# Occupational health physicians: unwilling or unable to practise ethically

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David Kern discovered a cluster of cases of interstitial lung disease among employees of Microfibres Inc. a synthetic textile manufacturing company in Rhode Island (1). Dr Kern was head of the department of occupational and environmental health at Brown University's school of medicine, Rhode Island, USA. At first accepted as consultants by the plant management, the team met increasing resistance to its efforts as it uncovered evidence of work-related causes of the disease and attempted to communicate its findings to both workers and the union. Ultimately the plant's management dismissed the occupational medicine team and threatened legal action if it presented or published its scientific findings. Both the hospital and university administrators attempted to thwart the team's efforts to publish its findings, and colluded in summarily terminating the occupational health programme and Dr Kern's employment contract.

The Kern saga illustrates the conflict-prone nature of the practice of occupational medicine. Even if one tries to ignore the politics, the potential for conflict is ever present. Private medical schools struggling for funds depend on industry. Hence it is not surprising that the services of Dr Kern were terminated. He got a lot of support online from professionals all over the world, but in the end it was business as usual for the company.

In Bangkok, Thailand, Dr Orapun was head of the occupational health department, a governmental body. She recorded cases of lead poisoning among workers of the multinational company Seagate that manufactures PC hard disks. The Thai government sacked Dr Orapun and her staff and shut down the occupational health department.

The above two incidents, one each from a developed and a developing country, are common wherever economic motives prevail and workers are put at risk for the sake of 'competitiveness'. Threats of factory closure or relocation are made to hold off investments required to address health risks.

In newly industrialised economies like South Korea, the situation is very bad for the occupational health physician. Let us take one example. A series of cases of carbon-di-sulphide poisoning was noticed in the Wonjin Rayon plant which had been imported into south Korea from Japan in the 1960s. Dr Rokho Kim served as an independent medical consultant in the case. Some victims were compensated after a long drawn-out struggle between the union and the management. One worker, who had been diagnosed as Carbon -di-sulpfide poisoning by Dr Kim, was denied access to medical treatment by a new medical committee (set up after the government thought that Dr Kim was too close to the workers), and hence died of cerebral haemorrhage within two months. After the worker died, it became a public scandal when the widow refused to have a funeral, but instead decided to stage a sit-in demonstration with other poisoned workers, placing her husband's coffin in front of the company gates. The sit-in lasted four months and faced severe police atrocities.

Dr Kim's performance as an occupational physician was at odds with the interests of business and the authoritarian government. His harassment continued for many years. When he was to leave for Boston for his doctoral training, at the last minute he was stopped at the airport and his passport confiscated. He was forced to co-operate in his own investigation. He was brought to a cell in a secret police building in central Seoul for questioning. It was a notorious torture chamber. (In 1987, a college student was tortured to death by drowning in such a cell.) There was a one-way mirror at the door where superiors taped the interview for review. All this was done without a warrant. He was asked about his college friends and asked repeatedly if he was a communist (professing communist ideas is illegal under the National Security law of South Korea). The accusations ranged from questioning his editorial writings (purportedly containing socialistic ideas) to alleging that he had instigated the company to go on strike. His family members also were questioned and humiliated. Many years later he was cleared of all accusations except one: the crime of 'interfering with business.

In India even though our law does not penalise the person for diagnosing an occupational disease, doctors take the easy way out by not issuing medical certificates that a disease was contracated as a result of the person's occupational risk. In 1995, to take one example there was no occupational disease recorded in the annual report of the Workmen's' Compensation Act (2). Studies sponsored by industry in medical colleges would obviously not talk about occupational disease. Even if they do discover occupational diseases in the course of the study, they are kept secret, and this information is inaccessible even to the institution, leave alone the affected worker. Hence in matters of occupational and environmental health, doctors must take sides if people and society are to benefit.

**References:**

1. Kern David G. The unexpected result of an investigation of an outbreak of occupational lung disease. *Int J Occup Environ Health* 1998;4:19-32.

2.Annual review of the Workmen's Compensation Act, Government of India, 1995.

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## Absentee doctor

An inquiry into the the death of a patient in an isolation cell at the Government Mental Hospital, Chennai, found he was seen by a doctor only twice in the 20 days between his admission and his death.

Mani MK. Letter from Chennai. *National Medical Journal of India* 2002; 15: 44-45.