

Pre-Employment Medical Examination of Migrant Workers - The Ethical and Legal Issues

G Jayakumar, MMed (Occup Med)

Department of Community Medicine, Melaka Manipal Medical College, Jalan Batu Hampar, Bukit Baru, 75150 Melaka

The number of legal migrant workers in Malaysia as of 2005 was 1,742,100¹. Illegal workers are believed to be in significant numbers too. The workers are subjected to medical examination at the country of origin by doctors appointed there by the Ministry of Health, Malaysia². The agents recruiting these workers make the necessary arrangements for these workers' pre-departure medical examination. They are required to reject those who fail the examination. Upon arrival in Malaysia, the legal workers are subjected to pre-employment medical examination within one month. FOMEMA Sdn Bhd undertakes the task with a big pool of doctors under its ambit. In Sabah, with effect from 1st December 2006, the task to undertake the medical examination was taken over by Growarisan Sdn. Bhd from FOMEMA Sdn Bhd³. However, the new company continues to utilise the existing FOMEMA database and medical examination requirements. In Sarawak, no private company has been given the concessionaire to conduct pre-employment medical examinations. The migrant workers undergo the pre-employment medical examination conducted by registered medical practitioners who follow similar guidelines as stipulated by the Ministry of Health, Malaysia.

Pre-employment medical examination is a medical examination for prospective employees before commencement of employment. It is conducted to assess whether they are fit to work⁴. A basic data (benchmark) about the worker for future comparison is also created. While screening ideally should not be used to limit disease incidence at a workplace by dismissing workers with abnormal findings, employers do not normally wish to be burdened with treating medically unfit prospective foreign employees. Most importantly, medical screening is not a substitute for hazard control⁵.

As physicians, we inherently need to practice within certain norms. Methods of practice and tools physicians use may raise ethical, legal and jurisprudential queries. We need to recognise the difference between approaching a patient with the noble intent to diagnose and treat and pre-employment medical examination. In the former, physicians practice *priori* viz. a systematic approach of complete history, physical and laboratory examinations to clinch a diagnosis. In the latter, it is a physician's role to tailor the approach specifically to assess fitness to do a particular job, ensuring before employment that the worker has no serious diseases⁶.

In Malaysia, as a developing nation in the quest to forge ahead as a developed nation, we are at the cross roads on how to approach pre-employment medical examination for migrant workers. Medical literature elsewhere is limited with regards to this. However, we are committed to observe the fundamental principles of WHO namely Health for All, the Charter of Human Rights, United Nations Convention on the Protection of the rights of all Migrant Workers and members of their family as well as other conventions. Pre-employment medical examination fundamentally is preventive. In reality in Malaysia, it seems to be for triple reasons, preventive, economic and for social reasons. FOMEMA stipulates a set of laboratory examinations that are mandatory to be carried out by physicians. They are namely blood tests like blood grouping, HIV, hepatitis B, VDRL/TPHA, malarial parasites, urine tests for colour, specific gravity, UFEME, opiates, cannabis, pregnancy tests and sugar and lastly chest radiograph⁷.

Compulsory HIV testing puts the physician and the worker at odds. Technically, compulsory testing constitutes a violation of a worker's integrity and

Corresponding Author: Jayakumar Gurusamy, Department of Community Medicine, Melaka Manipal Medical College, Jalan Batu Hampar, Bukit Baru, 75150 Melaka

private life, if performed without the latter's consent⁶. Medically, the worker may have a false negative test due to the window period. Secondly, a negative test speaks little as there can be an exposure after the test itself. Thirdly, even if a worker is found to be positive for HIV, the worker may still be able to carry on with the work functionally. The Code of Practice on Prevention of HIV/AIDS at Workplace clearly stipulates that employment practices should be based on scientific and epidemiological evidence that people with HIV/AIDS do not pose a risk of transmission of the virus to co-workers through ordinary workplace contact⁸. As physicians, we are left with a dilemma here! The argument is that even some of our own citizens are not receiving some of these costly treatments and therefore the situation should not be further aggravated by attempts to treat foreigners. The pertinent point is that such workers are cut off from families and social systems coupled with experiencing cultural differences and often lacking knowledge in HIV/AIDS. A migrant worker in the host environment might be attracted to engaging in risk behaviours, such as unprotected casual sex, commercial sex or intravenous drug use⁹.

