UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Law

The impact of dual loyalty on health care practitioners' decisions

By

Dr Dipalesa Mokoboto

Submitted in fulfilment of the requirements for the degree

Master of philosophy in Medical Law and Ethics

In the Faculty of Law,
University of Pretoria

April 2019

Supervisor : Prof P Carstens

Co-supervisor: Dr W Oosthuizen

TABLE OF CONTENTS

PAGE

.

TABLE OF CONTENTS ii

SUMMARY........ v

DECLARATION OF ORIGINALITY........ vi

ACKNOWLEDGEMENT........ vii

CHAPTER 1: BACKGROUND AND INTRODUCTION .... **Error! Bookmark not defined.**

1.1 Introduction 1

1.2 Background to the problem 2

1.3 Research problem........ 3

1.4 Objectives and aims of the study 3

1.5 Research questions 4

1.6 Research methodology 4

1.7 Significance of the research 4

1.8 Format of the study 6

1.9 Conclusion 7

CHAPTER 2: OCCUPATIONAL MEDICAL PRACTITIONERS, DUAL LOYALTY AND INCAPACITY 8

2.1 Introduction 8

2.2 Human rights and dual loyalty 8

2.3 The context of power and occupational health 9

2.4 Dual loyalties and conflicts of interest 10

2.5 Implications of dual loyalty on occupational health practice........ 12

2.6 Aspects of medical incapacity guidelines 13

2.6.1 Disability 13

2.6.2 Impairment........ 13

2.6.3 Medical incapacity 14

2.6.4 Inherent job requirements 14
2.6.5 Minimum health standards (MHS) 14
2.6.6 Progressive conditions 14
2.6.7 Medical incapacity management committee 15
2.6.8 Medical incapacity disputes 15
2.7 Guideline on minimum standards of fitness, required to perform work 15
Legal framework 16
2.8 Constitution 16
2.8.1 Right to equality 17
2.8.2 Right to dignity 17
2.8.3 Right to labour relations 17
2.9 The Labour Relations Act and incapacity legislation 18
2.9.1 Incapacity: Poor health and injury 18
2.9.2 Guidelines in dismissal arising from ill health or injury 18
2.9.3 Employment Equity Act (EEA) 19
2.10 Health Professions Act (HPA) 20
2.11 Medical core ethics, dual loyalty, values and standards 21
2.12 Conclusion 24
CHAPTER 3: CASE LAW ON DUAL LOYALTY (CONFLICT OF INTEREST AND OMP DECISIONS ON FITNESS) 25
3.1 Introduction 25
3.2 Conflict of interest: Principles and concepts 25
3.3 Duty to protect the interest of others 26
3.4 Characteristics of fiduciary obligations 26
3.5 The nature of a fiduciary relationship 27
3.6 Fiduciary position: Forbidding conflict of interest and duty 28
3.7 Accommodation of difference 28
3.8 IMATU v CCC (Labour Court) 29
3.8.1 The decision of the occupational health medical practitioner or OMP 29
3.8.2 According to the trade union’s submission on the employee’s behalf 29
3.9 McLean v SASOL Mine (Pty) Limited Secunda Colliery / McLean v SASOL Pension Fund 31

3.10 Conclusion 32
CHAPTER 4: CASE STUDIES ON OMP DECISIONS CONCERNING EMPLOYEE FITNESS .33
4.1 Introduction 33
4.2 Case A: Premature incapacitation of employee 33
4.3 Case B: Lacking individualised examination 34
4.4 Case C: Applying a blanket ban 35
4.5 Case D: Intolerance of physical condition of employee 36
4.6 Case E: Lacking individualised assessment and prejudice 37
4.7 Conclusion 37
CHAPTER 5: LEGISLATION, CASE LAW, CASE STUDIES AND ETHICS 397
5.1 Conclusions 399
5.2 Recommendations 411
BIBLIOGRAPHY 444

TABLE OF ABREVIATIONS.... 48

SUMMARY

While ethical codes have been established for practitioners, there is a possibility that dual loyalty affects occupational medical practitioners' (OMPs) decisions in determining fitness status of employees. Literature indicates dual loyalty of OMPs leads to ethical dilemmas. The study's main objective is to determine if dual loyalty participates in OMPs' decisions and influences OMPs to breach medical ethics required in their profession, resulting in employees unfairly losing their jobs.

The study interrogates literature review on dual loyalty and adopts a multi-layered approach focussing on the Constitution; relevant Acts and guidelines; case law and ethical principles. Case studies from the Medical Inspector's archives are interrogated to determine the influence dual loyalty has on OMPs' decision-making.

Case law indicates that conflict of interest is the source of dual loyalty. Occupational medical practitioners have fiduciary duties and need to serve the best interests of the employees. From case studies discussed, the study shows that OMPs are affected by dual loyalty and tend to disregard medical ethics. They may be conflicted when making decisions concerning employees' fitness to work, especially when individualised assessments are not conducted.

A guideline addressing ethical obligations and human rights should be drafted for OMPs, guiding them on dealing with dual loyalty. Employers will need awareness training in various institutions so that OMPs are supported and encouraged to have sound medical ethics. This will promote best practice in doctor-patient relationships, avoiding dual loyalty dilemmas.

Key words: discrimination ; dual loyalty ; fitness to work; ; human rights; individualised assessment ; medical appeal ; medical ethics ; medical incapacity; Medical Inspector ; OMP

University of Pretoria

Declaration of originality

.

Full names of student: **DR Dipalesa Mokoboto**……

Student number: **2023 1769**……………

Declaration

1. I … **Dipalesa Mokoboto….** understand what plagiarism is and am aware of the University's policy in this regard.
2. I declare that this… **mini-dissertation**… is my own original work. Where other people's work has been used (either from a printed source, Internet or any other source), this has been properly acknowledged and referenced in accordance with departmental requirements.
3. I have not used work previously produced by another student or any other person to hand in as my own.
4. I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.

Signature of student:.………………………………………

Signature of supervisor:……………....………………………

ACKNOWLEDGEMENTS

I would like to warmly thank, and confer appreciation to several people who assisted me at every point during my studies to cherish and achieve my goal:

My Supervisor, Prof P Carstens, for giving me an opportunity to study Medical Law and Ethics, providing professional guidance by teaching me a great deal about medical law and arranging different skilled lecturers, who had specialised knowledge in the different topics.

My Co- Supervisor, Dr W Oosthuizen, whose encouragement made it possible to achieve my goal and whose help and sympathetic attitude reassured me that my topic was interesting, when I was in doubt.

My employer, Department of Mineral Resources, for allowing me to improve my knowledge and skills by funding my studies.

The Medical Inspector officials, for support and assistance with administrative functions.

My three boys: my husband and two sons for their support and unending inspiration, and my youngest for consistently asking about the progress of my dissertation, keeping me on my toes.

My dad, mom, brothers and sister, who are always proud of me furthering my studies and achieving my goals, extending their support through a wicked sense of humour that helped one to de-stress.

CHAPTER 1: BACKGROUND AND INTRODUCTION

1.1 Introduction

Concerning dual loyalties concepts, medical practitioners encounter dilemmas regarding their loyalties. They encounter situations where they cannot determine whether their obligations are with their patients or their employers. Most health care practitioners are involved with third parties who are their employers. Employers may include, but are not limited to, government departments, insurance companies and mining companies, amongst others. The involvement of a third party might lead to competing obligations where the practitioner is amidst the employer and the patient. The mining industry usually hires medical practitioners with occupational health qualifications to assess the medical fitness status of employees. For this study, employees are regarded as patients. In the industry, practitioners are referred to as occupational medical practitioners (OMPs).

Alike other practitioners employed by third parties, OMPs may be conflicted concerning their decisions. Dual loyalty ensues if the health professional is entangled between the employer and the employee/patient who have certain expectations from the OMP, but these expectations might not be coordinated. The employer expects the OMP to consider that production should not be compromised, thus employees should be medically fit, with no impairment. The employee, who might acquire an occupational disease or sustain an injury in the line of duty, might expect some sympathy from the employer, and to be provided a chance to remain employed, even though in an alternative position. Employees diagnosed with treatable conditions expect to be accommodated in suitable positions until they are cured. It is stated “In several cases, health professionals who succumb to the pressure to fulfil third party needs at the expense of their patients end up breaching the ethical obligations of their profession and violating human rights of the same person who is entitled to the health professional’s strongest loyalty. Ethically, a health professional is obligated to act in the interest of the patient above all other concerns”.[1]

[1] Dual Loyalties: The Challenges of Providing Professional Health Care to Immigration Detainees. Physicians for Human Rights. March 2011.

1.2 Background to the problem

This study focusses on analysing possible dual loyalty of OMPs in the mining industry. "Every employer who establishes a system of medical surveillance must engage services of an occupational medical practitioner…"[2] The Mine Health and Safety Act (MHSA) mainly regulates the mining sector[3], addressing health and safety requirements in the mining industry. For this study, special focus is on Sections 13 and 20 of the MHSA. Section 13 provides "the employer should have a system of medical surveillance"[4]. Section 20 provides "an employee may dispute a finding of unfitness to perform work" by lodging an appeal to the Medical Inspector (MI). The Chief Inspector of Mines must "appoint an officer, with prescribed qualifications and experience as the Medical Inspector"[5]. The MI serves as a regulator, investigating and adjudicating the appeals according to Section 20 of the MHSA. This section provides employees in the mining industry an opportunity to dispute decisions of unfitness made by OMPs. These include unfair decisions, affected by dual loyalty and breaching medical ethics. Section 20 of MHSA is limited to medical related disputes and is not labour related.

