vulnerable party. (The "undivided loyalty" rule).
4. The fiduciary owes a duty of confidentiality to the vulnerable party. (The "duty of confidentiality").

Bartlett, Grubb (1994) and Brazier and Lobjoit (1999) have all presented strong arguments in support of the fiduciary nature of the DPR, although Kennedy (1996)[32] objects to this mainly on the basis that it "entrenches the paternalism and power of the doctor".

OM models

I propose three models to describe the current UK OP-worker (OPW) interactions, accepting that this may not be exhaustive.

Model 1: The "quasi[33]-therapeutic" model

As mentioned previously, OH services do not provide treatment in the UK, except for first aid. Some argue that because some OH departments administer vaccinations (such as against hepatitis B in health care workers, or for business travel) or can refer workers for physiotherapy or counselling, these constitute some element of "treatment", or at least of clinical care. On the other hand, although truly "therapeutic" encounters may be not part of OM in the UK, there are instances where OPW interactions may come close to being indistinguishable from the traditional doctor–patient ones, especially where a worker self-refers to the OH service or to the OP for advice. Although the OP cannot prescribe or treat in this scenario, the encounter is often similar to a therapeutic one, in terms of the doctor giving advice, and presumably the worker trusting this advice, having sought it in the first place, hence a "quasi-therapeutic" encounter.

[22] p 2.

[23] p 31.

[24] p 9.

[25] p 10. A recent poll commissioned by the BMA, Munn (2011), also confirms that the public trusts doctors far more than politicians.

[26] GMC (2006).

[27] See for example: Dyer and Bloch (1987) p 15; and Brazier and Lobjoit (1999) p 187.

[28] p 111.

[29] p 62.

[30] para 2.4.9.

[31] p 198.

[32] v 131–132.

[33] As in "seeming to be something but not really so", Oxford Essential English Dictionary, Oxford University Press, 2011.

Model 2: The "independent[34] expert" model

This model describes work such as IHR applications,[35] where the OP assesses the evidence presented (including specialist reports and evidence of attempts at workplace adjustments) against the medical criteria of the pension scheme. It would have similarities with expert witness work that doctors of any speciality can carry for the courts. However, for IHR medical assessments, it is the submitted evidence rather than the individual that is being assessed, so the applicant does not even have to be present in person[36] at a "consultation". One would expect the same advice by the GMC given to UK expert witnesses to apply,[37] for example in terms of the requirement to be "honest, trustworthy, objective and impartial".[38] This makes it clear that the expert's position is to be unbiased. In contrast, in an adversarial legal system, a lawyer must "present his client's best case and draw the court's attention to the weaknesses of the opposing party".[39] Both sets of ethical obligations, for the expert to be unbiased on the one hand, and for the lawyer to be biased[40] on the other, are clear and unequivocal (albeit with some qualification for the lawyer). One would like to believe that other doctors (in a non-expert role) are also bound to be objective, unbiased and impartial in their judgments and their advice, but clearly this could be in conflict with their "duty of undivided loyalty" to their patient. This leaves them in the uneasy position where their duties from the two sets of obligations can be in direct opposition to each other.[41]

Model 3: The "impartial[42] doctor" model

This model will be used to describe the majority[43] of OP work, which usually arises from referrals by managers, asking for advice on workers' fitness for work, or health aspects of attendance or performance problems. Although the FOM recognises the need for OPs to be impartial,[44] it does also stress that OPs, like other registered medical practitioners, have an ethical responsibility to put the interests of individual patients first. Thus a physician, learning of a health risk to a worker, has "a responsibility to protect the health of the employee, even if this is to the detriment of the employer".[45] In the context of a health risk from work, this is understandable. However, in the UK workplace stress and musculoskeletal problems have become the predominant occupational illnesses. These are often more multifactorial in causation, and it remains an OP's responsibility to advise on such matters. But what does "putting the interests of individual patients first" actually mean in such cases? The employer may argue with some justification that it is the role of the GP to put the interests of his patient first. So in the UK, where the employer pays for the OP's advice, if this were to be no different to that received from a worker's GP, then the employer might question the value of paying for an OP's advice at all. An example would be where a worker suffers from work-related stress, which he alleges is caused by his manager bullying him. A report from his GP, if one were obtained, would be heavily biased towards his patient.[46] However, in many cases, there are other factors that may be relevant, such as feedback on poor performance by the manager to the worker prior to the alleged bullying. The OP should have a more balanced account of the situation, and be able to recommend more objective approaches, such as the use of stress risk assessments[47]or workplace mediation. If the OP were also simply to "put the patient first" in such circumstances, there is a risk that UK employers

