LEGAL AND ETHICAL ISSUES:
Case Study on a Migrant Worker with a Non-Work-Related Illness

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Doctors face professional, ethical and financial challenges in providing adequate healthcare to domestic and non-domestic semi-skilled migrant workers in Singapore. Treatment and care of work-related injuries and issuance of medical leave have received much attention and discussion.[1,2] The Jurong Health Clinical Ethics Committee (CEC) and the National University of Singapore Centre for Biomedical Ethics [through its Clinical Ethics Network and Research Ethics Support (CENTRES) initiative] recently held a forum on legal and ethical issues in providing healthcare services to migrant workers with non-work-related healthcare problems. A case adapted from a referral to the Jurong Health CEC was used to focus the discussion. We present the case below and examine questions discussed at the forum, which raise considerations of standard of care, role of the employer in decision-making and medical repatriation.

Case example

Mr R, a 45-year-old semi-skilled worker from a neighbouring country, is admitted to a public hospital with localised fits affecting his right upper limb. His condition is not work-related. Doctors discover that he has a lesion in his frontal lobe, which is most likely the cause of the fits. Typically, in such a situation, the medical team would recommend a biopsy and excision of the tumour, followed by rehabilitation. However, given that Mr R is a migrant worker on a work permit, there is concern about the appropriate course of action, particularly in relation to the question of who will bear the cost of treatment. Mr R does have medical insurance, as the law[3] requires that employers buy and maintain medical coverage of at least $15,000 per year for each work permit holder. However, this will fall far short of the amount that will be required to provide Mr R with what is generally considered the standard of care in cases such as his. This case raises questions which we will look at below:

(i) To what extent should the employer be involved in the decision-making process?

(ii) What if the employer interferes by offering Mr R money to return home rather than to continue with treatment?

(iii) What if the employer refuses to pay for the treatment if the medical costs exceed the mandatory insured amount?

Employer's involvement in the decision-making process

The medical team will need to inform Mr R about their initial findings, as well as provide him with advice and information regarding further diagnostic tests and treatment options. Mr R has the capacity to make his own healthcare decisions and provide informed consent for any procedure. However, the team is concerned that Mr R's treatment may prove to be very expensive. As a foreigner, Mr R will be charged private rates and he is only insured for $15,000. There is no doubt that Mr R will be unable to bear the additional costs and the team recognises that this burden is likely to fall on his employer. This raises the question of whether it would be appropriate to involve Mr R's employer in the discussions regarding the management of his condition.

From a legal standpoint, Mr R is the only person who is able to provide a valid informed consent for any procedure. However, this assumes that Mr R is given sufficient information and a range of options, and that he is free to choose a certain course of action from the options provided. Whether or not Mr R is free to choose his preferred medical treatment is one of the issues at stake in this case. One of the fundamental principles of medical ethics is respect for persons. This translates to treating people as individuals with autonomy or the right to self-determination. The nature of the employer-employee relationship does not typically involve shared medical decision-making. It would be rather extraordinary if a doctor informs a patient who happens to be his/her junior colleague, local or foreign, that he/she should confer with the Chairman of the Medical Board about his/her medical condition and treatment options. Therefore, if Mr R has the requisite capacity, allowing any other individual to interfere with his decision-making process would amount to failing to respect his right to self-determination. It would be very difficult for the medical team to justify this violation of Mr R's autonomy.

It is true that some employers may genuinely want to act in the best interest of their employees and could provide useful information and assistance to the medical team as well as support to their employees. However, doctors have a legal and ethical duty to maintain the confidences of their patients, and disclosing any information or permitting the employer to be involved in any way with decision-making should only be conducted with the full and free consent of the employee. Doctors should always consider the different aspects in which the employee may be in a vulnerable position. It is worth noting that as a foreign worker, Mr R will probably be heavily reliant on his employer to pay for his medical expenses *and* his stay and accommodation in Singapore. Unlike a Singaporean employee, he will probably not have access to any other support system within Singapore to mitigate his reliance on his employer. Therefore, allowing his employer to participate in the decision-making process may risk violating Mr R's right to make his own decisions and may undermine his ability to make a free and voluntary choice.

Medical stabilisation and repatriation

It is a reality that in any situation, the choices available to a patient will depend on a variety of factors, including a person's financial situation and dependency. The question therefore is not simply whether Mr R should be free to choose a course of treatment but also whether there are legitimate reasons for limiting Mr R's choices.