Medical appeals lodged to the MI, are interrogated to ascertain if decisions pertaining to the fitness status of employees, were fair and ethical. The Act provides the MI the right to "confirm, set aside or vary the decision or finding of the OMP"[6], after the appeal was holistically considered. This process requires OMPs to provide the MI with reasons indicating why an employee was declared unfit to work, providing the MI an opportunity to assess if dual loyalty might have a function in OMPs' decisions.

---

[2] Section 13(3) (a) (i) of the MHSA, 29 OF 1996.
[3] Mine health and safety Act, 29 of 1996 and Regulations, used to regulate the mining industry concerning health and safety.
[4] Section 13(1) of the MHSA, 29 of 1996.
[5] Section 49(1) (b), (the Medical Inspector should be a medical doctor with post graduate qualifications in occupational health).
[6] Section 20(4) of the MHSA, 29 of 1996.

1.3 Research problem

Some mining companies regard OMPs as mere employees, who should disregard medical ethics when performing their duties during medical surveillance of miners. As a result, OMPs' decisions might be influenced by employers' prescriptions, especially when focussing on production. Decisions might be unfair to the mining employees, trampling on their human rights. This might result in miners unnecessarily losing their jobs. Some OMPs might discriminate against mining employees with certain conditions and channel their findings, indicating that employees might be medically incapable of performing their duties, based on inadequate reasons.

1.4 Objectives and aims of the study

The study's main objective is to determine if dual loyalty participates in OMPs' decisions and if it influences OMPs to breach medical ethics required in their profession, at the expense of the miners losing their jobs. The objectives of the study focus on assessing:

- The concepts of medical incapacity[7] and fitness to work, interrogating legislation available in South Africa and guidelines used in the industry.
- If OMPs consider principles of medical ethics when determining the fitness status of the miners.
- If OMPs discriminate against mine employees with certain conditions and produce negative decisions regarding their fitness statuses.
- If the discrimination is likely to be influenced by dual loyalty.

The most important objective is to suggest recommendations on how OMPs can be aware of dual loyalty and how to avoid being entangled.

[7] As defined in Guideline on management of medical incapacity due to ill health and injury. Page 6.

1.5 Research questions

- Is dual loyalty of healthcare practitioners responsible for unfair decisions by the practitioners concerning medical incapacity/disability?
- Does dual loyalty of OMPs lead to discrimination of mine employees with certain medical conditions?
- Does dual loyalty result in unfair and unethical decisions?
- Are decisions of OMPs, declaring employees unfit for their occupations even when it is not justified, affected by OMPs' dual loyalty?

1.6 Research methodology

The study uses a multi-layered approach, exploring the literature review on dual loyalty. The study covers relevant legislation, including the Constitution, case law examples addressing fitness to work, exploring how courts interrogated OMPs decisions in the specified cases. The relevant guidelines used, and the ethical principles involved are identified. Case studies from the Medical Inspector's archives are also interrogated, with special focus on medical appeal cases received by the MI, where decisions of OMPs were reserved. The MI identified these cases, where OMPs fail to apply holistic measures in decision-making. Most selected cases indicate that they were not assessed individually, thus decisions are established as unfair. The unfairness could be due to conflicted OMPs resulting from dual loyalty. It is necessary to endeavour to assess if dual loyalty participated in unfair and discriminatory decisions of various OMPs.

1.7 Significance of the research

Dual loyalty is often considered to occur in closed government institutions, such as prisons and mental institutions, involving doctors working in those institutions. Although OMPs do not necessarily treat patients, they might also be affected by dual loyalty, involving employees, in this case, mining employees.

Health professionals have concerns regarding human rights, which are historical and mostly common in political environments, especially in the Apartheid era. A case in point is "the case of

Steve Biko”[8], a historic political prisoner, treated appallingly and unprofessionally by medical practitioners. These practitioners were employed by the state as district surgeons. They consistently under-reported Biko’s injuries after examining him and provided false reports about his medical condition. “Occupational health professionals are often faced with conflicts of interest in routine practice that may be similar, where loyalty to a third party, the employer, may interfere with the doctor-patient relationship and with the obligations of fidelity imposed by professional ethics”[9].

The mining industry mainly involves hard manual labour. Fitness requirements for miners tend to be stringent. Guidelines on minimum standards of fitness to perform work exist[10], promulgated by the government, to assist OMPs to determine the fitness status of employees. Guidelines also require OMPs to be holistic in their assessment, using discretion when determining the fitness status of employees. Since mine owners are mostly concerned with production, they usually expect that only individuals without any impairments, should be declared fit, neglecting the functionality and experience of employees. This compels OMPs to discriminate against employees with slight impairments. These disadvantages mining employees, as alternative employment is not often offered by the mine. The miners usually do not have alternative skills to leave the industry and to work in other non-mining related industries.

The study attempts to indicate dual loyalty of OMPs needs to be considered seriously as most are often established in a conundrum, to an extent that they are even afraid of fitness decision-making. They become overly cautious, settling for what the employer wants, sacrificing employees’ human rights.

“Traditional bioethical literature has, until recently, largely neglected consideration of the dilemmas facing occupational health professionals”[11]. “The failure of health professionals to

---

[8] K Moodley *et al.* Dual Loyalties, Human Rights Violations, and Physician Complicity in Apartheid South Africa**.**
[9]Walsh, 1986; Rosenstock and Hagopian, 1987; McCrary, 1992; Lurie, 1994; Berlinguer *et al.* 1996; Higgins and Orris, 2002.
[10] Guideline for a code of practice on minimal standards of fitness to perform at a mine, No. 39656 Government Gazette, no 39656, promulgated 5 February 2016.
[11] E. Emanuel. 2002. Introduction to occupational medical ethics. Occup. Med 17:549-558.

prioritize their ethical obligations to their patients in the face of dual loyalties led to some of the most egregious cases of human rights violations under Apartheid"[12]. This was one of the most important findings from the commission. The study would assist in raising awareness of how dual loyalty affects actions and decisions by OMPs, with profound consequences for employees.

1.8 Format of the study

Chapter 1 establishes the tone by providing a background to the research, the research problem and questions; providing an indication of the aim and objectives of the research; motivating the significance of this study and methodology followed.

Chapter 2 focusses on literature review of dual loyalty in the occupational health space; legislation on medical incapacity, HPCSA guidelines and a booklet on the conduct of medical practitioners, identifying what the Constitution provides concerning rights of employees.

Chapter 3 addresses various examples of case law available, focussing on issues related to conflict of interest; incapacity/disability and the ruling provided by the judges regarding cases concerned. It also addresses ethical principles, illustrated by Beauchamp and Childress.

Chapter 4 examines and interrogates various case studies, from the Medical Inspector's archives, especially exploring cases where the Medical Inspector reserved decisions of OMPs, which either seemed discriminatory, unfair or unethical.

Chapter 5 concludes the study, based on the analysis of legislation, case law, case studies and ethical principles. A recommendation is provided on assisting OMPs to manage dual loyalty.

[12] Baldwin-Ragaven *et al.* 1999. Truth and Reconciliation Commission, 1998.

1.9 Conclusion

The study assumption indicates that dual loyalty leads to several uncertainties when OMPs are required to make decisions pertaining to the fitness status of employees. Decisions in a state of uncertainty are likely to be flawed, thus the study intends to demonstrate that dual loyalty exists in OMPs, especially in the mining industry. It needs to be addressed in a strategic manner.

CHAPTER 2: OCCUPATIONAL MEDICAL PRACTITIONERS, DUAL LOYALTY AND INCAPACITY

2.1 Introduction

This chapter focusses on dual loyalty involving OMPs, exploring conditions leading OMPs into conflicted situations. These include human rights obligations of OMPs and legislation governing medical incapacity of employees and the HPCSA[13] booklet, guiding the conduct of medical practitioners, irrespective of the practitioner's field.

2.2 Human rights and dual loyalty

Occupational health practice mostly focusses on preventive health, dealing with groups of individuals, unlike what occurs in the typical doctor-patient relationships. "The use of ethical codes and bioethical reasoning alone may be insufficient to protect employees from violations of their rights."[14]

Instead of focussing on protecting vulnerable groups, there might be an inclination to "represent only one of many competing ethical concepts, such as obligations and duties, character virtues, standards of values, goodness of outcomes, justice in the allocation of resource, and respect for morally acceptable laws rather than recognizing their unique primacy".[15] Most mine employees are regarded as vulnerable, due to illiteracy and power concerns, indicating that employers are more powerful than employees.

"Literature covering bioethical issues focussed on ordinary health care practitioners. It neglected the occupational health professionals and the dilemmas they encounter."[16] An example of human rights violation is demonstrated by White, explaining what black miners endured during the

[13] Health Professions Council of South Africa (HPCSA), General ethical guidelines for the healthcare professionals, booklet 1, (2008).
[14] LS Rubenstein *et al.* Dual Loyalty Working Group. (2002).
[15] R Gillon, Medical ethics: Four principles plus attention to scope, BMJ 309:184-188. (1994).
[16] E Emanuel, Introduction to occupational medical ethics. Occup Med 17: 549- 558, (2002).

Apartheid era in pre-employment assessments. “Naked men were being examined in groups under demeaning conditions that violated human dignity”.[17] Conditions in the mining industry have since improved concerning initial and periodic examinations. Miners are not assessed being naked and in groups, instead they are individually assessed, although decisions by OMPs on fitness, might not be individualised. Some unions and employees indicate that human rights are not observed equally concerning OMP decisions. When determining fitness of black vs white employees, disparities still exist, with a tendency to be more accommodative to white employees' impairments than to black employees.

