cant to believe that they are making the hiring decisions based on the medical findings.

5. The dilemma for the physician to switch from a treating role to an investigating role is well understood. Therefore, to avoid a conflict of interest, most occupational health physicians recommend that the same physician avoid treating a patient and performing a preemployment or fitness-for-duty examination. Most would agree that physicians who perform a preemployment evaluation do not have physician-patient relationships.

Finally, if employers insist on performing unnecessary testing, we as physicians should attempt to educate employers about what testing is medically indicated to answer the question of whether the applicant can perform a prescribed job.

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References

1. Holleman WL, Matson CC. Preemployment evaluations: dilemmas for the family physician. J Am Board Fam Pract 1991; 4:95-101.

To the Editor: As Holleman and Matson (J Am Board Fam Pract 1991; 4:95-101) have correctly observed, there is little in the recent literature that family physicians and other primary care doctors can use as a guide to performing preemployment examinations fairly and effectively. Their paper and others they cite indicate a need to take a fresh look at relevant ethical and procedural issues. Most of these matters, however, have proved less problematic in practice than might be expected on theoretical grounds.

Because applicants for employment are usually examined by physicians with whom they have no preexisting professional relationship, physicians should seldom face ethical pressure to overlook information that might properly lead to rejection. Indeed, the practitioner has both contractual and ethical obligations to record all significant findings. An applicant who has an alcohol problem severe enough to be evident to an examiner who has not seen the person before may be sick enough to pose danger to self or others on the job; accepting such a person for employment may also perpetuate his or her denial of the existence of the problem. It is reasonable for an employer to expect an applicant with an inguinal hernia to get it repaired surgically before starting work rather than later claiming it to be job related. Businesses that have faced deteriorating employee performance, rising work-related injury rates, and other consequences of illicit drug use in the workplace understandably want to do whatever they can to avoid hiring more drug users.

Holleman and Matson correctly note that applicants for work should be clearly informed that information obtained in the course of the preemployment examination, including drug screening tests, can be communicated to the employer and used as a basis for rejection. It has been my personal experience, however, that businesses want to know only whether applicants are capable of doing the work for which they are being hired; they do not wish to misuse information provided by the physician. As the authors have indicated, the practitioner should retain the physical examination record and notify the employer only that the applicant is acceptable for employment, acceptable with specified qualifications, or not acceptable. If something is found that requires further medical attention but is not disqualifying for the particular position, such as mild hypertension or glucose in the urine, it is a simple matter to write the findings on a piece of paper and hand it to the applicant with instructions to take it to his or her family physician for further action. The examiner keeps a photocopy of the note, of course.

The authors correctly note that most employers do not tell the examining physician what the job demands will be. There are three ways to address this problem. One is to ask the employer to provide the information. Another is to ask the applicant, who usually has at least general knowledge of what will be expected. The third and best is to pay a visit to the workplace. In my experience, employers are delighted when a physician asks for a plant tour. If nothing else, the practitioner will then know what an applicant means when he says, "I've been hired to run the batch machine," or whatever.

In my view, it is important for physicians not to fall into a Robin Hood posture, which sees all employers as avaricious and all workers who claim disability as deserving. In my section of the country, for example, there is a remarkable upsurge of reports of disability from chronic work-related backaches just before the first week of deer-hunting season. A large number of workers submit spurious or exaggerated injury claims, and the physician who helps an employer guard against them is not violating standards of medical ethics. The physician's commitment must be to the truth, whether that favors the worker or the company. That, in my experience, is what most employers want.

Performing preemployment examinations requires a different mindset than true family practice, but it is a service that family physicians and other primary care physicians can provide appropriately and without misgivings as an integral part of their practices without compromising appropriate standards of medical ethics.

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The above letters were referred to the authors of the article in question, who offer the following reply:

To the Editor: We appreciate the letters by Drs. Fung and Kennon and Dr. Gillette, which mostly support

and accent our concerns regarding the performance of preemployment evaluations by family physicians. We will restrict our comments to two areas that deserve further clarification.

Both letters state that because there is seldom a preexisting relationship between physician and patient-employee, the problem of switching from a therapeutic to an investigative role seldom arises. Our experience has been that many employees who see physicians for preemployment evaluations often become patients of those physicians following the evaluation. Many clinics perform preemployment evaluations for the purpose of recruiting patients. So even though there is no preexisting physician-patient relationship at the time of the preemployment evaluation, there may be one following it, and thus the problem of conflicting loyalties may develop.

The other area involves the employer's attitude toward confidentiality of medical information. We agree that employers generally do not have a malicious attitude toward prospective employees' privacy, nor do they generally wish to know anything other than whether a person is medically fit for employment. Our study showed, however, that medical information that should have been treated as confidential is, in fact, often given to the employer and often without the prospective employee's knowledge or consent. Our concern is not that the employer has connived to get this information, but that there may be persons in the personnel office or some other department who have access to this information and who may use it inappropriately.

We believe wholeheartedly that primary care physicians should not see themselves either as the Robin Hood rescuers of patient-employees or as the "hired hands" of the employers. Our study indicates that many family physicians perform preemployment evaluations in ways that could create inappropriate and unnecessary tensions in relationships with patient-employees and employers and diminish the overall value of the preemployment evaluation. We agree with Dr. Gillette that family physicians can provide preemployment evaluations without compromising appropriate standards of medical ethics. Our study raises the question of whether this regularly occurs.

We believe that examination of current practices and attention to the issues involved in preemployment evaluations will benefit both physicians in training and those currently performing these and other evaluations involving third-party payers.

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