A migrant worker's non-work-related injury, particularly one that requires mid- to long-term care, is complicated by the availability of "medical repatriation" by the employer. The position of the Ministry of Manpower (MOM) is that if a work permit holder's long-term medical care is for a condition unrelated to work, an employer may send him/her

home to continue treatment at his/her own expense.[4] However, this is only permitted once the employee's condition has stabilised and he/she is deemed fit to travel.

In the above scenario, on the employer's request, it would appear legally legitimate to limit Mr R's treatment to what is necessary to stabilise him for repatriation.[5] The regulations stipulate that it is a *Singapore-based* doctor who must make the decision on whether Mr R is stabilised and fit for repatriation.

However, the regulation does not provide a detailed explanation of what it means to stabilise a patient. It may be contended that Mr R is suffering from a life-threatening condition which is potentially curable and that the necessary interventions to stabilise him would include a biopsy, surgery and rehabilitation. Conversely, it is also arguable that as long as Mr R's fits are controlled, he is stabilised for repatriation.

Should doctors allow the employer to repatriate Mr R after his fits are controlled even though Mr R wants to stay in Singapore for treatment or better care – that he otherwise would not receive if he were to go home? In defence of this decision, it may be tempting to rely on the argument that if Mr R were in his home country, he would probably have fewer treatment options and therefore it is justifiable to limit his standard of care to what is available there. This is an untenable argument for two reasons. First, accepting this argument would mean accepting that different people can be treated differently based solely on the relative wealth or poverty of their country of origin. This is both illogical and discriminatory. Second, this violates the doctor's duty to uphold justice. The 2016 Singapore Medical Council's Ethical Code and Ethical Guidelines (ECEG) states that a doctor must: "Provide access to good medical care and treat patients without unfair discrimination, prejudice or personal bias against any characteristic of patients, for example, gender, race, religion, creed, social or economic standing, disability or sexual orientation."

Ultimately, medical repatriation is based on clinical judgement and the best interests of the patient, and any interests or arguments advanced by the employer should not sway the medical team. Doctors should always act in the best interest of their patients and provide the standard of care as prescribed by the ECEG. It is ethical and legitimate for the medical team to proceed with biopsy, surgery and rehabilitation if they think that these are necessary interventions to stabilise Mr R.

Employer offers money for patient to return home

The medical team decides that they have a duty to recommend that Mr R undergo a biopsy and Mr R consents to it. Soon after this, Mr R has a private discussion with his employer and now tells the medical team that he does not want the biopsy and wants to be discharged. Privately, he informs the nurse that his employer has offered him an attractive sum and an air ticket home. The nurse informs the medical team about this and they now have to decide on a course of action. They are unclear as to whether they should let Mr R sign an At Own Risk (AOR) form and discharge him, report the employer to MOM, or consult the hospital's ethics committee.

The concern raised by the employer's offer is that it might amount to coercion or undue pressure. On the other hand, such an offer might be viewed as a goodwill settlement. If Mr R understands the consequences of an AOR and genuinely prefers this option given the employer's offer, autonomy would dictate that his choice should be respected.

However, if the team is genuinely concerned that Mr R's autonomy has been compromised by his vulnerable position and that he is not making an informed and voluntary decision, they would have a duty to protect Mr R. What should be done to protect a patient like Mr R would depend on the resources available to the team and to Mr R,[6] and if they are unsure how to proceed, consulting the hospital's ethics committee would be a step in the right direction.

Employer's refusal to pay for the treatment

The employer cannot refuse to pay for the treatment even if the medical costs exceed the mandatory insured amount. The Employment of Foreign Manpower (Work Passes) Regulations stipulates that the employer must be responsible for and bear the costs of the upkeep and maintenance of the foreign employee in Singapore except as the Controller specifies otherwise in writing. The cost of upkeep and maintenance includes the provision of adequate food as well as medical treatment.[7]

The MOM will take action against employers who deny their workers access to necessary treatment, and hospitals can escalate cases of refusal of payment to the MOM using a foreign worker medical bill non-payment referral form.

To ease their financial burden in the event that their migrant worker employees suffer a non-work-related injury or illness, employers can arrange for their employees to bear part of the cost of medical treatment if it exceeds the minimum medical insurance

requirement. This arrangement must be stated explicitly in the worker's existing contract or collective arrangement. The MOM has cautioned that such arrangements should not be abused and that as a rule of thumb, they should not exceed six months and the amount paid by the worker should not exceed 10% of their monthly salary.[8]

To our knowledge, such contractual agreements are rarely made and 10% of a migrant worker's salary would, in many cases of non-work-related injury or illness, hardly ease the financial burden of the employer. When there are multiple valid treatment options, the treatment selected need not be the most expensive and best so as to be fair to the employer.