[34] For example, the term "independent" is used in the title "Independent Registered Medical Practitioner" (IRMP) in the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007. The IRMP signs the certificate including the following statement: "I have not previously advised, or given an opinion on, or otherwise been involved in this case, nor am I acting or have ever acted as the representative of the member, the scheme employer or any other party in relation to it". Similar terminology is used in some other public sector pension schemes, such as "IQMP" (Independent Qualified Medical Practitioner) for the Firefighters' Pension Scheme Order 1992.

[35] Other work that would fall in this category includes OPs sitting on Medical Appeal Boards for these pension schemes.

[36] For the NHS Pension Scheme, which is the largest in the UK, virtually all are done remotely.

[37] GMC (2008).

[38] para 14.

[39] Devaney (2012).

[40] However, he must not knowingly mislead the Court (Bar Council 2012, paragraph 302).

[41] It is beyond the scope of this paper to offer a solution to this situation, except to note this intrinsic tension in the therapeutic role. It is the aim of this paper however to show that the differences between a treating doctor and an OP are such that in some aspects of the OP role (as expert, or model 2), this ethical conflict should not exist.

[42] "Impartial" being defined as "not favouring one person or side more than another", Oxford Essential English Dictionary, Oxford University Press, 2011.

[43] 75 % of their workload, as previously mentioned, from the survey reported in: Suff (2007).

[44] "Occupational physicians also need to build good relationships with *managers*. Integrity, respect, good communication, and a focus on *impartial* (emphasis added) evidence-based medical advice are important elements in building a relationship of trust in which patients' health problems and health and safety issues can be discussed constructively", FOM (2010b) p 12.

[45] FOM (2006) p 4.

[46] This is not intended to be a criticism of the GP, as the latter is clearly expected to put his patient first, and in addition he would have only one side of the story.

[47] See for example http://www.hse.gov.uk/stress/standards/downloads.htm.

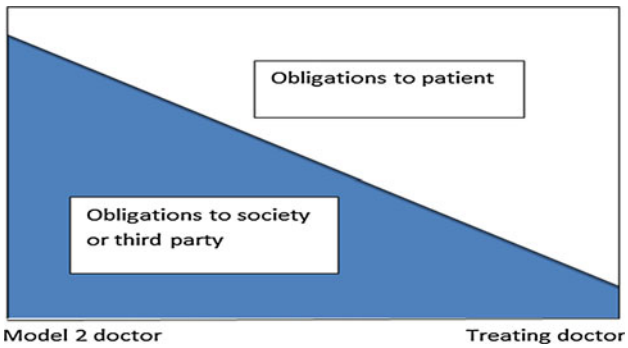

Fig. 1 Obligations to patients v. society in model 2 and treating doctors

would largely cease to fund OH services,[48] especially as only a small proportion of OH work is legally required.

OM models and moral implications

In model 1 ("quasi-therapeutic"), the OPW interaction is the closest to that between a doctor and patient in a normal DPR. Although a worker may not need to trust the OP with his "health and life", given that the OP will not carry out life-saving or other major interventions, he still needs to trust the OP to the extent that he is taking advice from the latter. Similarly, the power imbalance may be similar to that in the DPR, as the worker is generally in a position of knowing less than the OP about the health matter of concern. The main difference compared with the normal DPR is that fewer workers are likely to be as vulnerable as patients through pain and suffering, although some workers will seek help when they are distressed, especially if they have the facility to self-refer to the OH service. Given the similar levels of trust required and power imbalance in this model to the normal DPR, it is likely that the fiduciary obligations that arise in the normal DPR may also apply in model 1. Indeed, three of the four "central principles"[49] of a fiduciary relationship, namely the no conflict rule, the no profit rule, and the duty of confidentiality, seem appropriate in this context as well. On the other hand, the fiduciary's duty of "undivided loyalty" to the vulnerable party is less easy to support, given the OP's duty to the employer, and also to third parties if they could be harmed, for example. Although it could be argued that even in a therapeutic relationship, doctors also have obligations to third parties,[50] there is likely to be a difference of emphasis: the treating doctor usually puts his patient's interests first.[51] This is illustrated in Fig. 1.

