March 8, 2010

Medicine That Works: The Road Not Taken in Healthcare Reform

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THE ROAD NOT TAKEN IN HEALTHCARE REFORM

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ABSTRACT: *Although the immediate future of healthcare reform remains uncertain, it is clear that significant long-term improvements to American healthcare will require effective methods of controlling healthcare costs that go beyond those currently being proposed. The United States lags behind many European countries in health, spending much more of its GDP on healthcare while posting worse health outcomes, largely due to the increased prevalence of preventable chronic conditions. This article exposes an important but often ignored component of European preventive healthcare: the law of workplace health and safety, which imposes on employers the positive duty to identify and prevent harms to workers' health. In France, this duty is carried out through a comprehensive system of occupational medicine, required by the Labor Code, requiring all employees to be examined by a workplace doctor on a regular basis. The workplace doctors make individual and policy recommendations to employers to minimize risks to employee health, and monitor the workplace to identify and address these risks. To optimize the doctor's ability to protect employees' health, the law protects the doctors' independence from the employer through the formalization of medical ethics rules and special procedures for firing the doctor. The French model of occupational medicine as public health policy demonstrates the importance of integrating a more robust law of workplace health and safety into the project of healthcare reform. This insight is particularly relevant to current U.S. practice, as employers are increasingly establishing onsite workplace medical clinics focusing on preventive medicine to reduce healthcare costs. The French model cannot easily be transplanted on American soil, but it highlights the public health potential of employer-provided onsite clinics. To control costs and improve health outcomes, a new direction in healthcare reform should include the revitalization of workplace health and safety regulation.*

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INTRODUCTION

As the future of the healthcare reform bills hangs in the balance, it is time to develop a long-term perspective on the American healthcare crisis. It is clear that U.S. law and public policy need new mechanisms to control healthcare costs,[1] far beyond those proposed in the bills that are now stuck in Congressional impasse. According to the World Health Organization, the United States spends the largest percentage of GDP amongst high-income countries on healthcare, at 15.2 percent.[2] All other

[1] This point has been made both in the press and by legal scholars. See, e.g., Atul Gawande, Testing Testing, The New Yorker Dec. 14, 2009; Richard A. Epstein & David A. Hyman, Controlling the Cost of Healthcare: A Dose of Deregulation; available at http://ssrn.com/abstract=1158547; Edward A. Zelinsky, Reforming Health Care: The Paradoxes of Cost, available at http://ssrn.com/abstract=1479249; Timothy Stoltzfus Jost, Our Broken Healthcare System and How to Fix It, 41 Wake Forest L. Rev. 537, 565 (2006).

[2] See World Health Organization, World Health Report 2008: Primary Health Care – Now More Than Ever 82, figure 5.1 (2008).

high income countries spend between 8-11 percent of their GDP on healthcare.[3] The high healthcare costs in the United States are not explained by superior health outcomes. The United States ranks 72nd out of 191 countries in health outcomes, far behind many European countries that spend far less on health.[4] When it comes to overall health system performance, the United States is ranked 37th, lagging far behind France, the WHO's number one healthcare system, based on measures of life expectancy, infant mortality, and health spending as percentage of GDP.[5] A notable difference between the United States and Europe is the role of employment law in public health policy.

The United States also falls far short of France and other European countries when it comes to deaths from preventable, treatable conditions.[6] Studies have shown that America's high healthcare costs, to say nothing of the additional costs of lost productivity, are largely attributable to chronic diseases which could be prevented by healthier lifestyles and early detection.[7] The exceedingly high healthcare costs in the United States are at least partly attributable to our healthcare system's failures at delivering preventive care.

To understand this failure, and to think more imaginatively about how to overcome it, this Article exposes a significant feature of European healthcare that is largely ignored in debates about comparative healthcare costs and outcomes: employment law. In most European countries, the employer has a legal duty to prevent risks to employees' health.[8] In France, for instance, the Labor Code requires all employees to adopt a system of *médecine du travail*, or occupational medicine, which, in effect, delivers preventive care to a large swath of the French working population. This Article explores this French employment-law mandate, which operates alongside the public and private health insurance schemes,

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[3] Id.

[4] World Health Organization, The World Health Report 2000 – Health Systems: Improving Performance 152-55 (2000).

[5] Id. at 153-55.

[6] See Ellen Nolte & C. Martin McKee, Measuring the Health of Nations: Updating An Earlier Analysis, 27 Health Affairs 58, 65 (2008)

[7] See, e.g., Ross DeVol and Armen Bedroussian, An Unhealthy America: The Economic Burden of Chronic Disease: Charting a New Course to Save Lives and Increase Productivity and Economic Growth ii (2007).

[8] The member-states of the European Union are bound by a 1989 directive to impose on employers the obligation to "take the measures necessary for the safety and health protection of workers, including prevention of occupational risks and provision of information and training, as well as provision of the necessary organization and means." Council Directive of 12 June 1989, art. 6, 89/391/EEC.

to account for the superior health outcomes in France. While the American press and public policy scholarship have looked to healthcare in other countries to draw lessons for the United States, they have focused on insurance schemes[9] without considering other legal and institutional arrangements that play a significant role in controlling healthcare costs and outcomes.

The preventive monitoring of employees' health by occupational physicians is mandatory under the French law of occupational health and safety. Understanding this alternative legal regime, which is much more robust than the American counterpart, can open up new paths for American healthcare reform. A deeper awareness of the complex legal regimes that regulate health in other countries is valuable in three important respects: First, the comparison highlights the significance of employment law, especially occupational health and safety law, to healthcare costs and healthcare outcomes, which is seldom recognized in American discussions of healthcare reform. Second, the French model provides a critical perspective on the American experience with company doctors and occupational medicine, which has historically failed to protect workers' health. The alternative path taken by occupational medicine in France can bring the flaws of the American system into sharper focus. Third, the French experience demonstrates the public policy potential of employer-provided onsite care, with regard to preventive care and workplace health and safety, which should inform the law's response to the recent growth of company clinics in the United States. While historical, cultural, and institutional differences make the transplant of the French model unlikely in the United States, some strands of the French model can inspire strategies for incentivizing and improving the existing forms of employer-based onsite care.

This Article begins by exposing the legal regime of occupational medicine in France, focusing on the role of the workplace doctors, or *médecins du travail*, in delivering preventive care to employees, in Part I, Part II then describes the emerging onsite company clinics in the United States, with which large employers have been experimenting in the last few years in order to reduce healthcare costs. Part III contrasts the histories of French and American experiences with company medicine to show how American company doctors have undermined, rather than promoted employee health. Similar problems have not arisen in France, due largely to law's intervention. Part IV examines the evolution of the

[9] See, e.g., Anne Underwood, Health Care Abroad: Germany, N.Y.Times, Sept. 29, 2009; Anne Underwood, Health Care Abroad: Switzerland, N.Y. Times, Sept. 19, 2009; Anne Underwood & Sarah Arnquist, Health Care Abroad: France, N.Y. Times, Sept. 11, 2009; Victor G. Rodwin, The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States, 93 Am. J. Pub. Health 31 (2003); Timothy Stoltzfus Jost, Why Can't We Do What They Do? National Health Reform Abroad, 32 J. L. & Med. Ethics 433 (2004).

French *médecin du travail*'s role in the regulation of workplace health and safety. These developments highlight the public policy potential of onsite workplace doctors. Part V articulates the lessons of the French experience for American healthcare reform. While the United States cannot adopt the French Labor Code, it can must engage more closely with the public health consequences of employment law in order pave new paths for healthcare reform.