Conclusion

Migrant workers' healthcare and access raise complex legal and ethical issues at the intersection of medical professionalism, health financing and transient immigration work. At a national policy level, incremental changes have been made to meet the health needs of our migrant workers. Personal accident insurance coverage has been raised for foreign domestic workers (with effect from October 2017) and it has been suggested that the minimum sum for medical insurance coverage should also be increased (which should extend to non-domestic workers as well) to ensure adequate care.[9] However, further changes may still be needed. It is not ideal that foreign workers pay private rates for access to healthcare, as it significantly reduces the likelihood that the minimum medical insurance coverage will be adequate to meet the needs of those suffering from a serious illness. There is a need for a broader public discussion on future policy changes that takes into account the interests of all stakeholders and pays particular attention to the interests of vulnerable populations. Potential solutions include risk pooling, where a small percentage of the foreign worker levy is set aside by the Government to meet such healthcare costs.

At a professional level, this case demonstrates how doctors might be placed in very difficult situations when providing care to workers with non-work-related health conditions. While this case was a rather extreme one, as it involved a potentially curable life-threatening condition which required complex surgery, there are many situations involving conditions that may not lead to loss of life but rather limitation of function, which can be highly significant in areas where manual labour is the main industry. Ideally, doctors should know when the interests of employers are extraneous and illegitimate and make the welfare of migrant workers, like other individual patients, their central concern. This may not be so easily accomplished in practice and doctors who feel that they require greater support in making some decisions should refer their concerns to their clinical ethics committees and experienced clinicians.

References

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2. *Rajaraman N. A Reply to "The Dilemma of Medical Leave". SMA News 2017; 49(2):16-7.*

3. *Employment of Foreign Manpower (Work Passes) Regulations 2012.*

4. *Ministry of Manpower. FAQ response to "My WP holder requires long-term medical care. Am I obligated to pay for the entire course of treatment?" Available at: http://www.mom.gov.sg/faq/work-permit-for-foreign-worker/my-wp-holder-requires-long-term-medical-care-am-i-obligated-to-pay-for-the-entire-course-of-treatment.*

5. *This does not mean that the position is ethically defensible. However a consideration of this is beyond the scope of this present article.*

6. *It may be possible for the team to address some of their concerns about repatriation; for example, steps could be taken to ensure continuity of care – linking up with a doctor who can care for Mr R in his home country and transferring medical notes and test reports over.*

7. *Employment of Foreign Manpower (Work Passes) Regulations. First Schedule. Conditions of Work Permit.*

8. *Ministry of Manpower. FAQ response to "Can my foreign worker bear the entire cost of treatment if it exceeds the minimum medical insurance requirement?" Available at: http://www.mom.gov.sg/faq/work-permit-for-foreign-worker/can-my-foreign-worker-bear-the-entire-cost-of-treatment-if-it-exceeds-the-minimum-medical-insurance-requirement.*

9. *Cheng K. Foreign domestic workers to be better insured against accidents from Oct. TODAY 7 May 2017. Available at: http://www.todayonline.com/singapore/greater-personal-accident-insurance-protection-domestic-workers-oct.*

Two Case Vignettes

Text by Dr Tan Yia Swam, Editor

Further to the case study, Dr Tan Yia Swam shares in this article two additional case vignettes of migrant workers and the social-ethical issues involved in the care of their medical problems. These are accompanied by additional commentaries from the authors of the case study article. While there may not be any ready answers, we hope that healthcare workers on the ground will be more aware of this particular group of vulnerable patients.

Case 1: No access to follow-up treatment

Madam S, a 45-year-old who had been working in Singapore for the past three months as a domestic helper, was admitted with an acute intestinal obstruction. The CT scan showed obstructed sigmoid colon cancer with impending perforation and the patient underwent emergency resection with a stoma. Her employer was a single mother of three, and the sole caregiver to her own elderly sick mother. Consent for the operation was given by the patient via a translator and the employer was updated daily at the patient's request. The employer was forthcoming in sharing with the medical team that the mandatory insurance was not able to cover the current expenses, and that she planned to dismiss the patient once she was medically fit.

During the course of her five-day postoperative stay, the medical team explained to Madam S the final histology of Stage 3 cancer, and the need for adjuvant chemotherapy, yearly colonoscopy, as well as stoma care. In a routine situation, this patient can undergo a second operation to reverse the stoma (join back the intestine), which is generally more socially acceptable for patients.