2.3 The context of power and occupational health

Leslie London states “both rights and ethics are normative approaches that aim to maximize human well-being and alleviate discomfort and suffering. There are two senses in which power is critical to consideration of the ethical and human rights dimensions of occupational health practice.”[18] A need for the OMP as the professional exists, to be trusted by both employees and by employers, concerning medical ethics.

Society usually confers power to the health professional, provided the practitioner commits to meet practice norms and standards, which should be acceptable to the society. Individuals tend to trust health practitioners, believing they are ethical in their professional conduct, unlikely to abuse the power conferred to them by virtue of their professions. “Unequal relations of power severely compromise the extent to which any procedure requiring a worker's consent can adequately meet globally recognised standards for informed consent”.[19] “Several workplace health challenges only emerge because of power conflicts between management and employees, in which the health care provider is expected to intervene”[20]. In support of Nemery's theory, OMPs

---

[17] N White, Submission on systematic racial discrimination in the health sector and the consequences for the health of mine workers (1997).
[18] Leslie London, American journal of industrial medicine, (2005).
[19] Council for International Organizations of Medical Sciences (CIOMS), International Ethical Guidelines for Biomedical Research Involving Human Subjects, (2002).
[20] B Nemery, The conflict prone nature of occupational health research and practice, (1998).

in the mining industry are often intermediate. Employees do not trust OMPs' decisions, as they sense their decisions are influenced by employers.

South African health practitioners, displaying unethical behaviour in handling patients, resulted in a legacy of people not trusting health care practitioners. "Occupational health practitioners (OHPs) need to be mindful of the impact of failing to adhere to ethical standards that place the employee or collective of employees as the primary focus of preventive, promotive, and curative professional practice".[21]

2.4 Dual loyalties and conflicts of interest

The phenomenon indicating the health practitioner holding double obligations, might be direct or indirect to a third party, aptly capturing the concept of dual loyalty. The impact on the patient or employee might be observed as negative. In the mining industry where occupational health is practised, the third party is always the mine owner or the CEO of the mine, occupying the most senior position. "Whilst health professionals providing occupational health services are often in a contractual or employment relationship with industry bosses, they are expected to maintain doctor-patient relationships with employees as patients or users of occupational health services."[22]

Several contracted OMPs admitted being in compromising situations where the employer demands specific unethical requirements. They fear to refuse such demands as their contracts can be terminated. Some OMPs experienced exertions, encountering cessation or non-renewal of contracts, for decision-making contrary to employers' demands or expectations.

The occupational health practitioner might violate employees' human rights because of deficient ethical judgement; alike in the setting of clinical management of a detainee.[23] "On the one hand

[21] Baldwin-Ragaven *et al.* Learning from our Apartheid past: Human rights challenges for health professionals in contemporary South Africa. Eth Health 5:227-241, (2000).
[22] L London. 2005, page 3.
[23] Baldwin-Ragaven *et al.*; Learning from our Apartheid past: human rights challenges for health professionals in contemporary South Africa. Eth health 5: 227-241, (2000).

the health professional, bound by obligations of fidelity to the patient, must always seek to maximize the well-being of his or her patient."[24]

Appointments are scheduled for employees in occupational health settings, to consult with occupational health practitioners, providing services to the employee as required from an occupational health practitioner, stated in the employer-employee contract. "Almost always, the employer of the doctor is also the employer of the worker/patient".[25] Higgins further describes "the potential for a situation of dual loyalty of a health professional rests upon four elements" as follows:

- The existence of simultaneous obligations to the worker/patient and employer as third party.
- The incompatibility of these simultaneous obligations.
- The existence of some measure of pressure on the health professional from the third party qualitatively differ to the power of the employee.
- The separation of the health professional's clinical part from that of a social agent."

Human rights violations of employees may increase if dual loyalty is worsened by certain factors, especially concerning wrong, inappropriate and unethical decisions regarding management of the employee/patient. "Such exacerbating factors include risky employment relationships, role conflicts for health employees, personal bias, institutional discrimination and stigmatization of patients, the presence of a repressive political environment, and professional power and self-interest".[26] Occupational health practitioners who are not sure of their functions in the doctor-patient relationships, are deemed prejudiced, racist or unsupportive of interests of the employee-patient relationship. They are most likely to encounter challenges with dual loyalty. This concept will be discussed in more detail under case law, dealing with conflict of interest.

The contract between the occupational health practitioner and the employer may not be in favour of the employee-patient concerning various aspects. The contracts may focus on and distinctly

---

[24] D Deubner and R.E Sturm[24], *et al.* Patient advocacy versus employer protection. Occup. Med 17: 607-615 (2002).
[25] P Higgins and P Orris. Providing employer- arranged occupational medical care: Conflicting interests, Occup Medicine 17: 601-606 (2002).
[26]C Myser (2000). The problem of dual loyalties: standards of conduct for the professions.

mention specific legal obligations on the OHP, whilst “the OHP’s ethical obligation to the employee remains at a moral and hortatory level, subject to differing interpretations and lacking in legal enforceability”. [27] Medical ethics are not considered when contracts between employer and OHP are entered. It becomes the responsibility of the OHP to remember and observe medical ethics.

“Some health practitioners in the industry may feel the need to side with the company, even though there is no basis for that and the “contract of employment” does not necessarily demand that.”[28] In such instances, taking sides with the company is based on the person’s emotions, whereby the practitioner identifies with the company concerning values and how the company perceives important aspects in the working environment. This invariably leads to the health practitioner making “decisions in the best interests of the company”.[29] This often happens in the mining industry, where the mine employer is more focussed on profit and production than the interests of employees and the OMP must consider that when determining employees’ fitness, adopting the views and values of the employer.

Occupational health practitioners should be impartial concerning advising the employer. They should remain professional by promoting the health and safety of all employees under their care, without bias or discrimination. Any health practitioner who indicates independence and integrity in their professions and transparency will be respected and trusted by employees. They are also “necessary for the confidence of management, employees, and their representatives”.[30]

2.5 Implications of dual loyalty on occupational health practice

The International Commission on Occupational Health (ICOH) ethical code submits ‘‘occupational health practitioners... must acquire and maintain the competence necessary... to carry out their tasks.’’[31] In support of the ethical code, London suggests “knowledge of the workplace, its

[27] J Ladou *et al.*, (2002). Codes of ethics (conduct). Occup med 17: 559-585.
[28] K Rodham, 1998. Manager or medic: the role of the occupational health professional. Occup Med 48: 81-84.
[29] G Berlinguer *et al.*, 1996. Ethical problems in the relationship between health and work. Int J Health Serv 26: 147-171.
[30] Royal College of Physicians, Faculty of Occupational Medicine, (1999).
[31] ICOH. 2002. International code of ethics of occupational health professionals.

hazards, and the job activities expected of the worker-patient are essential components of the required ethical competence of an OHP". It is expected that the occupational health practitioner should consider interests of the employee, promoting employees' interests where possible. Several OHPs/OMPs may find it difficult to be impartial, acting in favour of employees' rights. Dual loyalty does not only apply to individuals when employees undergo medical surveillance, but also where the OHP needs to provide comments on policy documents, aimed to promote the health and safety of employees, without disadvantaging employees.

2.6 Aspects of medical incapacity guidelines

Concerning the medical incapacity guideline[32], promulgated by the Department of Mineral Resources (DMR), the following important definitions should be considered:

2.6.1 Disability

This is defined as "an alteration of an individual's capacity to meet personal, social, or occupational demands or statutory or regulatory requirements because of an impairment"[33]

2.6.2 Impairment

Defined as "loss of use, or derangement of any body part, organ system, or organ function. Impairment may be of a physical, or mental and/or a combination of both, or a sensory nature"[34].

[32] Guideline for mandatory code of practice on management of medical incapacity due to ill health or injury, 2016.
[33] Ibid, page 6.
[34] Ibid, page 6.

2.6.3 Medical incapacity

Defined as "the inability to find and retain employment due to a disease and/or injury that prevents the performance of the customary duties of an employee"[35].

2.6.4 Inherent job requirements

Defined as "those requirements the employer stipulates as necessary, for a person to be appointed to the job, and are necessary to enable an employee to perform the essential functions of the job"[36].

2.6.5 Minimum health standards (MHS)

Defined as "the health status required of an employee, or recruit, considering the health and safety hazards to which such a person will be exposed to, as well as the inherent job requirements, to execute the essential functions of a position in a way that will not pose any danger to the health and safety of such a person, or any co-employees or has the potential to cause damage to property of the employer"[37]. The DMR promulgated a guideline on minimum standards of fitness to assist and guide OMPs during decision-making regarding employee fitness (refer to section on minimum standards of fitness guideline below).

2.6.6 Progressive conditions

Defined as "those conditions that are likely to develop or change or recur with increased limitation of the person's ability to function effectively. People living with progressive conditions or illnesses are considered as people with disabilities once the impairment starts to be substantially limiting"[38].

---

[35] Ibid, page 6.
[36] Ibid, page 6.
[37] Ibid, page 7.
[38] Ibid, page 7.

2.6.7 Medical incapacity management committee

The directives for decision-making in this committee must be protection of employee rights of fair labour practices and protection of employer's rights to productivity, avoiding suffering unjustifiable hardship.

2.6.8 Medical incapacity disputes

In the mining industries, two main avenues dispute the decision of either the OMP or the medical incapacity committee. Where the dispute is based on procedural unfairness by the committee, the employee has a right to:

- Appeal to an internal appeal committee, if such a structure exists.
- Register a case with the CCMA.
- Ultimately present the case to the Labour Court.