I. Employment Law and Preventive Healthcare in France

In France, doctors and clinics have been important fixtures of the workplace since the end of World War II. These institutions, like American company clinics, evolved from 19th century industrial medicine. The purpose of the current system, required by law for all employers and employees since 1946, is to protect and promote employee health and safety. The 1946 law required every employer to have a "médecin du travail," a workplace doctor.[10] According to the statute, the role of these doctors would be "exclusively preventive, consisting of avoiding all alterations of the health of workers due to the fact of their work, notably in monitoring the conditions of hygiene at work, the risks of contagion, and the workers' state of health."[11] Since the adoption of this law, the Labor Code has specified the roles and duties of the médecins du travail, which include both the monitoring of individual employees' health as well as the evaluation of overall risks that the workplace environment may pose to its workers.

The Labor Code requires every employer to organize a "Workplace Health Service."[12] The Code allows employers to choose between "autonomous" services, where the health service is typically on-site and exclusive to a particular worksite, or "inter-enterprise" services, where external healthcare providers serve a variety of companies.[13] "Inter-enteprise" organizations of médecins du travail must be nonprofit, engaging exclusively in the practice of médicine du travail. [14]

A. Check-ups

Under the French Labor Code, every employee must be examined by the médecin du travail before beginning a new job, or at the very latest,

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[10] See Loi no. 46-2195 du 11 octobre 1946, Organisation des services médicaux au travail, JORF du 12 octobre 1946, page 8638.

[11] Id. Codified at C. trav. art. 4622-3.

[12] C. trav. art. D 4622-1.

[13] Id.

[14] C. trav. art. D 4622-23.

at the end of the trial period.[15] The check up has three purposes: first, to ensure that the employee is "medically apt" for the job for which he has been hired; second, to propose adaptations to the job or a transfer to other jobs if any health conditions require it; and third, to determine whether the employee poses a danger to any other workers. [16]

To effectuate these purposes, the medical examination includes: an interview to learn of the employee's professional and personal medical history,[17] urinalysis,[18] a clinical exam,[19] an analysis of the professional calendar and work to be done in relation to the employee's state of health, and advice regarding best health and safety practices in the job, as well as on individual health (such as tobacco use, alcohol use, nutrition). The employee's height, weight, heart rate, blood pressure, and body mass index are recorded. The urine test checks for protein, blood, and glucose, as they can be indicators for a variety of health conditions including kidney failure, kidney stones, diabetes, and many others. Based on the particular risks associated with the job, the doctor orders a variety of complementary tests, including x-rays, blood and urine tests to check for the presence of various toxic substances, hearing, vision, or respiratory function tests.[20]

In what sense are these check-ups obligatory? The Code provides that the new employee "benefits from" a medical exam, which suggests that it is a benefit that may be taken – or refused – by the employee. In reality, however, the employee may not refuse to undergo the medical exam. Since an employer can be subject to criminal sanctions for allowing an employee to work without having undergone the hiring exam,[21] an employer cannot hire any employee who refuses. During this checkup, the médecin du travail creates an "aptitude file" which remains with the workplace health service throughout the employee's career.

In addition to the hiring checkup, the Code requires each employee to undergo regular periodic checkups every 24 months.[22] The checkups

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[15] C. trrav. Art. R. 4624-10.

[16] C. trav. art. R. 4624-11

[17] Pol Dyèvre & Damien Léger, Médecine du travail : approches de la santé au travail 47 (3d ed. 2003).

[18] Id. at 44.

[19] Id. at 49.

[20] See Pol Dyèvre & Damien Léger, Médecine du travail : approches de la santé au travail 43-49 (3d ed. 2003).

[21] Crim. 4 janv. 1983; Crim. 4 mai 1976.

[22] C. trav. art. R 4624-16.

are similar to those performed when the employee is hired.[23] The purpose of these checkups is to ensure the continuing aptitude of the employee for his or her job.[24] In some sectors and situations, employees undergo "reinforced medical surveillance," meaning that the periodic checkups are more frequent than every 24 months.[25] Annual exams are required if a regulation has classified a job as higher-risk. The more frequent exams are also given for employees who have recently changed the type of work, those who have recently arrived in France, disabled workers, pregnant and nursing women, and workers under the age of eighteen.[26]

Furthermore, both the employer or employee can demand that an employee have a medical exam with the médecin du travail. The employee's request for a medical exam cannot be the basis of any disciplinary measure.[27] Typically, these examinations will be requested if the employer and employee disagree about whether the employee is medically apt to work. If the médecin du travail determines that the employee is apt to work, the employee cannot refuse to work based on the opinion or recommendation of his own doctor. An employee who so refuses may be fired for misconduct.[28]

Finally, there are required check-ups when an employee returns to work from certain types of absences authorized by the Labor Code: maternity leave, absence due to professional disease, absenc of at least eight days resulting from a workplace accident, absence of at least twenty-one days resulting from a sickness or accident that is not work-related, and repeated absences for health reasons.[29] Typically, the employment contract is suspended during these absences, and the medical exam confirming the employee's aptitude for the job is required in order for the contract to be put back into effect.[30] Again, the employee may not refuse these exams, and ordinarily will not be permitted to return to work until the exam has taken place. The employer can legitimately fire an employee for misconduct if she refuses the medical exam.[31] The requirement of

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[23] Dyèvre & Léger, supra note __, at 43.

[24] Id.

[25] C. trav. art. R 4624-19.

[26] C. trav. art. 4624-18.

[27] C. trav. art. R 4624-18.

[28] Soc. 9 oct. 2001.

[29] C. trav. art. 4624-21.

[30] Soc. 26 oct. 1999;.

such exams prevents the employer from firing an employee based on any perceived inaptitude resulting from the maternity or medical conditions justifying the leave.[32]

In the event that the médecin du travail determines that the employee is not apt for his or her assigned job, the employer has a duty to reclassify the employee into a different job for which he or she is apt, taking into account the recommendations of the médecin du travail.[33] Even if the médecin du travail determines that the employee is inapt for every job in the company, the employer must still search for ways of reclassifying the employee.[34] Nonetheless, the employer is not required to modify the employment contract of another employee in order to create a new position for which the employee is apt.[35] When reclassification is impossible because the employee is inapt for every available job in the company, the employer can legitimately terminate the employee for just cause,[36] in which case the employer must comply with procedural requirements and severance pay obligations under the Labor Code.[37]

As is the case with all other disputes surrounding an employee's termination, the employer bears the burden of proving that reclassification is impossible.[38] The Labor Code prohibits discrimination in any terms and conditions of employment, including termination, based on a person's state of health.[39] If an employer were to fire or otherwise adversely treat an employee based on health assessment by the médecin du travail, the discrimination provision would be violated unless the employer could show that the employee's reclassification was impossible. As is well known, French employment law offers employees strong job security protections, and this includes protection from termination based on health conditions. In this employment law regime, an employee need not fear that the mandatory checkup will uncover a health condition that will lead to his termination.

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[31] Soc. 29 nov. 2006. Note that, under the French Labor Code, an employee who is fired for misconduct, as distinguished from an employee who is fired for just cause, is not entitled to any severance payments. See C. trav. [cite].

[32] Soc. 28 fév. 2006

[33] C. trav. art. L 1226-2. Soc.4 juin 1998.

[34] Soc. 10 mars 2004.

[35] Soc. 15 nov. 2006.

[36] Soc. 29 novembre 1990.

[37] C. trav. art. L 1226-12.

[38] Soc. 5 décembre 2005.

[39] C. trav. art. L 1132-1.