This figure illustrates the continuum between the two sets of obligations and the two extremes of the doctor role. However, for the purposes of this paper I will consider the treating doctor's obligations to be mainly towards the patient, and the model 2 doctor to be mainly towards the third party, although this is clearly an oversimplification. In OM practice this different emphasis can be reflected in disagreements between the patient's treating doctor, such as the cardiologist of a train driver with a heart problem, and the OP who has to advise the employer on the risk assessment. The cardiologist may feel that the residual risk posed by his patient in terms of a sudden incapacitating event to be acceptable, but an employer or the public may take a different view.

In model 2 ("independent expert"), the OP acts as an expert assessor of evidence, for example for pension funds. There may be no direct contact with the worker (or applicant) in the UK, as the major public sector pension funds[52] use systems which involve the OP usually only reviewing the submitted evidence, and then presenting their advice or decision to the employer or pension fund managers. If there is any relationship at all between the OP and applicant, it would be, at best, an "arm's length" one, and therefore the level of trust required by the applicant would differ markedly from that expected of a doctor to whom he entrusts his life and health, or even accepts advice from. It would be limited to trusting that the OP has the appropriate training and qualifications to carry out this assessment, and will perform it competently and objectively. Such a level of trust bears little or no resemblance to that in the normal DPR, and would be more akin to that type of trust that we would have on a day to day basis in many individuals would provide us with a particular service, such as a surveyor assessing a building for electrical safety, and providing the required certificate.[53] Similarly, a power imbalance is less evident, or at least arguably less relevant.

[48] One of the consequences would be that less OH would then be available to UK workers, arguably to their detriment, as they would have even less access to expert advice and diagnosis for work-related conditions.

[49] As described by Bartlett (1997).

[50] For example Gillon (1985), p 158: "despite this acceptance (of obligations to society) doctors often talk and think as if they believe that they invariably give absolute moral priority to their patients over the moral demands of society". The GMC appear to reinforce this message: "you must make the care of your patient your first concern" (GMC 2006).

[51] In their role, one would find this partiality towards their patient acceptable, similar to Holm's (2011) arguments in support of such partiality in the context of public health care systems.

[52] This is the case for the largest fund, the NHS Pension Scheme. The other schemes may involve either a similar paper review, or a face-to-face assessment of the applicant.

[53] For example, if the property is to be let.

However, the OP is still in a some position of power,[54] as his advice or decision will determine whether the early release of the pension on ill-health grounds will proceed or not, and the applicant is in a position of vulnerability for the same reason. On the other hand, if there is no real relationship between the two parties, then the power imbalance seems to be an artificial consideration here. For example, although there is a clear power imbalance between a judge and a defendant when in court, this is not relevant in that context, and does not affect the validity of the process. The main reason for highlighting the power imbalance in the normal DPR (and other fiduciary relationships) is to provide the vulnerable party with some protection, by placing obligations on the fiduciary. In this model, the application of Bartlett's fiduciary principles to this context sits the least comfortably. One would not deny the need to avoid a conflict of interest or the OP profiting from his position, although it is difficult to see how the latter could do this, given the remoteness between the two parties. There could also be a need for some degree of confidentiality, although in practice most if not all the information will have been gathered by other parties beforehand. For example, the OP could find reference to distressing details in a psychiatric report about child abuse, and should be careful not to include such details in his report to the pension fund manager or trustees. However, such instances are rare, and a report for pension purposes will mainly concentrate on the applicant's ability to work, to perform certain tasks, and the likely permanence or otherwise of any health conditions and impairments. The fiduciary principle that would be completely incompatible with the OP's role would be the "duty of undivided loyalty", otherwise he could not give independent advice as required by the pension schemes.