Should the dispute concern the decision of unfitness by the OMP, based on medical grounds, the employee may lodge a Section 20 medical appeal to the Medical Inspector, in accordance with the MHSA, within 30 days of the decision of the OMP. Employees are sometimes confused by the aforementioned two processes and may lodge a Section 20 medical appeal, based on procedural unfairness**.**

2.7 Guidelines on minimum standards of fitness, required to perform work

This guideline[39] was drafted to assist OMPs to determine if employees hold minimum requirements to be declared fit for work. It outlines common approaches but should not be prescriptive. OMPs should introduce alternative approaches, using discretion. These approaches should be supported by evidence-based clinical trials or by medical associations. "The OMP is responsible for determining fitness to work and should be familiar with the working environment

[39] Guideline for a mandatory code of practice on minimum standards of fitness to perform work on a mine, 2016.

and requirements of jobs”.[40] There are certain considerations to be made by the OMP when determining fitness status of employees, such as:

- “Risk management principles, where the work exposure must be considered.
- Evaluating each case on its own merit as cases are dissimilar.
- There should not be blanket exclusions for employees with certain conditions.
- There are specific risks for specific jobs and thus risks should not be generalised.
- There are specifics of medical conditions and working environment.
- Medical conditions should be interpreted in functional terms and job requirements. They should not be interpreted in isolation, but a holistic approach should be adopted.
- Other legislations like the Labour Relations Act, employment equity Act, partake when decisions on fitness are made”[41].

Legal framework

For the study topic, a multi-layered approach is adopted to establish a solution to the research questions.

2.8 Constitution

The Constitution is the highest legal authority in South Africa[42]. The Bill of Rights is the epitome of democracy in South Africa and details the rights of all people in the Republic of South Africa. The following rights were considered as important for employees, who may be exposed to unfair decisions concerning medical incapacity, by OMPs grappling with dual loyalty.

---

[40] Ibid, page 9.
[41] Ibid, page 10-11.
[42] The Constitution of the Republic of South Africa, 1996.

2.8.1 Right to equality

"Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination, may be taken."[43]

2.8.2 Right to dignity

"…. everyone has the right to have their dignity respected and protected."[44] According to Forster[45], "…dignity is about *being human*, implying that every transaction must be managed to maximise the amount of dignity that is in it with reference to all the parties involved". Although focus is usually on patients, this concept also applies to employees, managed by OMPs in the industry. Ackerman further states "The right to dignity is a cornerstone of our Constitution"[46]. Employees whose human rights are trampled, often have their right to dignity denied.

2.8.3 Right to labour relations

"Everyone has a right to fair labour practices"[47]. Mine employees in the industry are also entitled to fair labour practices and should not be discriminated against, despite having certain medical conditions, often regarded as prohibited in the mining industry. People with specific conditions are often not accommodated in alternative positions in the mining industry as their employment is automatically terminated.

---

[43] Section 9(2) of the Constitution, chapter 2, Bill of rights.
[44] Section 10 of the Constitution, chapter 2, Bill of rights.
[45] C Forster. Human dignity in bioethics and law. 2011.
[46] J Ackerman in the case of National *Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC), para 30.
[47] Section 23(1) of the Constitution, chapter 2, Bill of rights.

2.9 The Labour Relations Act and incapacity legislation

2.9.1 Incapacity: Poor health and injury

“Incapacity on the grounds of ill health or injury may be temporary or permanent. If an employee is temporarily unable to work in these circumstances, the employer should investigate the extent of the incapacity or the injury. In cases of permanent incapacity, the employer should ascertain the possibility of securing alternative employment or adapting the duties or work circumstances of the employee to accommodate the employee’s disability”[48]. Several employees in the gold mines are exposed to silica dust and might develop silicosis[49]. Once an employee is diagnosed with silicosis, no alternative jobs are sought and the employee is released from work, based on medical grounds even if the employee is physically and functionally fit to continue working in other environments, where the employee would not be exposed to silica dust. This often disadvantages the employee, as the compensation received for silicosis is a once off amount, mostly insufficient to sustain employees and their families.

2.9.2 Guidelines on dismissal arising from ill health or injury

Section 11 provides “*any person determining whether a dismissal arising from ill health or injury is unfair should consider the following:*

- Whether the employee can perform the work.
- If the employee is incapable.
- The extent to which the employee can perform the work.

[48] Section 10(1) of the Labour Relations Act, 66 of 1995.
[49] An occupational lung disease which affects workers exposed to silica dust in the working environment. It might lead to fibrosis of the lungs with difficulty in breathing and poor lung functions.

(ii) the extent to which the employee's work circumstances might be adapted to accommodate disability, or, where this is not possible, the extent to which the employee's duties might be adapted; and

(iii) *the availability of any* suitable alternative work".[50]

2.9.3 Employment Equity Act (EEA)

- **Defining 'people with disabilities'**

The EEA[51] defines these individuals as "people with a long term; or recurring physical or mental impairment which substantially limits their prospects of entry into, or advancement in, employment**."**

- **Prohibition of unfair discrimination**

"No person may unfairly discriminate, directly or indirectly, against an employee in any employment policy or practice, on one or more grounds including race, gender, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language, and birth"[52]**.** Discrimination based on disability is rife in the mining industry, as it is expected that employees should be 100% medically fit.

- **Medical testing:**

  - "*Medical testing of an employee is permissible only when legislation requires testing or when this is justifiable for various reasons"*.[53] The MHSA requires that certain tests be

[50] Section 11 of the Labour Relations Act, 66 of 1995.
[51] Employment equity Act, No 55 of 1999.
[52] Section 7 of the EEA, No 55 of 1999.
[53] Section 7 of the EEA, No 55 of 1999.

conducted during medical surveillance of employees, ensuring a baseline is established, monitoring change.

- "*HIV testing is prohibited unless such testing is determined to be justifiable by the Labour Court*"[54].

Some occupational health practitioners test employees for HIV during pre-employment assessment. The argument used is that it would be better to know the status of employees before they are declared fit to work underground. This would be unethical though, as HIV testing is prohibited. Conversely, it suggests a possibility of denying these employees employment, based on their HIV status, thus indicating discrimination. Some mines test the CD4 count of employees in an endeavour to determine the employees' immune status. Should this count be low, employees are declared medically unfit for employment. This is unconstitutional; unethical and discriminatory. Physical and functional capabilities are not considered. Instead insinuations indicate that employees with low CD4 counts cannot cope with underground work demands. Unfair discrimination invariably sneaks in. In such cases when OMPs are conflicted, focussing on the worst-case scenario, an employee with HIV is already regarded as having full blown AIDS. Cases are not assessed on their own merit, but generalisation of conditions is adopted.

2.10 Health Professions Act (HPA)

This Act[55] provides guidance to medical practitioners concerning conduct when dealing with patients. These are also relevant in the occupational health environment; the patients would be employees in this case. The HPCSA, under the guidance of Health Professions Act, addresses the ethical conduct of medical practitioners. The conduct is included under the topic concerning medical ethics. The conduct is expected from all medical practitioners.

[54] Ibid, Section 7 of the EEA, No 55 of 1999.
[55] Health Professions Act, 1974 published under GN R717 in GG 29079 of 4 August 2006, as amended by GN R68 in GG 31825 of 2 February 2009 and GN R654 in GG 33400 of 30 July 2010).

2.11 Medical ethics, dual loyalty, values and standards

All medical practitioners are required to have professional conduct in all their interactions with their patients and should be guided by "ethical standards and values"[56]. The likelihood of a conflict occurring because of competing demands, resulting in the health practitioner having to choose between the competing demands, exists. Using ethical reasoning might aid in dealing with ethical dilemmas. The following core ethical values and standards required of healthcare practitioners, also apply to OMPs:

"**Respect for persons***:* Healthcare practitioners should respect patients as persons and acknowledge their intrinsic worth, dignity and sense of value. This includes respect of employees by OHPs;

Human rights*:* Healthcare practitioners should recognise human rights of all

Individuals: The OHP should not trample on human rights of individuals (employees), to please employers;

Integrity*:* Healthcare practitioners should incorporate these core ethical values and standards as the foundation for their character and practice as responsible healthcare professionals"[57]. An OHP with integrity is respected and trusted by employees and even employers sometimes.

Gerhard[58] records that the "discipline of occupational medicine is concerned with the relationship between work and health, promoting the health of employees and the workforce collectively"; it is also essential for employees to be maintained in a state of wellness. Exposure to hazards must be dealt with effectively through occupational hygiene measures. It is also pertinent that the OMP considers the Labour Relations Act, even though for the mining industry, the main Act to comply

[56] Health professions council of South Africa, Booklet 1, General ethical guidelines for the health care professions, edited by the human rights, ethics and professional practice, Pretoria, 2016.
[57] Ibid, page 2.
[58] G M Grobler, respecting patient autonomy in occupational medicine practice, occupational health SA, Vol 18 No 4 July/August 2012.

with is MHSA. Of note is that the employer is the boss for both the OMP and employees and they both derive salaries from the same employer. Whilst most employers might provide OMPs autonomy to employ their skills and medical knowledge when deciding on employee fitness, several are more focussed on profits and productivity and may not tolerate any decision of the OMP that might hamper production.

For example, most employers are intolerant of employees who, for medical reasons, cannot perform their duties although the situation is temporary. This might put the OMP in a difficult situation, forcing them to declare employees permanently unfit for conditions that can be cured or improved.