B. Accommodations to Protect Individual Employees' Health

The médecin du travail has significant power to bring about individual changes in the workplace on a variety of issues:

> The médecin du travail is authorized to propose individual measures as well as changes or transformations of work stations, justified by considerations notably of age, physical resistance, or the physical and mental health of the workers.
>
> The employer is required to consider these propositions, and in the case of refusal, to reveal the opposing reasons.
>
> In case of difficulty or disagreement, the employer and the employee can appeal to the Labor Inspector, who shall make a decision according to the opinion of the Medical Labor Inspector.[40]

Although this provision does not give the médecin du travail the power to enact change unilaterally, it authorizes a procedure by which employers and employees become aware of the possible changes that could improve health and safety in the workplace. It also catalyzes processes of change that could take effect if the employee appeals to the relevant state authorities.

In practice, the system of regular check-ups to confirm the employee's aptitude effectively makes the médecin du travail the most important authority with regard to accommodations for disabilities or for other health conditions that may affect an employee's ability to work. If an employee refuses to perform certain tasks because a health condition makes her unable to do so, the opinion of the médecin du travail controls whether or not the employee's refusal constitutes "misconduct," [41] which would justify termination without severance pay. The only circumstance under which an employee can be terminated for inaptitude is when the doctor declares him inapt for every possible job in the company. Short of such a declaration, the employee is deemed only partly "inapt," and the employer has a duty propose to the employee another job appropriate to his or her capacities.[42]

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[40] C. trav. art. L4624-1.

[41] In one case, an employee refused to perform a task due to back pains certified by her own doctor. The Cour de cassation held that the opinion of the médecin du travail, rather than that of the employee's own doctor, determined whether the employee was apt for the job, since the médecin du travail was likely to be familiar with the work that the employer required the employee to perform. See Soc. 9 octobre 2001, Bull. Civ. V. no. 313.

[42] See C. trav. art L 1226-2, L 1226-10. Although these provisions impose the duty with regard to employees who resume work after a suspension of the employment contract due to non-professional or professional accidents or illnesses, one treatise suggests that this right to reclassification applies regardless of the origins of inaptitude. See Bourgeot & Blatman 419.

The proposal must take into account the opinions of the médecin du travail regarding the existing tasks within the company that the employee might be capable of performing. The Code requires that the job proposed should be "as comparable as possible" to the job previously occupied, even if this means that modifications and accommodation to the job or a reduction in working hours are needed.[43] Furthermore, the Cour de cassation has interpreted this provision as requiring the employer to accommodate the employee even when the médecin du travail has declared him or her inapt for every job in the company.[44] In such circumstances, the employer must consider all the possible modifications and accommodations to every job so that the employee may remain employed.

If an employee's aptitude is in question, the doctor cannot simply declare partial or limited inaptitude without researching and proposing solutions that would resolve the difficulties of the employee's inaptitude.[45] Indeed, in such situations, the employee is not declared "inapt," but rather, the employee is declared "apt with restrictions" or "apt with an accommodation of the job."[46] When making such a declaration, the doctor will highlight the aspects of the job that the employee is medically capable of performing, with recommended limitations. For instance, the doctor might indicate a limitation to the hours the employee can tolerate in a particular position or a limit on the weight the employee can lift. The opinion will also identify any tasks that the employee cannot perform.[47]

But, due to the requirements of medical confidentiality, the doctor may not provide a justification for these recommendations by reference to the particular medical situation of the employee.[48] If the limitations or accommodations recommended by the médecin du travail in her aptitude assessment cannot be pursued by the employer, the procedures for inaptitude are then followed. The médecin du travail may not declare an employee inapt without first doing a study of the job, a study of the working conditions in the company as a whole, and to medical examinations of the employee, two weeks apart.[49] As a result, in any situation where there is a question as to whether the worker's health is compatible with the job, the job itself, as well as overall working

[43] C. trav. art. L 1226-2.

[44] Spc/ 18 juillet 2000, no. 98-41.361; 10 janvier 2001, no. 98-43.970.

[45] See Bourgeot & Blatman, supra note __, at 399.

[46] Id.

[47] Id.

[48] Arrêt du Conseil d'Etat du 3 décembre 2003, no. 254000.

[49] C. trav. art. R 4624-32

conditions, are studied by the decisionmaker who recommends accommodations or limitations on the work.

Thus, in this legal regime, accommodations are not limited to those who fit the statutory definition of the "disabled." There are various Labor Code provisions that address the particular rights of disabled persons, and the employers' duty to integrate them into the workplace. For instance, disabled employees have a right to the individualized adjustment of their hours in order to facilitate their access to the job, their professional practice, and the maintenance of their jobs.[50] Disability is defined by the Labor Code as "any person for whom the possibilities of obtaining or keeping a job are effectively reduced due to the alternation of one or many physical, sensory, mental, or psychic functions."[51] But in practice, all employees in France can get accommodations based on the relationship between their state of health and their jobs, through the framework that requires each employee to be declared apt or reclassified.

C. A Mandated Preventive Care System

Every person who works and is covered by the Labor Code in France is essentially required to undergo regular checkups as a condition of remaining employed. Although the Labor Code does not cover public employees, there is a patchwork of laws that require médecine du travail regimes for public hospital employees, public school teachers, university professors, and other state employees. These regimes are similar to that required by the Labor Code; public employees are also required to submit to regular checkups. Thus, most French employees, public or private, are required to have regular checkups as a condition of remaining employed. Although the purpose of these checkups is to ensure that the employee's health is compatible with her job, the examinations also function to deliver preventive healthcare to a significant portion of the French population. Due to the nature of the tests done at these exams, many health conditions that could worsen if left untreated are detected early. The effects of exposure to carcinogens and other health risks in the workplace are measured on a regular basis.

The French system of occupational medicine is effective in delivering preventive healthcare to the French population because it is compulsory. Every employer is legally required to provide a *médecin du travail*. Every person who is employed in France must attend regular checkups as a condition of remaining employed. Employees simply cannot avoid the regular visits to the doctor based on laziness, fear, or cost. Thus, it is highly unlikely that a chronic disease or health condition will go undetected and unmanaged. The mandatory nature of French occupational medicine is what ensures that preventive medicine is

[50] C. trav. art L 3122-26.

[51] C. trav. art. L5213-1.

delivered to a large swath of the population. When preventive healthcare is only delivered to those who seek it out, it may not reach the people who need it the most.

Although the médecin du travail is not authorized to provide prescribe medicines or provide primary care except in the case of emergency,[52] the identification of any health problems by the checkups with the médecin du travail, whether or not they affect the employee's aptitude for work, often leads the employees to seek treatment from their own "treating" physician, which is usually reimbursed the national health insurance regime as well as private supplemental insurance.

The regular checkups also operate as a comprehensive workplace wellness program. In the individual consultations that occur during the course of these regular checkups, employees are given regular advice about how to maintain good health. The doctors tailor advice regarding both professional and non-professional health risks to the individual's health profile that is established by the checkup. Thus, individuals are given information and guidance on the management of various factors that may compromise their health, such as tobacco use, alcohol consumption, exercise, diet, stress and work-family conflict. In addition to these individual preventive care consultations, many médecins du travail also conduct group workshops within the workplace on these health issues.

II. The New Company Clinics in the United States

The French system of legally mandated, employer-provided onsite preventive healthcare may seem alien and politically implausible to Americans. But there are some threads of resemblance between workplace healthcare in France and the recently growing American phenomenon of the on-site company clinic. In the beginning of 2007, about 10 percent of the nation's largest employers had on-site medical services; in 2009, a third of these large employers do. It is expected that company clinics will grow from 2,200 today to about 7,000 in 2015. By 2015, these clinics are likely to serve 10-15 percent of the U.S. population under the age of 65.[53] Large self-insured companies have been creating on-site medical clinics to provide primary care to employees, and in some

[52] Art. L 4622-3 of the Labor Code provides that "the role of the médecin du travail is exclusively preventive." This has been interpreted to mean that the médecin du travail may not prescribe medicine for non-urgent matters. Civ. 1ère 24 janvier 2006. See also Evelyn Bledniak, Santé, hygiene, et sécurité au travail: prevention, responsabilité, contentieux 220 (2008).