Model 3 ("impartial doctor") represents the majority of OPW interactions in the UK, and reflects the need for OPs to be impartial in a "dual obligation" system. The types of interactions and obligations are more difficult to characterise, given the wide range of activities that are included here. However, that range can be illustrated by two examples[55] of activities in this model: on the one hand, for "health surveillance"[56] activities, the OP may be towards the right of the Fig. 1 "model 2/treating doctor axis". That is, there is significant obligation towards the worker, as this activity concerns protecting workers' health from workplace agents.[57] On the other hand, for sickness absence referrals (the majority of OP work) the OP would be more to the left of that axis, as usually this is more for the employer's benefit. From a relationship perspective, model 3 is in the "middle ground"[58] between models 1 and 2, and the worker may be somewhat disappointed that the OP is not "taking his side". In the normal DPR, the importance of trust and the power imbalance in that relationship is very evident. It is not suggested that in this third model, trust or power imbalance play no part. Rather, it is likely that the nature and extent of any trust and power imbalance are different. As O'Neill points out, we can trust individuals in some matters but not others,[59] or to different extents. For example, in the DPR, patients should be able to "trust doctors with their lives and health".[60] This level of trust is not required from workers in the normal OH consultation. Indeed, it would be rather surprising if anyone expected such a level of trust. On the other hand, one would hope for some trust in the OP, for example of his competence at evaluating health and work issues (although some workers challenge this when the assessment results are not to their liking), and of his honesty and integrity (although this trust becomes less evident when increasing emphasis is placed on signed consent(s), and a worker reading the report before its issue). Similarly, in the normal DPR it is argued that the power imbalance arises partly from the patient being ill and more vulnerable than he would otherwise be, and partly from the doctor's power. In the OPW situation, the worker is often not ill, but may still be more vulnerable through lack of expert knowledge, which the OP will have. However, there are also situations where the power imbalance shifts in the opposite direction, for example, when workers attend with their union representatives who can be very knowledgeable on the relevant issues, or be coercive (such as threatening to refer the OP to the GMC) if the favourable outcome were not obtained for their member. Although such situations are relatively rare, they

[54] On the other hand, the power imbalance can be reversed, for example when the applicant or his union representative threatens the OP with referral to the GMC and the courts if early ill-health retirement is not recommended.

[55] Although these examples serve to illustrate the different levels of obligations in model 3, the main aim of this paper is to demonstrate that at the extremes (i.e. models 1 and 2), the underpinning ethical reasons for doctors' obligations are different, so that the anomalies and conflicts arising in the ethical guidance are due to its being based on wrong assumptions. .

[56] That is, monitoring workers' health from workplace exposures to chemical, physical or biological agents, under legislation such as mentioned at ref (14).

[57] However, this is also to a lesser extent for the benefit of employers, for example, in discharging their duties under health and safety legislation.

[58] But as seen from the examples, the middle ground is not a fixed point on the Fig. 1 "model2/treating doctor axis", but will vary according to the type of activity, and maybe the context.

[59] O'Neill (2002), where at p 9 she gives the following examples: "I might trust a schoolteacher to teach my child arithmetic but not citizenship … I might trust my bank with my current account, but not my life savings.".

[60] GMC (2006).

Table 1 Trust, power imbalance and fiduciary obligations in the three OM models compared with normal DPR

	Normal DPR	Model 1 "QUASI-THERAPEUTIC"	Model 2 "INDEPENDENT EXPERT"	Model 3 "IMPARTIAL DOCTOR"
Trust	Very important	May be similar to normal DPR	Very limited	Limited. For example, that even in a non-therapeutic context, certain professional standards will apply
Power imbalance	Usually significant	May be similar to normal DPR	May not be relevant	Variable
Fiduciary obligations 1. No conflict (of interest) rule 2. No profit rule 3. Duty of undivided loyalty 4. Duty of confidentiality	Consistent with all four fiduciary central principles	May be similar to normal DPR, except for duty of "undivided loyalty"	Fiduciary obligation of "undivided loyalty" is totally incompatible as independence is essential	Limited fiduciary obligations

serve to illustrate that the power imbalance may not always be as one imagines it to be.[61]