Such situations clearly expose OMPs to ethical dilemmas, hence national and global bodies issued ethical codes and guidelines for occupational health practitioners. Despite the availability of these codes, OMPs may still encounter daily ethical dilemmas. They need extra qualities, such as being open minded, practical, flexible and empathetic to the needs of employees. Medical ethics and law are intrinsically interwoven, forming an integral part of doctor-patient relationships, underpinning good healthcare practice; The Beauchamp-Childress model on principlism seems to be preferred concerning medical ethics, compared to other ethical philosophies. “Principlism talks to moral problems in medical ethics and can best be approached by applying one or more of the four basic “moral principles”, indicating respect for autonomy, non-maleficence; beneficence and justice.”[59]

- **Autonomy**

This translates into honest communication; respecting the privacy of others; protecting confidential information; obtaining consent for interventions; and when asked, assisting others to make important decisions. Autonomy is concurrent with the Constitution, specifically the following:

[59]Prof. P Carstens; Introduction to MPHIL (medical law & ethics) 2015: lecture guide; Faculty of law; University of Pretoria.

"the right to bodily integrity"[60]; "the right to dignity"[61] and "right to privacy"[62]. The context of Sections 36 and 39 of the Constitution should be considered.

In the mining industry, autonomy might be non-existent, as OMPs tend to be paternalistic, deciding what they sense is right for the employee. Several OMPs practice defensive medicine, when considering the hazardous conditions employees are exposed to and focussing on the worst-case scenario. Sometimes employees are declared unfit for work, based on fear of "something" happening, thus resulting in paralyses and a fear of decision-making on the fitness status of employees, not to upset the employer. In such cases, 'half-truths' are communicated to employees concerning reasons they were declared unfit for work, because the practitioners are conflicted.

- **Beneficence**

The following aspects are regarded as relevant for the dual loyalty of OMPs: Protecting and defending the rights of others; preventing harm from occurring to others; assisting persons with disabilities. Assisting those with disabilities seems to be a challenge in the mining industry, as it does not bode well with the employer's requirements of having only healthy employees without any physical, mental or sensory problem, to ensure production is not hampered.

- **Justice**

Refers to fairness, thus fair treatment for all employees, assessed by the OMP. A need exists to respect morally accepted legislation and human rights. Legally these correspond to certain sections of the Bill of Rights as follows: Section 9 covers "rights to equality" and Section 11 addresses the "right to life". All employees have a right to be treated equally. This implies that OMPs must be fair during decision-making concerning medical conditions and fitness of

[60] Section 12(2) (b) of the Constitution.
[61] Section 10 of the Constitution.
[62] Section 14 of the Constitution.

employees. These decisions need to be transparent, guided by the available morally accepted legislation.

2.12 Conclusion

The occupational medical practitioner is not exempted from complying with ethical rules, compulsory for all medical practitioners. Conflict of interest is likely to occur where the medical practitioner and the employee share the same employer. The OMP is surrounded by legislation that clearly guides and assists concerning decisions pertaining to medical incapacity and fitness to work. The Constitution and medical ethics should still be considered. Concerning the mining industry, the DMR released guidelines, assisting the OMPs. The guidelines are not prescriptive and should not be used as a crutch by OMPs to be unethical or refusing to adopt a holistic approach during decision-making, regarding the fitness status of employees.

Decisions by OMPs should not apply to the worst-case scenario or a blanket ban, as it may appear discriminatory. The following chapter signifies case law, demonstrating cases where conflict of interest was interrogated and how courts interpreted OMPs' decisions. The cases concerning conflict of interest signify OMPs' fiduciary duties.

CHAPTER 3: CASE LAW ON DUAL LOYALTY (CONFLICT OF INTEREST AND OMP DECISIONS ON FITNESS)

3.1 Introduction

OMPs are mostly in managerial positions and thus expected to promote the interests of the employer. Conversely, occupational health practitioners should be guided by ethical principles in their professions when dealing with employees. Role conflict is bound to occur between ethical duties to an employee and contractual obligations to the interest of a third party, representing the mine employer in this case. Where the practitioner focusses on the employer's interests, wrong discriminatory decisions are invariably made to please the employer. This chapter observes, case law; the dual loyalty foundation, demonstrating conflict of interest and fiduciary duty, and decisions by OMPs. Attributable to discrimination, these decisions are likely based on conflict of interest or dual loyalty.

3.2 Conflict of interest: Principles and concepts

Conflict of interest and conflict of duty, especially in the case of a person in a fiduciary position to another person, are the subjects of several decisions. A crucial aspect of these decisions is the duties of directors, managers and supervisors. It should be identified whether duties and responsibilities of management members are the same or if they differ, depending on the person involved. OMPs hold fiduciary positions to employees in the occupational health environment and are thus exposed to conflict of interest during decision-making.

3.3 Duty to protect the interest of others

The Appellate Division in 1921 ruled that "…. *[w]here one man stands to another in a position of confidence involving a duty to protect the interests of that other, that person has a range of duties to that other person."*[63]

The Supreme Court of Appeal ruled that the duty of a fiduciary to not abuse their trust *"extends not only to actual conflicts of interest but also to those which are a real sensible possibility".*[64]

Gower states the following:

"... *these duties, except in so far as they depend on statutory provisions expressly limited to directors, are not so restricted but apply equally to any officials of the company who are authorized to act on its behalf, and in particular to those acting in a managerial capacity*."'[65]

As indicated above, OMPs act in managerial capacity and on behalf of the employer concerning overseeing the fitness status of other employees. This means they usually act on the company's behalf and thus the duties mentioned above apply to them as well.

3.4 Characteristics of fiduciary obligations

The Supreme Court of Appeal ruled "*relationships in which a fiduciary obligation has been imposed are marked by three characteristics:*

- Scope for the exercise of some discretion or power.
- That power or discretion can be used unilaterally to affect the beneficiary's legal or practical interests.

[63] Robinson v Randfontein Estates Gold Mining Co_Ltd 1921 AD 168 at pages 177-178.
[64] In Phillips v Fieldstone Africa (Pty)_Ltd 2004 (3) SA 465 (SCA), para 31.
[65] In Aero service v O'Malley supra at 381, Gower in Principles of Modern Company Law, 3rd ed. (1969), p. 518.

- A peculiar vulnerability to the exercise of discretion or power". [66]

OMPs should exercise their discretion during decision-making on the fitness status of employees, using their medical, ethical and the working environment knowledge, considering the employees' experience and their capability to perform tasks as required in their occupations. In some cases, the discretion is abused; decisions tend to be unilateral and channelled to benefit the employer. Employees with certain conditions may be discriminated against and declared unfit for their jobs, as they would be perceived as not being productive.

3.5 The nature of a fiduciary relationship

A court defined the relationship as follows:

"A fiduciary is someone who has undertaken to act for or on behalf of another in a particular matter in circumstances which give rise to a relationship of trust and confidence";

The same court ruled on the duties of a fiduciary as follows:

A fiduciary "*must act in good faith; he must not make a profit out of his trust; he must not place himself in a position where his duty and his interest may conflict; he may not act for his own benefit or the benefit of a third person without the informed consent of his principal. This is not intended to be an exhaustive list, but it is sufficient to indicate the nature of fiduciary obligations."*[67]

The OMP being the fiduciary, is expected to act in the best interest of the employee and should avoid situations where conflict may result, because of acting for the benefit of the third person, who is the employer in this case.

[66] Phillips v Fieldstone Africa (Pty) Ltd 2004 (3) SA 465 (SCA), para 31.
[67]LJ Millet in Bristol and West Building Society v Mothew [1998] Ch. 1, 18.

3.6 Fiduciary position: Forbidding conflict of interest and duty

Lord Herschell states that "*based on the reality that human nature being what it is, there is danger... of the person holding a fiduciary position being swayed by interest rather than duty, and thus prejudicing those whom he was bound to protect*"[68]

If OMPs, holding fiduciary duties, are swayed by performance bonuses from increased production, a likelihood is suggested that they would be biased concerning decisions regarding employees' fitness. These decisions might be subconscious, guided by human nature, but prejudicing employees.

3.7 Accommodation of difference

The court considered the following arguments concerning employee disability:

- "A failure to provide reasonable accommodation is unfair discrimination.
- Reasonable accommodation promotes equal opportunity and enjoyment.
- Society is designed for the "*able-bodied*".
- "*Positive action*" is required to promote diversity.
- Identifying appropriate reasonable accommodation is "an exercise in proportionality".
- Reasonable accommodation is crucial in discrimination fairness.
- Accommodation is indicated where a neutral rule has marginalising effects.
- Accommodation is indicated in context of conflicting interests"[69].

The mining industry particularly, subscribes to able bodied employees only. Accommodation is not entertained, especially in the context of conflicting interests. This is further established in the following case law examples:

[68] In an earlier case, Bray v Ford [1896] AC 44, 51.
[69] MEC for Education: Kwazulu-Natal and Others v Pillay (CCT 51/06) [2007] ZACC 21; 2008 (1) SA 474 (CC); 2008 (2) BCLR 99 (CC) (5 October 2007).

3.8 **IMATU v City of Cape Town**

This case[70] is about an employee who applied for a firefighter position but was denied employment because he had an insulin-dependent diabetes condition, known as type 1 diabetes. He underwent medical surveillance and relevant tests were performed. After the tests, he was considered medically unfit as a fire fighter. The OMP concluded that the employee had a risk of a hypoglycaemic attack, because he used insulin to treat his diabetes and was afraid that could cause disaster if the employee would work in a fire environment.