[53] See Fuld & Company, White Paper: The Growth of On-Site Health Clinics 2 (Feb. 2009).

instances, their dependents.[54] Clinics that do more than merely provide first aid come within ERISA's broad definition of "employee welfare benefit plan."[55] Employer expenditures for onsite clinics are tax-deductible.[56] Examining the similarities and differences between this new form of American healthcare and French workplace health services raises some important questions for the future of American healthcare reform.

A. A Focus on Preventive Care

The new American onsite clinics, like the French clinics, focus on preventive care. They are gaining attention in the human resource management literature, as well as the mainstream news media. When Toyota built a new plant in San Antonio, Texas, in 2006, it spent $9 million to build a 20,000 square foot medical center, which houses 22 examination rooms, a blood-test lab, an X-ray center, and a pharmacy. It is staffed by two full-time doctors, a part-time physician, and several nurse-practitioners.[57] In addition to preventive care (including diabetes screening, back-pain management, smoking cessation, and weight management), these clinics help employees manage chronic diseases by regularly monitoring conditions like diabetes and asthma, and addressing occupational health issues.[58] Employees can drop in for check-ups, allergy and flu shots, pregnancy tests or routine monitoring of chronic diseases.[59]

There is anecdotal evidence that these company clinics are saving lives: one Pepsi Bottling employee was at work when he felt pain in his chest and abdomen. He went to the on-site wellness center, where the health professionals urged him to go to the hospital. There, he was diagnosed with heart problems that were addressed through a coronary artery bypass surgery two days later. "If it wasn't for the clinic," the

[54] A. Michael La Penna, Workplace Medical Clinics: The Employer-Redesigned "Company Doctor," 54 J. Healthcare Management 87 (2009).

[55] See ERISA, 29 U.S.C. § 1002; see also Retail Indus. Leaders' Ass'n v. Fielder, 475 F. 3d 180, 196 (4th Cir. 2008).

[56] See Internal Revenue Code § 213(d), 26 U.S.C. § 213; Retail Indus. Leaders' Ass'n v. Fielder, 475 F. 3d 180, 196 (4th Cir. 2008).

[57] See Milt Freudenheim, Company Clinics Cut Health Costs, N.Y.Times, Jan. 14, 2007.

[58] See Paula S. Katz, Big Employers Bring Health Care In-House, American College of Physicians Observer, January-February 2007, available at http://www.acpinternist.org/archives/2007/01/clinics.htm.

[59] See Freudenheim, supra note __.

employee reported, "I probably would not have gone to the doctor right away, and who knows what would have happened."[60]

B. Reducing Healthcare Costs

Thus far, the snapshot of the American company clinic makes it looks remarkably similar to the French workplace health service. But an important difference is that, while the French model is a creature of law, the American clinics are products of the market. Company clinics have become popular with employers, not only to save lives, but more importantly for employers, to save money.[61] Many employers see the provision of primary care services to employees at an on-site clinic as a way of reducing the costs of healthcare and lost productivity. Company clinics save employers as much as 25 percent in employee health care fees,[62] even as the majority of employers providing this benefit do so with no cost-sharing by the employees.[63]

Companies tend to outsource the management of the on-site clinic to companies who are in the business of running medical clinics. Some examples include Take Care Health (owned by Walgreens), Whole Health Management, QuadMed, CHD Meridian Healthcare. The co-pays for company clinics are lower than those paid to outside doctors. The clinic charges less for the procedures performed (which can include X-rays, blood tests, treatment of broken bones) than the fees charged by specialists or the local hospital. There are fewer referrals to specialists. Take Care Health, for instance, refers 40% fewer patients to specialists as compared to the referral rate of primary care physicians. Take Care Health has also reduced emergency room visits at the companies whose clinics it manages

[60] See Susan J. Wells, The Doctor Is In-House: The Company Doctor is Back, Helping Workers Remain Healthy and Employers Reduce Health Care Costs, HR Magazine, April 2006, at 26.

[61] A recent study of onsite health centers by Watson Wyatt, a management consultancy, indicates that employers' main motivation for establishing onsite health centers is the reduction of medical costs. 70 percent of employers cited reduction of medical costs as among the top factors motivating the establishment of onsite clinics after 2000, as compared to 30 percent of employers citing the improvement of quality of care as a top motivation. See Watson Wyatt, Realizing the Potential of Onsite Health Centers 4 (2008).

[62] See Maureen Glabman, Employers Move Into Primary Care, Managed Care Magazine, June 2009 available at http://www.managedcaremag.com/archives/0906/0906.companydoc.html.

[63] See Watson Wyatt, Realizing the Potential of Onsite Health Centers 8 (2008).

by 72%.[64] At Toyota's San Antonio plant, there has been a 33 % reduction in referrals to specialists and a 25 % reduction in urgent care and emergency visits.[65] When medicines are prescribed, company clinics tend to steer patients to less-expensive generic drugs rather than the branded products.[66]

Furthermore, managers of the company clinics report that they tend to do more screening for long-term health conditions than traditional company-supported health insurance plans. Companies have an incentive to spend on on-site screening in order to avoid conditions that lead to high rates of absenteeism and higher healthcare costs that can materialize after the conditions have gone undetected and untreated for a long time.[67] Companies tend to experience a 15 productivity loss due to health problems, some of which can be efficiently counteracted by an on-site physician.[68] The company doctor for Power Flame, a 187-employee manufacturer of gas and oil burners in Kansas, reported that employee health profiles diagnosed three diabetics, including two who were unaware of their condition.[69] Screening in a company clinic is less costly than an equivalent exam at a doctor's office, in part due to the convenience of being on-site. As one clinic doctor puts it, a mammogram "is a 20-minute exam that takes four hours"[70] when the employee has to interrupt her work day to travel to the doctor's office, wait for her exam, and travel back to work. Company clinics tend to spend more time with each patient per visit, and the wait times tend, on average, to be low compared to wait times at the doctor's office.

In addition, as our heart-attack anecdote demonstrates, employees are more likely to see the doctor for conditions that do not seem at the time to be a big deal. An employee might hop over to the on-site clinic for a migraine, which would otherwise make his day less productive, instead of trying to see a doctor across town for it.[71] Employees do not lose pay

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[64] See David Welch, Health-Care Reform, Corporate-Style, Business Week, July 29, 2008, at __.

[65] See Maureen Glabman, Employers Move Into Primary Care, Managed Care Magazine, June 2009.

[66] Id.

[67] Id.

[68] Glabman, supra note __.

[69] See Susan J. Wells, The Doctor Is In-House, supra note __, at 51.

[70] See Katz, Big Employers Bring Health Care In-House, supra note __.

[71] Id.

for the time they spend at the on-site clinic.[72] As a result, colds can be treated before they turn into bronchitis, and high blood pressure can be managed before it leads to a stroke.[73] In short, employees can manage their health by spending 20-30 minutes with the on-site doctor, without worrying about the professional consequences of taking a half a day off to attend an appointment at a doctor's office.