It then transpired that the patient's social and educational background could not prepare her for the subsequent care. She had never heard of "cancer", much less "chemotherapy". Her home in a small town is a three-hour bus ride to the nearest hospital in the city. She was given a comprehensive discharge letter, copies of her scan, and operation and histology reports, and told to look for a specialist to continue care in the following weeks.

However, once Madam S was fit for discharge, the employer picked her up, with luggage in tow, and sent her to the airport straightaway.

Some thoughts and concerns

1. Can Madam S cope with stoma care in her hometown? Will the necessary supplies be available? Is there going to be stigmatisation from her own family?
2. Without adjuvant chemotherapy, the chances of subsequent relapse and death are high. How else could we have helped her? Is there a way that follow-up can be ensured for these workers who come from remote areas?
3. If anything were to happen to the patient once she reaches her village, will the Singapore doctors who did not follow up her case be medico-legally liable for any complications?
4. Should the employment agents be required to find secondary or tertiary care centres where migrant workers can be referred to should they fall ill in Singapore?
5. Can we increase the value of the mandatory insurance coverage given the rising healthcare costs and the decision to charge them at the same rate as private patients and medical tourists? Or can that decision be reversed to allow work permit holders entitlement to B2 rates (right now, they stay in B2 wards but are charged full paying rates for all other services, including drugs, procedures, and radiological and laboratory examinations)?

Commentary

This case visits the issues of standard of care and medical repatriation raised in the original article, and raises the separate issue of follow-up (elaborated further below). It prompts one to think whether while stabilising a patient, a doctor should consider not only the fitness of the patient to travel back to her home country, but also enquire into the situation the patient is returning to, and try to ensure appropriate care and treatment for the patient in her home country given the resources. If so, the steps of ensuring follow-up care could be construed as part of medical stabilisation, which means that these steps fall under the scope of the doctor's duty under the law in relation to medical repatriation.

The doctors would not be liable unless the patient's complications were a direct consequence of a breach of the standard of care in relation to the treatment she receive d locally, or they inappropriately certified her as stable and fit for travel and she suffered complications as a direct consequence of their certification.

For follow-up and transfer of care, it might be an option to contact the embassy or local non-governmental organisations (NGOs) for advice. It might be the case that alternative arrangements are available but the employer does not know how to access the information or assistance. While it may not be a legal duty to ensure follow-up care, all stakeholders should be asking such questions and exploring the options available by way of direct communication between healthcare providers, governments, NGOs and humanitarian aid agencies.

Case 2: An "ideal" scenario of patient-centric care

Madam V is a 38-year-old single lady who was working in Singapore as a domestic helper. Her employers are a married couple who are both professionals. Madam V presented with a breast lump of three years' duration and recent severe back pain. Inpatient workup confirms the diagnosis of advanced breast cancer with impending spinal cord compression. She was put on bed rest and advised on the treatment options: urgent spine operation for stabilisation, followed by palliative chemotherapy. Her employers were updated at her request and the medical team held combined discussions with both the patient and her employers on the possible logistics and relative costs. She could have the surgery in Singapore, then return to her home country to continue care, or she could be medically evacuated back home with attendant risks and receive treatment there instead. The employers weighted the costs, which are similar, and decided to pay out of their own pockets for surgery to be done here. They then booked a flight for her to return home for treatment – while continuing to pay her a basic salary during the course of her treatment.

This was easier for the medical team to handle, as the employers were able and willing to cover the financial costs for Madam V. The medical team could manage the patient as deemed necessary without being distracted by concerns of costs, as should be the case, but this scenario is unfortunately rare.

Commentary

This is a really good outcome and it should be the norm rather than an exception! Employers should not be involved in discussions about management plans, but the decision should be taken in the best interest of the patient according to the SMC ECEG. This is a "positive example" brought about by the goodwill or kindness of the employers. Different employers have different relations with their workers, so things might be different for another worker facing the same situation.

It is thus fortunate that the employers did not consider the choice of medical repatriation but considered the two possible treatment routes put up by the medical team. Based on the case description, it appears that the decision was largely made by the employers. What might ethically improve the process is to provide decisional support to the employee and help her make an informed choice. For all we know, she might have reasons to want the surgery to take place in her home country, and making this choice would not impose additional financial burden on her employers. Application of the best interest principle on the doctors' part in this case is about offering appropriate treatment choices, which they did. Concerning the choice of treatment, patient autonomy rather than best interest should be the guiding principle. Offering treatment and selecting treatment should not be conflated in terms of their guiding principle. This does not mean that the decision cannot be delegated to her employers should the employee wish so. An alternative that should be explored is to initiate a shared decision-making process and the employee could decide on whether to involve her employers. ◆