3.8.1 The decision of the occupational health medical practitioner or OMP

It was the OMP's opinion that "the appointment of [the employee] as a fire fighter, given the occupational requirements of the job, would have represented an unacceptable safety risk to [the employee] himself, to other employees, to the public and to the respondent by reason of his medical condition as an insulin dependent diabetic."[71]

3.8.2 According to the trade union's submission on the employee's behalf

"[The employee's] disappointment at the decision to exclude him is predicated on his observation that the blanket ban unjustifiably applies outdated, prejudiced stereotyping to his individual situation."[72]

"In his 13 years of active fire-fighting, [the employee] has never had a severe hypoglycaemic episode, defined by the medical experts as an episode where third party intervention is needed. [His] last severe hypo was at the age of 10 or 11, within the first year of being diagnosed with Type 1 diabetes."[73] This case indicated there was a tendency to put a blanket ban on all employees who had insulin-dependent diabetes, despite being well controlled. Individual

---

[70] IMATU v City of Cape Town (2005) 14 LC 6.12.2.

[71] IBID, para 17
[72] IBID, para 18.
[73] Ibid, para 20.

assessments are necessary as the risks posed by certain conditions might not warrant blanket bans.

Peter Strasheim in his presentation further indicated the following: "*By upholding a requirement of individual assessments, courts in other jurisdictions... gauged the risks posed by diabetes in potentially hazardous occupations as not warranting blanket bans.*"

- For instance, "The City of Toledo was permanently enjoined by the US Federal Court from facilitating a blanket exclusion for persons with insulin-dependent diabetes from employment as police officers. "[74]
- Similarly, the Court of Appeals held "…an individualised investigation of the plaintiff's ability to perform the job was required."[75] The City had declared the plaintiff unfit to be a police officer because he had insulin-dependent diabetes.

  Further support on the blanket ban concept was by the Canadian courts which indicated the same resolve and preference for individualised assessments…… "The complainant lodged a complaint against the respondent under the provisions of the Canadian Human Rights Act, alleging that the respondent's policy of excluding insulin-dependent diabetics from the position of trainman was a discriminatory practice."[76]
- The British Columbia Human Rights Council found Quintette Coal Limited discriminating against McKenzie when it refused to hire him as a miner because he was an insulin-dependent diabetic. The judge commented as follows:

"*I am satisfied that Type 1 diabetes is an analogous ground to the listed grounds of disability……. Controlled diabetics seek dignity with the demand that their capacity to function as normal members of society now be recognised to the extent that modern pharmacological and technical advances make that possible.*" He further said: *"Arbitrary, irrational and unfair exclusions predicated upon anachronistic generalised assumptions impair their dignity and seriously affect*

[74] Bombrys v City of Toledo 849 F.Supp. 1210.
[75] Kapche v City of San Antonio 304 F 3d 493 (2002).
[76] Nowell v Canadian National Railway Ltd [1987] DLQ 8.

them adversely by limiting the full enjoyment of the right guaranteed by section 22 of the Constitution, to pursue a chosen trade, occupation or profession…." [77]

3.9 McLean v SASOL Mine (Pty) Limited Secunda Colliery / McLean v SASOL Pension Fund

The High Court raised the following:

"... *There is a need for an individualized assessment to ensure that unfounded generalizations…… are not made*".

"*Where a rule or a practice makes generalizations about people solely on the basis of disability without regard to the particular circumstances of the specific class of individuals affected, then this is, in my view, entirely unfair to the individuals*".

"*Moreover, for there to be true individualization, a close, assessment should be made of the individual in question since even persons with the same disability vary markedly in how they personally function and cope with their affliction or vary in the degree of impairment because of different stages of their infirmity."*[78]

The above cases are relevant concerning decisions by OMPs, which often involve making blanket decisions without individualised assessments. Employers' policies mostly prompted these decisions, which are unfavourable to any employee with a condition, presumed to be unsuitable for work. Decisions are most often influenced by conflict of interest, whereby the OMP is afraid to decide, contrary to the employer's expectations.

[77] McKenzie v Quintette Coal Ltd (1986) 8 CHRR D/3762 (BCCHR).
[78] McLean v SASOL Mine (Pty) LTD Secunda Colliery.

3.10 Conclusion

The aforementioned case law examples indicate that OMPs in fiduciary positions are exposed to conflict of interest, especially when caught between the employer and the employee. It is human nature that their decisions would not necessarily be in the best interest of the employee. If the company policy indicates that people with certain conditions would not be employed, a blanket ban is usually imposed, irrespective of whether the employee's condition is controlled.

Assessments are not individualised to obtain a true reflection, thus decisions become discriminatory. Dual loyalty has a function in these decisions, as OMPs are conflicted. Instead of decisions based on medical ethics; individual assessments; medical information available about the condition; and the working environment; they are based on blanket bans to remove employees, deemed less than perfect, from the working environment. In the case of "IMATU v City of Cape Town"[79], the expert witness, who was South Africa's leading authority on diabetes, states "employers were overcautious and unnecessarily restrictive" concerning employees with type 1 diabetes. This is the case in the mining industry, as the working environment is regarded as hazardous, rendering OMPs fearful of the wrong decision. OMPs are mostly restrictive and practice defensive medicine, should "something" fail concerning the employee's condition, disregarding that failures might still occur with employees, deemed completely fit, and indicating no medical conditions during medical surveillance.

[79] IMATU v City of Cape Town"[79] (2005) 14 LC 6.12.2

CHAPTER 4: CASE STUDIES ON OMP DECISIONS CONCERNING EMPLOYEE FITNESS

4.1 Introduction

The Mine Health and Safety Act was adapted from the Occupational Health and Safety Act, though MHSA only focusses on occupational health and safety in the mines. It is more advanced than the OHSA. The possibility of conflict involving the mine OMPs was recognised, hence the Act provides for employees to obtain a second opinion from another OMP, known as the Medical Inspector (MI), appointed by the state as per requirements of the MHSA[80]. The Section 20 medical appeal process allows mine employees to dispute the decision of the mine OMP.[81] This section provides an advantage for mine employees to appeal, and it does not exist under the OHSA. This chapter assembles some of the cases received by the MI, with special focus on those where the MI disagreed with decisions of the mine OMP. These cases address OMP decisions that seem conflicted, hence not approaching the cases holistically, appearing to be discriminatory in certain cases. The following were considered as sample cases, demonstrating conflict with resultant failure for individualised assessments, imposing blanket bans on certain conditions.

4.2 Case A: Premature incapacitation of employee

Mr L. sustained an injury on duty (IOD) and suffered burns on one hand and fractures of some fingers. Whilst still recovering, he was referred for functional assessment. He failed the test attributable to experiencing pain. The OMP declared the employee permanently unfit for his position because of failing a functional assessment test, conducted prematurely. “Fitness to work decisions should reasonably practicably be delayed until the state of maximum medical improvement is reached”[82]. The employee lodged a Section 20 medical appeal to the MI as he disputed the OMP’s decision that he was unfit to perform his occupational duties. The MI referred

[80] Section 49(1) (b) of the MHSA provides that the Chief Inspector of Mines, should appoint an officer with prescribed qualifications and experience as the Medical Inspector.

[81] Section 20(1) (a) of the MHSA provides that an employee may appeal to the Medical Inspector against a decision that the employee is unfit to perform any category of work.

[82] Guideline on Minimum standards of fitness to perform work at a mine, No. 39656, Government Gazette, 5 February 2016.

him for RFA[83]. He performed well concerning physical and functional assessments. The impression is that the employee was prematurely declared permanently unfit. He was still in the recovery process when his functionality was assessed. Whilst he was recuperating, he was not productive enough according to the employer, hence the decision to dismiss him from the working environment permanently, despite that he was not maximally treated yet. The OMP declared the employee permanently unfit, despite being aware that the employee was temporarily unfit. The OMP was conflicted, as the employer did not want unproductive employees in the workplace, albeit temporarily.

4.3 Case B: Lacking individualised examination

Mr M. was reported to struggle to pass the heat tolerance screening (HTS) test, conducted for employees who would be exposed to excessive underground heat. He worked underground, exposed to high temperatures for over 10 years. During these years, he never suffered from any heat related illness. During medical surveillance, he was required to undertake an HTS test and he failed it. He was provided an opportunity to return to work for six months. During that period, he still did not indicate any heat related illnesses. He was required to undertake another HTS after 6 months and he failed again. He was then declared unfit for his underground occupation.

The employee lodged a Section 20 medical appeal as he perceived that he could still perform his duties efficiently without any difficulties, alike the past 11 years. Apart from failing the HTS tests, there was no evidence indicating that he could not perform his required duties. RFA test results indicated that he possessed adequate physical and functional capacity to perform his tasks. He did not experience any heat related illnesses, indicating that he was not heat intolerant. The employee was a healthy individual, with no chronic medical condition. The decision of the OMP was reversed, as there was more evidence supporting the employee's fitness than his unfitness. The OMP compared the employee with other employees who failed HTS, without considering this case on its own merit. A court judgement confirmed this observation, stating "an individualised

[83] Rehabilitation and functional assessment, as one of the tools mentioned in the guideline in (3), to assist OMPs to assess fitness to work.

assessment, rather than a blanket ban, should be followed in cases where the employer seeks to differentiate on health grounds in an employment policy or practice"[84].

4.4 Case C: Applying a blanket ban

The employee, Mr M. was a qualified electrician employed in the mining industry since 1989. He was diagnosed with Insulin-Dependent Diabetes Mellitus (IDDM) in 2009. His work was adapted in line with his medical condition and he was declared fit to continue working as an electrician. He was under the care of two specialists: A physician and a cardiologist. Both indicated that the employee's diabetes was well controlled and no hypoglycaemic attacks were reported. No negative work-related incidents were reported, resulting from his medical condition. The OMP indicated that the employee was declared unfit because of the risk hypoglycaemia would cause. The OMP recommended an alternative position as he feared the likely risks; an alternative position was unavailable as the OMP implemented several restrictions.