Although systematic data measuring employers' savings from company clinics has not been compiled, reports from individual employers are illuminating. Over a short period of time, the company clinics have reduced employers' healthcare costs in significant ways. Power Flame, for instance, had health insurance costs about double the national average. Power Flame's claims were rising at a double-digit rate annually, largely due to catastrophic claims. Within two years of implementing the company clinic, which provided free access to an on-site physician, wellness profiles, and information sessions, the company was able to reduce health care costs by $4,587 per employee.[74] Many clinics report a 3:1 return on investment within 12-18 months. Harrah's spent $1 million to implement an on-site clinic, and expected to break even within 12-18 months.[75] It costs Freddie Mac $586,000 per year to run its on-site clinic in Washington, DC, but the return—direct costs plus added productivity – is $900,000 a year.[76] One study suggests that employers can see a return of $3 to $6 for each dollar spent over two to five years on workplace health program strategies, which include company clinics as well as health programs like healthier food in the company cafeteria.[77] Port Lucie, a city in Florida, opened its on-site clinic in 2007, with a 3:1 return on the investment in the first six months. The city invested $443,000, and saved $600,000 in net health plan costs, since employees went for fewer primary care visits, with fewer outpatient drug, lab, x-ray, and occupational health costs. In addition, the city reduced sick hours by 11,850. If multiplied by an hourly rate of $20, the savings on sick hours amounted to $237,000.[78] These recent reports suggest that company clinics improve employees' health and productivity while reducing costs for both employers and employees.

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[72] Susan J. Wells, The Doctor Is In-House, supra note __, at 51.

[73] See Glabman, supra note __.

[74] Id.

[75] See Paula S. Katz, Big Employers Bring Health Care In-House, supra note __.

[76] Id.

[77] Susan Wells, supra note __, at 50 (citing study in American Journal of Preventive Medicine).

[78] Glabman, supra note __.

III. Contrasts

Both French and American workplaces have onsite medical services focusing on preventive care. The two systems of medicine in the workplace have common origins in 19th-century industrial medicine, but they have developed in strikingly different ways. Comparing American company medicine to its French counterpart sheds light on the limits of American company clinics' potential to optimize employee health outcomes. A significant challenge facing the new company clinics in the United States is employee distrust of company doctors, who have traditionally promoted the company's interests at the expense of employee health, unrestrained by law. By contrast, French company medicine, unlike the American version, is part of a robust and paternalistic regulatory framework whose explicit purpose is to protect and promote employee health.

A. Common Origins

American company clinics are not a 21st- century invention. The company doctor has been a familiar figure in the American workplace since the post-Civil War era.[79] In the United States, industrial medicine developed in the late nineteenth and early twentieth centuries as part of American "welfare capitalism." Companies provided a broad range of welfare services, such as healthcare, schools, housing, and social and religious programs.[80] These welfare programs were provided by companies to instill long-term loyalty in workers. Dating back to the 1860s, large companies in the railroad, mining, and lumbering sectors employed doctors due to the large number of injuries and accidents on the job.[81]

The company doctor preceded both the new company clinics and the modern-day employer-based health insurance schemes. Company doctors were funded through monthly deductions from workers' paychecks. In the early twentieth century, industrial doctors functioned more like the French médecins du travail than they do today. They conducted periodic and pre-employment health examinations, and were concerned with the health supervision of workers. The demand for company doctors grew in part due to the passage of state workers' compensation laws after 1910. Since these laws required employers to report and pay for occupational injuries and illnesses, companies

[79] See Paul Starr, The Social Transformation of American Medicine 202 (1982).

[80] See Starr, supra note _, at 202.

[81] Id. at 10.

contained costs and compensation awards by hiring physicians who would directly see their employees.[82] The workers' comp system also incentivized industrial doctors to become involved in preventive medical engineering of the workplace to avoid injuries.

Similarly, the French workplace medical services existed for decades before the law required them in 1946. Many companies had "factory medicine" centers, which were primarily concerned with urgent care. In France, the development of industrial medicine had an American influence: the first considerations of the medical dimension of the organization of work were influenced by the scientific management theories of Frederick Winslow Taylor.[83] In France, the nineteenth-century factory doctors also examined workers when they were hired, and monitored absenteeism as well as aptitude. During this era, as in the United States, healthcare was only one of the many services offered by French companies to their workers. Companies also provided housing, social work, and schools. The focus on preventive care grew out of discussions between unions and employers through committees and associations devoted to safety. The unions tended to support an expansion of the company medical services. Indeed, it was the metalworkers and miners' union who established the onsite "prevention service," which became a model for other sectors.[84]

B. Divergent Evolutions: Conflicts of Interest and Confidentiality

Despite these similar origins, company medicine developed in divergent ways in the United States and France. Whereas French unions called for a strengthening of company medicine, American unions have always been skeptical of company doctors. One study of the development of healthcare for the United Mine Workers notes that the miners who were cared for by company doctors had no choices with regard to the healthcare available to them and their families.[85] The American Federation of Labor particularly disapproved of compulsory medical care through employers, rejecting it as "paternalistic."[86]

Furthermore, in the United States, companies retained control over the doctors' practices. Miners perceived the company doctors as siding

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[82] Id. at 11.

[83] Id.

[84] See M. Maurice Rochaix, La Médecine du travail, Rapport présenté au nom du Conseil économique et social, J.O.R.F., Séances des 4 et 5 juillet 1988, at 19.

[85] Ivana Krajcinovic, From Company Doctors to Managed Care: The United Mine Workers' Noble Experiment 19 (1997)

[86] Starr, supra note __, at 203.

with management in a variety of important issues. The company doctor was thought to be pro-management in determinations regarding workers' compensation claims: company doctors were four times less likely than other doctors to submit industrial injury claims.[87] They would perform physical examinations to find grounds to discharge miners who were active in the union.[88] They would also serve as spies for management.[89] The doctors also had incentives to reduce healthcare costs in ways that were detrimental to workers' health. For instance, they were required to pay for medical supplies out of their salaries.[90] These company clinics rapidly declined during the Great Depression, largely because they were too costly for employers to maintain.[91] Furthermore, American unions pushed for cash benefits in lieu of company medicine.

The differences between French and American unions' attitudes towards workplace doctors reflect deeper differences in labor-management relations in the two countries. French workers have more power and voice in the workplace than their American counterparts, which is formalized in various provisions of the Labor Code. A very significant difference between French and American employment law is that, since 1945, the French Labor Code requires all large employers to form a *comité d'entreprise*, or works council, comprised of representatives of management and workers.[92] The workers' representatives are elected, and in companies with 300 or more employees, a union representative must be included.[93] The law requires the employer to consult the works council on a variety of matters, including the general management of the company, policies on the research and development of new technologies,[94] changes in the company's economic organization,[95] and most relevantly, working conditions.[96] The Labor Code also provides for employers with 50 or more employees to form workplace health and safety committees,

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[87] Id. at 21.

[88] Id.

[89] Id.

[90] Id. at 22.

[91] See Paul Starr, A Social Transformation of American Medicine (1982).

[92] See C. trav. L. 2322-1; L. 2324-1.

[93] C. trav. art. L. 2324-2.

[94] C. trav. art. L. 2323-13.

[95] C. trav. art. L 2323-19.

[96] C. trav. L 2323-27.

comprised of management and workers.[97] The médecins du travail attend the committees' meetings.[98] These Labor Code provisions evolved from 19th century corporatism in France, which empowered workers sufficiently to ensure that onsite doctors did not function as a mere agent of management. American workers, by contrast, have never been able to wrest control of the company doctor away from the employer. These enduring differences may limit the extent to which American employees will trust and use company clinics.