It is pertinent to advocate pre and post testing HIV counseling to all migrant workers. This seems to be lacking in Malaysia. Indonesia and Philippines have pre-departure programmes for their potential migrant workers. This will help the workers to adapt to the new socio-economic environment and healthcare system of the recipient country. The Philippines has in place legislation for compulsory orientation on HIV/AIDS for these workers. This programme needs to be extended to other labour supplying countries. In 2002, United Nations Development Programme at a meeting in Philippines got together representatives from Brunei, Indonesia, Malaysia, Philippines and Singapore to develop the Migrant Workers' HIV Vulnerability Reduction programme. It emphasised on the need on Pre-Departure, Post Arrival and Returnee Reintegration programmes. The Post-Arrival programme refers to a structured orientation programme given by the host countries to the migrant workers upon their arrival in the host countries, followed by a continuum of accessible medical, health, social and referral services⁹.

Statistics from FOMEMA for 1999, showed that the incidence of Hepatitis B was 53.7% and other sexually transmitted diseases were 18.7% of the total diseases of migrant workers who were certified unfit from second

year onwards of working in Malaysia¹⁰. Health education on healthy lifestyle including safe sexual practices, monogamy or barrier methods and good hygiene practices need to be emphasised. Health education materials need to be distributed to them in their native languages to get the message through. Currently, the emphasis on health education is lacking either due to time constraint of the physician or due to the language barrier. A concerted effort by the Ministry of Health, Ministry of Human Resource, Malaysian Employers Federation and by the physicians must be undertaken to enhance the delivery of health education to the employees.

Hepatitis B, syphilis and tuberculosis are some of the communicable diseases that are listed as category one conditions where the migrant workers are considered unfit for employment under FOMEMA and Ministry of Health guidelines. Ethical issues may be raised here. Malaysia being a developing country, perhaps it may be acceptable for now. In future, as we head towards a developed nation, we may need to change our stand to take into account of the fundamental aspects of pre-employment screening, human rights and equality in keeping in tandem with established international protocols. As a developed nation, this is perceived as role model to other aspiring nations. The debate will however remain as to what proportion of the tax payer's money need to be channeled for this good cause.

Non communicable diseases like hypertension, diabetes mellitus, peptic ulcer diseases, heart diseases and others are listed as category two conditions. Here, fitness to work is decided by the physician subject to the final approval by FOMEMA. The examination should not be used as a double edged sword to hire and fire based on the medical condition. A well controlled hypertensive can work perfectly well. Opponents may argue that this will escalate the healthcare costs. While this may be true, we need to be mindful of the fundamental aspects. Jurisprudence clearly states the risk of the disease need to be significant and be scientifically, statistically and medically proven. This will disallow workers from being excluded on the basis, for example, of a radiological anomaly that has no clinical correlation and which is associated with a favourable prognosis⁶. Making it mandatory for insurance coverage for workers who are disease free at the point of employment can minimise the cost for these workers to obtain treatment in the event they contract any of these diseases later.

Leong in this journal highlights that 22.4% of female Indonesian domestic helpers who were found to be unfit in his clinical practice upon their arrival to Malaysia suffered from Pulmonary Tuberculosis (PTB) from the year 1997-2004. This is in spite of being certified fit in their country of origin before departure¹¹. It has to be noted that chest radiographs are insensitive as diagnostic tools. Ten percent of patients with PTB may depict normal chest radiograph¹². A good history correlation with clinical symptoms and AFB sputum smear should be considered at the pre-employment examination. It is also not uncommon for significant proportion of workers to return to Malaysia within weeks after repatriation due to medical problems. They are known to obtain travel documents under different names or returning illegally by other surreptitious means. Hence, it is time for the authorities to come out with a biometric identity card with health records for migrant workers. Though biometric cards are expensive, it makes sense considering the high number of illegal migrant workers lurking around with emerging and reemerging infections.

Hepatitis A, cholera and typhoid epidemics occur in clusters. Patients may remain apparently healthy but in reality may be chronic carriers. Many come from low socio-economic background with poor personal

hygiene. Migrant workers who are to be employed as domestic helpers or restaurant workers should be screened for typhoid and cholera by rectal swabs if the clinical history is suspicious or if there are signs and symptoms. Some may perceive this as a cumbersome screening tool but it remains simple, cheap and reasonably effective. Immunisation against typhoid and Hepatitis A need to be considered too.

Conducting pre-employment medical examination for migrant workers is an arduous task to keep up to expectations of all the ideal values within reasonable financial and social considerations. We may not be able to satisfy all the expectations now. Nevertheless, as we aspire to and eventually attain a developed nation status, it is imperative that we try to advocate the best for these migrant workers. Morally and ethically, as physicians or as reasonable fellow human beings, we owe them the best professional care.

What needs to be stressed is the need for doctors conducting the pre-employment medical examination to be vigilant and to take the necessary steps to ensure that all the tests on the migrant workers are carried out judiciously and objectively. We should resist pressures from various interest groups to pass as fit clearly unfit workers.

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