The employee was displeased with the decision of the OMP and appealed. He felt that his diabetes was well controlled, as confirmed by the two specialists who treated him. On further enquiry, the OMP also observed that the employee was still fit for his job but was afraid to declare him fit, as the company code of practice (COP) excluded all people with IDDM from performing certain functions, including electricians. A blanket ban was imposed on him because he had IDDM. The employee never had hypoglycaemia; he was well versed with his condition and it remained well controlled for 10 years without any complications. The MI overturned the decision of the OMP since a blanket ban was inappropriate. A court in a similar case[85] determined that "The ban as such, and its specific application to the second applicant, who was in all respects a well-controlled diabetic, was unjustified and constituted unfair discrimination concerning the EEA"[86].

[84] The Constitutional Court judgment in *Hoffmann v SA Airways* (2000 ILJ 2357 (CC))
[85] IMATU v City of Cape Town (2005) 14 LC 6.12.2
[86] Section (6) of the Employment Equity Act which reads as follows: "No person may unfairly discriminate, directly or indirectly, against an employee in any employment policy and practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour,

4.5 Case D: Intolerance of physical condition of employee

The employee, Ms N. worked in a plant above the ground. Her job involved walking through the plant and climbing stairs. The employer had a problem with the employee's obesity although she was employed whilst in that condition. Her weight was apparently increasing despite being provided time to lose weight. The employee argued that she could not follow through with the dietician's food plan as the work environment did not allow employees to bring their own food. She had to eat what was offered, apparently not coherent with the dietician's recommendations. The employee was declared permanently unfit because she was obese and not losing weight. It was decided that her obesity posed a risk to her occupation.

The employee disputed the decision of the OMP, stating that she was always obese but that did not prevent her from performing her required duties. She performed the same responsibilities for 10 years without challenges, despite her obesity. She learnt to govern herself and could climb stairs if required, at a suitable pace. There were no reports indicating her inability to cope with her job nor were any incidents reported because of her obesity. When further clarity was requested regarding the employee's inability to function, it was stated that she worked on heights and that there was no safety harness that could fit her. Further enquiries on how the employer dealt with the problem in the past ten years, had no response. The employee indicated that in all the years she worked, she never needed to use a harness and that working on heights included less than 10% of her daily tasks. She also indicated that she worked with a team of 20 individuals; they all assisted each other. The employer could not tolerate the employee's obesity and the OMP had to make a decision concerning her fitness status. The employee was declared unfit, serving as punishment for not losing weight as instructed, not because she could not perform her duties, constituting unfair discrimination.

---

sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth".

4.6 Case E: Lacking individualised assessment and prejudice

The employee, Mr O, applied for a loader operator position at the mine. He left the mines four years before because of a medical condition, indicating painful knees. The OMP was aware of this previous history and decided the employee would not cope with the proposed job without assessing him. He was subsequently declared unfit, based on his physical status of four years ago.

The employee disputed the decision of the OMP to the MI. He was referred for a physical and functional assessment to determine his suitability for the proposed job. The test results revealed good physical and functional capabilities, meeting the inherent job requirements. He experienced no pain or discomfort during the test and was motivated to work. The decision of unfitness was based on the previous physical status of the employee and not his current physical status. The decision was unfair and discriminatory. A person’s physical status may change in a year; thus, it was necessary to re-assess the employee to obtain a true reflection of his physical status.

4.7 Conclusion

Although it might be difficult for OMPs to admit, most of their decisions on employees’ fitness status are influenced by the employer’s requirements. Most employers want their employees to be super-fit, without any impairment, no matter how mild the impairment might be. Any chronic condition might be frowned upon, as it implies that the employee would not be 100% effective concerning production. OMPs might emerge with unfair and discriminatory decisions. These decisions might be unethical, infringing employees’ human rights.[87]

OMPs start to fear decision-making and become overly cautious, imposing restrictive `actions, applying the blanket ban across board for certain conditions. Individualised assessments are not considered, despite the knowledge that people are different. This is supported in case law,[88]

---

[87] Specifically addressing sections 9 and 10 under the Bill of rights in the Constitution of South Africa, 1994, providing for the right to equality and dignity not to be discriminated against, irrespective of the cause.
[88] McLean v SASOL Mine (Pty) LTD Secunda Colliery.

stating: " …for there to be true individualization, a close, assessment should be made of the individual in question since even persons with the same disability vary markedly in how they personally function and cope with their affliction or vary in the degree of impairment because of different stages of their infirmity.."

CHAPTER 5: ANALYSIS OF LEGISLATION, CASE LAW, CASE STUDIES AND ETHICS

5.1 Conclusions

Ethical principles guide all medical practitioners in their doctor-patient relationships. They may encounter a dilemma whereby demands of core ethical values and standards contravene, because of competing demands. Health professionals cannot decide or choose where their loyalties lie whenever a third party is involved. "Medical ethics are clear about where obligations of health practitioners should lie, and that should be in the best interest of their patients". [89]

Dual loyalty was identified as a challenge in confined institutions, such as prisons, but the occupational health environment has OMPs encountering conflict of interest, leading to dual loyalty. The Case law in Chapter 3 indicates that OMPs have a fiduciary duty to employees and are obligated to protect the rights of others. The concept of doctor-patient relationship is not straight-forward in the occupational health sphere. OMPs do not necessarily treat mine employees. This might be the reason some OMPs might assume that they are not obliged to act in the best interest of employees. OMPs are invariably captured between the interests of employees and those of the employer, ensuing conflict of interest dilemmas. 'Occupational physicians ought not to allow the employer's business objectives to bias their professional judgement'.[90] In the mining industry, this is more difficult in practice. The business objectives of the employer focus on continuous production to ensure the business derives profits. All senior staff in the mining industry, including OMPs, obtain bonuses when the companies performed well concerning production. It is thus in the best interest of OMPs to support the employer's business objectives.

The objective of this dissertation was to demonstrate that dual loyalty influences OMPs in decision-making. Considering the research questions, literature review on dual loyalty in the occupational health space, legislation including the Constitution, common law and case law, were

---

[89] *Definition of the Hippocratic Oath,* MedicineNet.com, (Jul. 13, 2002), *http://www.medterms.com/script/main/art.*

[90] G M Grobler; Vol18 No 4 July/August 2012; **occupational health Southern Africa; www.occhealth.co.za.**

interrogated to obtain answers to the research questions. The MHSA and promulgated guidelines lead mine OMPs. They also have to be cognisant of the Labour Relations Act, EEA and medical ethics. If these Acts are considered and if OMPs regard the four principles in medical ethics[91], they would find it easier to manage ethical dilemmas. OMPs need to adopt a comprehensive approach when deciding on employee fitness and should not base their decisions solely on one parameter or generalisation on certain conditions, whilst ignoring individualised assessments of cases. It was affirmed that "a physician shall owe his patients complete loyalty and all the resources of his science."[92]

The case studies gleaned from the MI's archives, indicate that OMPs' decisions are not necessarily supported by legislation and medical ethics, but mostly based on their own emotions and employers' policies, which might be outdated, overtaken by medical developments. It is thus important that OMPs are updated on the latest medical developments, including best practices to advise their employers accordingly, observing medical ethics. Relevant cases are those applying the blanket ban and discriminating unfairly concerning certain conditions, without individualised assessment.

Considering these cases, combined with case law and decisions of courts, it is apparent that dual loyalty influences OMPs' decisions. Some are conflicted, indicating a fear of decision-making, should they upset the employer. They would rather err on human rights of employees, as they are unlikely to retaliate. The information available from the case studies, supports the implication that dual loyalty affects OMPs' decision-making in the mining industry.

Concerning autonomy, the truth should be communicated to employees regarding their working conditions and influence on their functioning. Whilst acknowledging that employees might not be at an intellectual level to apprehend medical jargon, most comprehend if treated with dignity and

---

[91] .Beauchamp TL & Childress JF (1994) *Principles of biomedical ethics* 4th Ed New York: Oxford University Press.

[92]World Medical Association, International Code of Medical Ethics (Oct. 1949), *http://www.wma.net/en /30publications/10policies/c8/index.html*

if they are not unfairly discriminated against. A right to autonomy should improve in the industry, with less paternalism, suggesting a tendency to decision-making on behalf of employees.

The study asserts that dual loyalty of occupational health practitioners occurs because employers obstruct ethical practices. All evidence available indicates the existence of dual loyalty and its influence on decisions of OMPs, though the extent of the challenge is unknown. The mining industry should be monitored closely.

The MI may conduct a survey where OMPs will be interviewed. Specific questions will be directed to determine how rife the challenge of dual loyalty is and how independent the practitioners are concerning decision-making. Once practitioners with ethical dilemmas are identified, relevant steps can be determined to encourage “practitioners to make the best ethical choices when faced with conflicts of dual loyalties”[93]. It is thus necessary to make recommendations to assist OMPs in handling ethical dilemmas. “The choice to follow an ethical course of action may lead to adverse consequences for the OHP”[94] and thus “the role of professional collectivities is critical in addressing dual loyalty”[95]. All those working in the occupational health space will benefit from training to improve awareness on issues of dual loyalties and this should include main occupational health organisations and employers of these practitioners.

5.2 Recommendations

A global working group proposed guidelines on dual loyalties for health professionals to manage the existing challenge concerning dual loyalties [Rubenstein *et al.*, 2002]. The mining industry health practitioners would benefit from such guidelines, focussing on the individual’s conduct and incidences in institutions, exploring ethical behaviour and human rights protection.