Although employer-based healthcare evolved in the United States from the company doctor model towards the employer provision of healthcare benefits, some companies have continuously used on-site doctors. Before the emergence of the new company clinics described in Part II, the company doctors did not really provide primary care, as they did in the past. The role of the company doctor was primarily to examine employees filing workers' compensation claims. Another legal development that increased the demand for company doctors was the Occupational Safety and Health Act of 1971. Since OSHA regulated the levels of workers' exposure to toxic substances, company doctors were needed to test workers' exposure levels. Today, company doctors testify in workers' compensation proceedings, participate in OSHA rule-making hearings, and make disability determinations to aid the company's compliance with the Americans with Disabilities Act.[99]

Eileen Draper's 2003 study shows how, in many companies, managers send employees whom they believe to be a "thorn in the side" of management to the company doctor. The company doctor screens these individuals, and turns information about their health over to management. Thus, if there is a "troublemaker," typically a union activist, the company doctor might be able to discover an underlying psychological or physical condition that is then used to justify that employee's termination.[100] Draper notes that "[t]hose who testify for the employer on worker's compensation claims generally know that their job is to try to find a non-occupational cause for a worker's ailment and to provide a judgment that would serve the company's interest."[101] At OSHA hearings regarding proposed safety standards, transcripts indicate that the doctors tend to defend the company's interests, by saying that a safety standard is

[97] C. trav. art. L 4611-1; L 4613-1; L 4613-2.

[98] C. trav. art. L L 4613-2.

[99] Draper, supra note __, at 13-14.

[100] Draper at 78-82.

[101] Id. at 82-83.

unnecessary, or that a substance is not as dangerous as OSHA thinks it is.[102]

The conflict of interest faced by these company doctors is illustrated in the case of Millison v. E.I. DuPont de Nemours & Company. Former employees of DuPont sued the company and company physicians, arguing that the doctors fraudulently concealed the employees' diseases resulting from asbestos exposure from them. The plaintiffs claimed that, "although the physical examinations performed by the company doctor and the x-rays indicated asbestos-related injuries, the doctors did not inform plaintiffs of their sicknesses, but instead told them that their health was fine and sent them back to work under the same hazardous conditions that had caused the initial injuries."[103] The DuPont case demonstrates the reality of company doctors' decisionmaking situations where the employer's production and profit interests conflict with employees' health. Under such circumstances, company doctors' incentives are aligned with the company's interests because the company is the doctor's employer.

In addition, even though ethics rules require company doctors to keep their patients' medical information confidential, these rules have no legal bite. Consider the 2003 case of New York Times v. Horn. Dr. Horn, a company doctor for the New York Times, brought a wrongful discharge action against the New York Times, challenging her termination for her refusal to disclose employees' medical records to the Labor Relations, Legal and Human Resources departments without the patient-employees' consent.[104] She also claimed that the Times' Human Resources department instructed her to misinform employees about whether their injuries were work-related in order to limit the Times' workers' compensation liability.[105] The New York Court of Appeals held that, since she was an at-will employee, she could be legitimately discharged for these reasons, and that the physician-patient privilege was not central to the company doctor's conduct of her practice on her employer's behalf.[106] The court noted:

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[102] Id. at 86.

[103] Millison v. E.I. du Pont de Nemours & Co., 501 A.2d 505, 516 (N.J. 1986). The legal issue was whether the plaintiffs' claims could move forward in light of the New Jersey workers' compensation law's provision of exclusive remedies for injuries on the job, with an exception for intentional wrongs. The New Jersey Supreme Court held that the doctors' alleged concealment of the plaintiffs' illnesses came within the intentional wrongs exception.

[104] Horn v. New York Times, 790 N.E. 2d 753, 754 (N.Y. 2003)

[105] Id.

[106] Id. at 758-59.

> When Horn made assessments as to whether a Times employee had suffered a work-related illness or injury, she was surely calling upon her knowledge as a physician, but not just for the benefit of the employee. Rather, she was applying her professional expertise in furtherance of her responsibilities as a part of corporate management.[107]

In short, a company doctor who refuses to violate a patient's confidentiality can reasonably fear being fired.

Thus, in the United States, company medicine has come to be seen as both paternalistic and inimical to employee health. This widespread perception creates some obstacles to the effectiveness of the new company clinics. One consultant specializing in company clinics reports that some workers could be deterred from using the company clinic due to fears that the in-house doctors are only working in the company's interest and not respecting the employee's privacy.[108] One solution, which is actively pursued by many employers providing onsite healthcare, is to outsource the company clinic to a third-party vendor.[109] But outsourcing does not necessarily ensure that the employee's medical information will be kept confidential from the employer. One onsite health clinic operator reported, "Since all our clinics have electronic medical records, we have a connectivity advantage in that we can collect clinical information and give a very meaningful report to an employer on what is happening with its employee population."[110]

In France, by contrast, many of the problems associated with American company doctors are avoided due to legal rules that protect the médecin du travail's independence and the specific duties of confidentiality that apply to these doctors. The 1946 law required all companies to institute a medical service devoted to the "avoidance of all alterations of workers' health by virtue of the work."[111] In addition to making the provision of onsite healthcare obligatory, the law established various principles, which have been strengthened in the last fifty years. These principles included the obligatory nature of employer management of occupational medicine, the exclusively preventive orientation of these medical services, the technical independence of doctors and respect for

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[107] Id. at 758.

[108] See Maureen Glabman, Employers Move Into Primary Care, Managed Care Magazine (June 2009).

[109] Id.

[110] Id.

[111] Loi no. 46-2195 du 11 octobre 1946, Organisation des services médicaux au travail, JORF du 12 octobre 1946, page 8638.

medical ethics, the specialization of the médecins du travail, and the need for their training, and the control of the medical service by the works council.[112] In France, the law formalized an existing practice – employers' provision of company doctors – and transformed it by optimizing its ability to protect workers' health.

The Independence of the Médecin du Travail

There are various legal rules that regulate the relationship between the doctor and employee to minimize doctors' incentives to favor the company's bottom line over the employee's health. These rules have created a legal culture in which the doctors see themselves primarily as employee advocates rather than as employees or agents of the company. The self-perception of French médecins du travail stands in contrast to that of American company doctors.

Ethics Rules

In France, medical ethics rules have the force of law. Drafted by the National Council of the Order of Doctors, the organization of the medical profession, the Code of Medical Ethics became law by decree in 1995. By contrast, in the United States, the American Medical Association's Code of Medical Ethics does not have the force of law. Indeed, some of its rules coincide with provisions of state and federal law. But, for the most part, American medical ethics are distinct from law.

In France, articles 95-99 of Code of Medical Ethics explicitly establish the duties of "salaried" doctors, including médecins du travail. Article 95 provides:

> The fact of a doctor of being tied in his professional practice by a contract or status to an administration, a collectivity, or any other public or private organism has no effect on his professional duties and in particular on his obligations concerning medical confidentiality and independence in his decisions.
>
> In no circumstance may the doctor accept limitations on his independence in his medical practice on the part of the enterprise or the organism that employs him. He must always act, as a priority, in the interests of the public health and in the interests of the persons in the companies or organisms and their safety.[113]

Another broadly-worded provision prohibits the doctor from operating any under monetary incentives based on the norms of productivity: "A salaried doctor may not, in any case, accept any compensation founded on

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[112] See M. Maurice Rochaix, La Médecine du travail, Rapport présenté au nom du Conseil économique et social, J.O.R.F., Séances des 4 et 5 juillet 1988, at 19.

[113] Décret no. 95-1000 du 6 septembre 1995 portant code de déontologie médicale, art. 95, JORF du 8 septembere 1995, page 13305, 13310.

norms of productivity, scheduled output, or any other arrangement which would have as its consequence a limitation or abandonment of his independence or an effect on the quality of care."[114]

Médecins du travail are also prohibited from "using their office to increase their clientele."[115] This means that they cannot see patients other than those who are assigned to them through the workplaces for which they function as médecins du travail. Finally, médecins du travail, whose role is "exclusively preventive" under the Labor Code, are subject to the ethics code provision which prohibits preventive medical care providers from engaging in medical treatment.[116]

These rules make it impossible for employers to structure their relationships with the médecins du travail in ways that might incentivize the doctors to consider or protect the company's productivity or bottom line in making their determinations regarding individual patients' aptitude. Even when making policy recommendations for the company as a whole, these doctors are bound to prioritize the public health and the health of the people in the company.