OPs aim to be impartial whichever model they are operating in, as it is a requirement of their function. Nonetheless, it is a difficult balance to achieve in everyday practice.[62] In model 1, where the relationship may be close to the DPR, there is probably a greater risk that the OP could develop a closer affinity with the worker's views, although he may not recognise this himself. However, even in this model, if the outcome of that consultation were unwelcome by the worker, the OP is still not bound by a "duty of undivided loyalty". Indeed, the duty of undivided loyalty cannot be expected of the OP in any of the three models, although the incongruity of expecting such a duty in OPW interactions is most evident in model 2, where the independence of the OP is essential. If in the DPR, trust and power imbalance are of central importance in the analysis of that relationship, then it is suggested that in this third model, the emphasis should be on the *impartiality* of the OP. This need for impartiality can create tensions with the worker and the employer (and other stakeholders, such as "the public"[63]).

Other doctors with dual obligations, such as in sports, insurance[64] or military medicine, may also be in situations where some of their roles fit the normal DPR paradigm, but at other times be in roles where that paradigm does not apply.[65] In the latter cases, as with the OM situation, different ethical guidance for the situations that are similar to models 2 and 3 that recognises these differences may help to reduce or resolve moral conflicts.

Table 1 summarises the main differences described above.

[61] It is accepted that even in the DPR, a GP may occasionally feel threatened by his patient, and prescribe some medication or write a certificate, against his better judgment.

[62] These models are intended to be a description of current UK OM practice, rather than what it ought to be. It is accepted, for example, that if OH provision became state rather than employer funded, this would change the pressures arising from the employer-OP relationship. Alternatively, OPs could adopt a definite servant-master approach with employers, which arguably would make it clearer for all parties to understand the OP role(s). However, whether one of these, or other approaches were to be pursued, it would still take some time to come into effect. In the meantime, it is hoped that a clearer understanding of the different tensions, and why they arise, will help OPs in their practice, and regulators producing ethical guidance.

[63] For example, passengers and other members of the public, when a train driver suffers from epilepsy and does not want this to be disclosed by the OP.

[64] For example, Grubb (1994) p 334, opines that the insurance medical context would not give rise to a fiduciary relationship: "One of the most important conditions for the (fiduciary) duty to arise is absent: an entrusting of power by the beneficiary which is to be exercised *only for his benefit*." This condition is also absent in OM models 2 and 3, and presumably in some sports medicine and military medicine situations.

[65] It is envisaged that the equivalent of models 1 and 2 could be reasonably clearly established for other dual obligation disciplines, though they would be different to the OM models. For example, in sports medicine, model 1 would actually be therapeutic, and the arm's length model 2 arises for example during a pre-transfer medical assessment of a prospective team player. The middle ground, model 3, could arise for example when the team coach wanted a player recovering from injury to play possibly too early in an important match, and the club doctor had to advise.

Conclusion

Ethical guidance for doctors is usually based on the assumption that a normal DPR exists. By using the modelling approach in OM, it becomes evident that not all OPW interactions fit this assumption. On the one hand, in model 1 the OPW interaction is close to the normal DPR, and therefore not surprisingly most of the ethical constraints in a normal DPR make sense in model 1. At the other extreme, when the interaction is very "arm's length" (model 2), most of the underlying assumptions used in the normal DPR are incorrect in that situation. The fiduciary obligation of undivided loyalty, for example, is incongruous if applied in a context where independence is essential. In model 2, the ethical requirement (by the GMC) for the OP to offer to show his report (of an independent assessment) to the applicant before submitting it to the employer or pension fund manager would be akin to a judge offering a defendant first sight of his judgment, and requiring the defendant's consent before delivering it. It would be helpful if regulators such as the GMC could make a distinction between these different situations, and adjust the guidance to reflect the reality of the different OM roles.

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