---

[93] L London, 2005, American journal of industrial medicine.
[94] H Frumkin, 1998; Right, wrong and occupational health: lessons learned. Int journal of occupational enviro health 4: 33-34.
[95] L S Rubenstein *et al.* 2002. Dual loyalty and human rights in the health professional practice. Proposed guidelines and institutional mechanisms.

"This integration of human rights and ethics is an evolving perspective that has much to offer ethical practice"[96]. Other important considerations that need to be prioritised would comprise:

- "Raising the level of awareness amongst employer bodies of the need to respect practitioner independence and impartiality would be a first step in enabling individual practitioners to assert such ethical obligations".
- "Secondly, the nature of the occupational practitioner's contract with a third party should explicitly include the ethical obligations of the OHP and be buttressed by regulations"[97].

By including the ethical obligations in the contract, means the employer would be recognising that health practitioners should be independent in their daily functions and practices. If health practitioners are impartial, they are able to continue practising their ethical obligations instead of being influenced by employers in their decisions.

The importance of dual loyalties in ethical dilemmas has been recognised by the working group, focussing on occupational health practice in the workplace.

It would be advisable to have the guidelines tailor- made for specific workplaces as occupational health settings may differ in various industries and this also depends on awareness and support by various employers. Further engagements with relevant stakeholders would also be beneficial to ensure that proposed actions are relevant and facilitating. Most OMPs might be unaware of the guidelines mentioned, providing the DMR, with the guidance of the MI, the opportunity to draft guidelines that would assist OMPs to maintain their ethical obligations when encountering conflict. Since guidelines in the mining industry are drafted to assist employers, the guideline would provide the DMR an opportunity to raise awareness to employers of the health practitioners and guiding the health practitioners in dealing with dual loyalty dilemmas.

---

[96] [British Medical Association, 2000] including that in the occupational and environmental health fields [Smith, 2003].

[97] J Ladou *et al.*, 2002; Codes of ethics (conduct). Occupational Med 17: 559-585.

Most health care practitioners may be unsure of their medical knowledge and decisions because of dual loyalty conflicts, as they find themselves ethically and morally conflicted.

"Awareness of and commitment to established medico-ethical principles empower occupational health doctors and nurses to negotiate the ethical caveats characterising their profession. But if physicians employed in industry are the only ones calling for sound occupational health ethics, their voices are easily drowned in the noise of production targets or may even to some managers, sound like misplaced medical antics"[98].

Most organisational structures, where occupational health is practised, are such that OMPs find themselves reporting to non-medical peers, such as engineers and safety individuals. This tends to exacerbate the challenge of dual loyalty, as ethical obligations are not considered in the OHPs contracts. Non-medical supervisors are mostly interested in production and expect that OMPs should prioritise that when determining fitness status of employees. OMPs invariably become conflicted; overly cautious or discriminatory when determining fitness of employees and employees with specific impairments suffer because of conflicted decisions by OMPs.

It was established that dual loyalty by occupational health practitioners exists and a guideline dealing with ethical obligations and human rights should be made available to practitioners and awareness training should be provided to employers in the various institutions. Occupational health practitioners should be supported and encouraged to have sound medical ethics and best practice in their doctor-patient relationships, to avoid dual loyalty dilemmas.

[98] GM Grobler, Respecting patient autonomy in occupational medicine practice. Vol18 No 4 July/August 2012. OHSA.

BIBLIOGRAPHY

Literature

1. Baldwin-Ragaven *et al*. Learning from our Apartheid past: Human rights challenges for health professionals in contemporary South Africa. Ethn. Health 5:227-241, (2000).
2. Berlinguer G. *et al*. Ethical problems in the relationship between health and work. Int. J Health Serv 26: 147-171,(1996)
3. [British Medical Association, 2000] including that in the occupational and environmental health fields [Smith, 2003].
4. Council for International Organizations of Medical Sciences (CIOMS), International Ethical Guidelines for Biomedical Research Involving Human Subjects, (2002).
5. Definition of the Hippocratic Oath, MedicineNet.com, http://www.medterms.com/script/main/art.
6. Deubner D. and Sturm RE. *et al*. Patient advocacy versus employer protection. Occupational. Med 17: 607-615, (2002).
7. Dual Loyalties: The Challenges of Providing Professional Health Care to Immigration Detainees.
8. Emanuel E. Introduction to occupational medical ethics. Occup Med 17: 549- 558, (2002).
9. Forster C. Human dignity in bioethics and law. 2011.
10. Frumkin H; Right, wrong and occupational health: lessons learned. Int. journal of occupational enviro health 4: 33-34, (1998).
11. Gillon R. Medical ethics: Four principles plus attention to scope, BMJ 309:184-188, (1994).
12. Grobler GM; Vol18 No 4 July/August 2012; occupational health Southern Africa; www.occhealth.co.za.
13. Health Professions Council of South Africa (HPCSA), General ethical guidelines for the healthcare professionals, booklet 1, (2008).
14. Higgins P. and Orris P. (2002), providing employer- arranged occupational medical care: conflicting interests, occupational medicine 17: 601-606
15. Howard J. and Gereluk W. (2001), Core Labour Standards and Human Rights in the Workplace
16. ICOH. International code of ethics of occupational health professionals. 2002

17. International Institute for Environment and Development (IIED), London
18. Ladou J. *et al*. Codes of ethics (conduct). Occupational med 17: 559-585, (2002).
19. London L. American journal of industrial medicine, (2005).
20. Myser C. The problem of dual loyalties: standards of conduct for the professions. (2000).
21. Nemery B. The conflict prone nature of occupational health research and practice, (1998).
22. Physicians for Human Rights. March 2011.
23. Rodham K. Manager or medic: the role of the occupational health professional. Occupational Med 48: 81-84. (1998).
24. Royal College of Physicians, Faculty of Occupational Medicine, (1999).
25. Rubenstein L.S. *et al.* Dual Loyalty Working Group. (2002).
26. Rubenstein LS *et al*., Dual loyalty and human rights in the health professional practice. Proposed guidelines and institutional mechanisms.(2002).
27. White N. Submission on systematic racial discrimination in the health sector and the consequences for the health of mine employees (1997).
28. World Medical Association, International Code of Medical Ethics (Oct. 1949), *http://www.wma.net/en/30publications/10policies/c8/index.html*

CASE LAW

29. Aero service v O'Malley supra at 381, Gower in Principles of Modern Company Law, 3rd ed. (1969), at p. 518.
30. Bombrys v City of Toledo 849 F.Supp. 1210.
31. Bray v Ford [1896] AC 44, 51.
32. Bristol and West Building Society v Mothew [1998] Ch. 1, 18.
33. Hoffmann v SA Airways (2000 ILJ 2357 (CC).
34. IMATU v City of Cape Town (2005) 14 LC 6.12.2
35. Kapche v City of San Antonio 304 F 3d 493(2002).
36. McLean v SASOL Mine (Pty) LIMITED Secunda Colliery.
37. McKenzie v Quintette Coal Limited (1986) 8 CHRR D/3762 (BCCHR).

38. MEC for Education: Kwazulu-Natal and Others v Pillay (CCT 51/06) [2007] ZACC 21; 2008 (1) SA 474 (CC); 2008 (2) BCLR 99 (CC) (5 October 2007)
39. National Coalition for Gay and Lesbian Equality v Minister of Justice 1999 (1) SA 6 (CC).
40. Nowell v Canadian National Railway Limited [1987] DLQ 8
41. Phillips v Fieldstone Africa (Pty) Limited 2004 (3) SA 465 (SCA) at para 31.
42. Robinson v Randfontein Estates Gold Mining Co Limited 1921 AD 168 at pages 177-178

.

LEGISLATION

Acts

1. The Constitution of the Republic of South Africa, 1996.
2. The Constitution, chapter 2, Bill of Right. Section 9 and 10
3. The Constitution, chapter 2, Bill of Rights. Section 23(1)
4. Employment equity Act, No 55 of 1999.
5. Employment Equity Act. No 55 of 1999. Section. 6
6. Employment Equity Act. No 55 of 1999. Section 7
7. Health Professions Act, 1974 published under GN R717 in GG 29079 of 4 August 2006, as amended by GN R68 in GG 31825 of 2 February 2009 and GN R654 in GG 33400 of 30 July 2010).
8. Labour Relations Act, 66 of 1995. Section 10(1)
9. Mine health and safety Act, 29 of 1996 and Regulations.
10. MHSA. Section 20(1) (a)
11. MHSA. Section 49(1) (b)

Guidelines

1. Guideline on Minimum standards of fitness to perform work at a mine, Government Gazette No. 39656, 5 February 2016.
2. Guideline for mandatory code of practice on management of medical incapacity due to ill health or injury, 5 February 2016.
3. Health professions council of South Africa, Booklet 1, General ethical guidelines for the health care professions, edited by the human rights, ethics and professional practice, Pretoria, 2016.

Table of Abbreviations

COP	Code of practice
DMR	Department of Mineral Resources
EEA	Employment Equity Act
HPCSA	Health Professions Council of South Africa
HTS	Heat Tolerance Screening
ICOH	International Commission on Occupational Health
IDDM	Insulin-Dependent Diabetes Mellitus
IMATU	Independent Municipal and Allied Trade Union
IOD	Injury on duty
LRA	Labour Relations Act
MHS	Minimum health standards
MHSA	Mine Health and Safety Act
MI	Medical Inspector
OHP	Occupational health practitioner
OHSA	Occupational Health and Safety Act
OMP	Occupational medical practitioner
RFA	Rehabilitation and functional assessment
SA	South Africa

.