Privacy and Confidentiality

In addition, médecins du travail observe strict norms of employee privacy and confidentiality. The ethics code provides that they have the same duties with regard to confidentiality as all other doctors. Article 4 of the medical ethics code provides, "Medical confidentiality, instituted in the interest of patients, is necessary for every doctor according to conditions established by the law."[117] Criminal sanctions are imposed for breaches of medical confidentiality. The Penal Code provides: "The disclosure of confidential information by a person who is its agent, whether for the state or for a profession, even if it is by function of a temporary mission, is punished by one year of imprisonment and a fine of 15,000 euros."[118]

The medical ethics code also requires all doctors to protect all medical documents of the persons he has examined or treated from any indiscretion.[119] The Labor Code's establishment of health services in companies does not abrogate these duties – it simply requires the médecin du travail to make determinations about the aptitude or inaptitude of the

[114] Id. at art. 97.

[115] Id. at art. 98.

[116] See id. at art. 99.

[117] Id. at art. 4.

[118] C. pén. Art. 226-13.

[119] Id. at art. 73.

employee for their jobs. This means that employers are simply informed as to whether the employee is apt or inapt; the médecin du travail cannot reveal the medical details and explanations of any finding of inaptitude.

In some instances, a medical examination by the médecin du travail may reveal a health condition, such as borderline diabetes, which does not affect the employee's current aptitude for the job, but which may have long-term consequences for the employee. Under such circumstances, the médecin du travail has two important obligations under the Code of Medical Ethics: she must inform the employee of the health condition,[120] so that she can seek treatment, but must not inform the employer. In some circumstances, the médecin du travail may determine that an employee is temporarily inapt for the job. In that scenario, the doctor provides appropriate information and advice to the employee so that she can receive treatment, but does not inform the employer of the nature of the inaptitude.

Special Termination Procedures for Médecins du Travail

The Labor Code also stipulates special protections for médecins du travail from termination, beyond the ordinary protections of the Labor Code for all other employees, in order to protect the doctors' independence. Employers cannot fire the médecin du travail without first consulting the employee representative body. In the case of nonprofit "interenterprise" organizations of médecins du travail, doctors cannot be fired without a consultation with the governing committee. Furthermore, the termination of a médecin du travail is not valid until the Labor Inspector authorizes it.[121]

Under the regulations, the employer must petition the Labor Inspector to terminate a médecin du travail in writing, with the reasons articulated. A hearing is held with the employee representative body or the interenterprise governing committees.[122] The Labor Inspector then conducts an adversarial investigation, in which the médecin du travail can accompanied by any person of his choice belonging to to the employer's health service.[123] Even when the Labor Inspector authorizes a termination of a médecin du travail, the decision can be reviewed by the Ministry of Labor or an administrative court.[124] If the termination is invalidated, the

[120] Under Article 35 of the Code of Medical Ethics, the doctor owes any person he examines "loyall, clear, and appropriate information on his condition." Id. at art. 35.

[121] C. trav. art. L 4623-5.

[122] C. trav. art. R 4623-22.

[123] C. trav. art. R 4623-23.

[124] C. trav. art. L 4623-6.

doctor has a right to return to his job or an equivalent job, and the employer is liable for damages.[125]

Thus, unlike ordinary employees, who are already protected from unjust dismissals in the French Labor Code, médecins du travail cannot be fired without the consultation of workplace committees and the authorization of the state. The procedural hurdles to the termination of these doctors are significant. As a result, médecins du travail cannot reasonably fear termination as a consequence of exercising independent medical judgment that may be contrary to the preferences and productivity goals of the employer.

IV. The Doctor's Role in Workplace Health and Safety

A. The Third-Time Rule

Under the Labor Code, the employer has a general duty to "take measures necessary to ensure safety and to protect the physical and mental health of the workers."[126] These measures include preventive actions for professional risks, information and training, and implementing an organization and adapted methods.[127] To aid the employer in fulfilling its general safety and health duties, the Code provides nine "general principles of prevention":

1. Avoid risks;
2. Evaluate the risks that cannot be avoided;
3. Combat the risks at their origin;
4. Adapt work to man, in particular, in that which concerns the conception of jobs as well as work equipment and methods of work and production, in view notably of limiting monotonous work and [cadence] work and to reduce the effects of such work on health;
5. Be aware of the state of evolution of technique.
6. Replace that which is dangerous with that which is not dangerous or with that which is less dangerous.
7. Plan prevention by integrating, in a coherent way, the technique, organization of work, conditions of work, social relations and environmental factors, notably risks related to moral harassment . . .
8. Take measures of collective protection in giving them priority over individual protection
9. Give appropriate information to employers.

[125] C. trav. art. L 4623-7.

[126] C. trav. art. L 4121-1.

[127] C. trav. art. L 4121-1.

The Labor Code also assigns to the médecin du travail an important role in enabling the employer to discharge these functions.

First, the médecin du travail must participate in shaping company policies to protect workers' health and safety. The Labor Code regulations assign the médecin du travail the role of adviser to the employer on all of the following matters: (1) improvement of life and work conditions in the company; (2) Adaptation of sites, techniques, and rhythms of work to human physiology; (3) Protection of workers against the totality of nuisances, and notably against risks of workplace accidents or the use of dangerous products; (4) General hygiene of the establishment; (5) Hygiene in the cafeterias; (6) Prevention and health education within the workplace in relation to professional activity; (7) New construction or renovations; (8) Modifications of equipment; and (9) The implementation or modification of nighttime work.[128]

The Labor Code requires médecins du travail to devote a third of their time to learning about the work environment.[129] Thus, the doctors have free access to the workplace, and can visit at their own initiative or at the request of employers or employee committees.[130] These visits can aid the doctor in fulfilling her statutory duties to study new methods of production and to receive safety training,[131] and to learn about the composition of products and materials used in work, as well as any measures or analyses done on new methods of production or safety training.[132]

The Labor Code authorizes the médecin du travail to demand information from the employer. The médecin du travail can ask for documentation verifying the employer's compliance with safety regulations.[133] The employer is required to consider the doctor's opinion with regard to employment laws addressing disabled workers.[134] The doctor can, at the employer's expense, undertake or commission necessary studies on conditions and risks in the workplace.[135]

The doctor must be informed by the head of the company any time an employee declares an occupational disease or accident. If the doctor

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[128] C. trav. art. R 4623-1.

[129] See C. trav. art. R 4624-1 to R 4624-9.

[130] C. trav. art. R 4624-1.

[131] C. trav. art. R. 4624-3

[132] C. trav. art. R 4624-4.

[133] C. trav. art. R 4624-5.

[134] C. trav. art. R 4624-6.

[135] C. trav. art. R 4624-7.

deems it necessary, the doctor prepares a report on measures to avoid the repetition of such facts in the future. The report is then given to the employee committee on hygiene, safety, and work conditions, as well as the head of the company, who then must submit it to the Labor Inspector and the Medical Labor Inspector.[136]

The médecin du travail also carries out the employer's reporting requirements with regard to workplace health and safety. The médecin du travail is required to author two important documents: the "company file" on professional risks, and the annual activity report. The "company file" identifies all of the risks faced by its employees[137] – physical, chemical, infectious, those related to particular work situations, and accident risks. It also identifies the measures taken by the employer to address these risks. The company file is submitted to the employer, who must send a copy to the Labor Inspector and the Medical Labor Inspector.[138] The annual activity report is distributed to the Works Council as well as to the governing committees of the inter-enterprise organizations of médecins du travail.[139] The report is a summary of the médecin du travail's activities for the year. A copy is sent to the labor inspector as well as the medical labor inspector.[140]

In addition to the roles and duties assigned to the médecin du travail by the Labor Code, there is an additional duty stemming from the Social Security Code with regard to the prevention of workplace diseases:

> In view of the prevention of professional diseases and a better knowledge of professional pathologies and the extension or revision of the tables [of professional diseases and pathologies], it is obligatory, for every doctor in medicine who might know of their existence, notably the médecins du travail, to make a declaration of any symptom of toxic exposure and every disease, if they have a professional character and appear on a list established by an interministerial order after the opinion of the Superior Council for the Prevention of Professional Risks.
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> [The doctor] must also declare any symptom and any disease not on the list but which presents, in his or her opinion, a professional character.[141]

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[136] C. trav. art. R 4626-19.

[137] C. trav. art. D. 4624-37.

[138] C. trav. art. D 4624-40.

[139] C. trav. art D 4624-43

[140] C. trav. art D 4624-44.

[141] C. séc. Soc. Art. L 461-6.

Thus, the médecin du travail works together with the state to develop and enforce health and safety standards that are tailored to the particular workplace in question.

The laws requiring employers to provide workplace doctors function as French public health policy in two respects: First, it delivers regular preventive care to most French employees. Second, it provides a mechanism by which health risks, including the factors that cause chronic diseases in the long term, are identified and addressed in specific workplaces. Employment law protects and regulates workers' health beyond imposing minimum safety standards enforced by a government agency.

B. Emerging Issues in the Prevention of Workplace Health Risks

The legal rules governing the role and duties of the médecin du travail have enabled the médecin du travail to evolve as an important policymaker and regulator in the French workplace. The French system of médecine du travail is not perfect; it is currently undergoing reform to make it more effective in responding to emerging regulatory issues in the French workplace. The current challenges include the médecin du travail's role in addressing mental health risks, such as stress and harassment, and the shift in the médecin du travail's emphasis, from individual employee medical exams towards a more robust policymaking role in workplace health and safety regulation. Thus, we shall see how the French institution of medicine du travail provides an avenue for robust employer self-regulation that is lacking in the United States.

1. Psychosocial Risks

Prior to 2002, the médecin du travail's power to propose individual measures and changes in the workplace did not make reference to "physical and mental health." It simply authorized the médecin du travail to propose changes justified by workers' health.[142] The 2002 law on social modernization specified that these changes could be justified by "physical and mental health."[143] Today, "psychosocial risks" are considered among the most important for workplace health policy.[144] The most significant of these risks are stress and harassment.

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[142] See C. trav. art. L 240-10-1 (2001).

[143] Loi no 2002-73 de modernisation sociale du 17 janvier 2002, JORF du 18 janvier 2002 page 1008, art. 175.

[144] See Ministère de l'emploi, du travail, et de la solidarité sociale, Plan Santé au Travail 2005-2009 § 4.2 (2005); Philippe Nasse & Patrick Légéron, Rapoprt sur la determination, la mesure et le suivi des risques psychosociaux au travail, 12 mars 2008, at 5 (submitted to the Ministry of Labor, Social Relations, and Solidarity).

The 2002 law, charging employers with the duty to prevent mental as well as physical health risks,[145] introduced the prohibition of "moral harassment at work" into both Labor Code and the Penal Code.[146] The Labor Code provision reads: "No employee must be subject to repeated instances of moral harassment which have for their purpose or effect the degradation of his or her work conditions that may undermine his or her rights and dignity, or to alter his or her physical or mental health or compromise his or her professional future."[147] The concept of "moral harassment" includes, but is not limited to sexual harassment.[148] Coined by the psychiatrist Marie-France Hirigoyen in her eponymous 1998 book,[149] moral harassment is a term that can refer to a variety of abusive, humiliating behaviors that Americans might call "bullying,"[150] such as an instruction to "make Mme. X crack in her work, physically and morally."[151] But it also includes various annoying behaviors when they have no work-related justification: The Cour de cassation identified in a 2004 case recognized the following behaviors as "moral harassment": the confiscation without justification of her professional-use cell phone, the imposition of a new obligation without justification to report to her supervisor's office every morning, the assignment of tasks that had no relationship to her job.[152]

Most interestingly, "moral harassment" includes conduct that violates other employment-law norms, when they have the purpose or effect of psychologically harming the employee. For instance, one court has upheld the liability of an employer who made an employee work during his holidays and Friday afternoons without pay, and without breaks except at the supervisor's discretion. This constituted moral harassment because of the "real moral prejudice" sustained by the employee, who cried, was unable to sleep, and just could not contain himself.[153]

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[145] See Loi no. 2002-73, supra note __, art. 173.

[146] See id., art. 169, 170.

[147] C. trav. art. L 1152-1.

[148] See Gabrielle Friedman & James Q. Whitman, The European Transformation of Harassment Law, Discrimination Versus Dignity, 9 Colum. J. Eur. L. 241 (2003).

[149] Marie-France Hirigoyen, Le harcèlement moral : la violence perverse au quotidien (1998).

[150] See David C. Yamada, The Phenomenon of "Workplace Bullying" and the Need for Status-Blind Hostile Work Environment Protection, 88 Geo. L.J. 475 (2000).

[151] See CA Riom, soc. 2 avril 2002 [excepted in Bourgeot & Blatman 183].

[152] Soc. 27 octobre 2004, No. 04-41008, Bull. 2004 V No. 267, No. 243.

[153] CA Riom, soc. 1 octobre 2002, No. 1293/01 [excerpted in Bourgeot & Blatman 183].

In authorizing the médecin du travail to propose workplace changes in the interests of workers' physical and mental health, the 2002 statute explicitly envisioned a role for these doctors in addressing the problem of workplace harassment. Given the range of workplace behaviors and norms violations that can constitute "moral harassment" and cause harm to the mental health of employees, the médecin du travail's power to intervene to address physical and mental health matters is considerable. Since exclusively mental injuries are compensable under French workers' compensation law,[154] an employee can declare a workplace accident when he or she is harassed. The form has to be accompanied by a medical certificate, which the médecin du travail (or the employee's own physician) can provide.[155]

Another form of intervention that is available to the médecin du travail is the power to propose individual measures and changes in the interests of workers' mental health. If an employee is being harassed by her supervisor or co-workers such that the employee bears risks or sustains harms to her mental health, the médecin du travail can propose changes such as the reassignment of the employee and/or the alleged harassers to minimize the occurrence of harassment.[156] In extreme cases, the médecin du travail can declare the harassed employee partially or totally inapt for his or her job, or for any job in the company.[157] In instances of severe harassment, a declaration of inaptitude might be welcomed by the employee, since the employer may, and ordinarily does, terminate any employee that the médecin du travail declares totally inapt for any job in the company. Although being fired is not ideal, the employee is far better off if she is fired for inaptitude than if she resigns her job, since the former entitles her to a severance,[158] whereas resignation does not.[159] However, this method of resolving a moral harassment problem is controversial because, according to a regional medical labor inspector, declaring total inaptitude in such circumstances becomes "by subversion a therapeutic

[154] See C. séc. Soc. Art L 411-1; Cass 2e civ. 1 juillet 2003.

[155] See Dyèvre & Léger, supra note)), at 188-89.

[156] See Sylvie Bourgeot & Michel Blatman, L'Etat de santé du salarié : De la preservation de la santé à la protection de l'emploi 194-95 (2d ed. 2009).

[157] Id. at 195.

[158] C. trav. 1234-9,

[159] See art. C. trav. 1237-1. In the case of resignation, the employee is required to give notice. The notice periods are set by collective agreements. If the notice period is not observe by the employee the employee may have to pay damages for resignation to the employer. See Soc. 18 décembre 1986.

prescription removing the patient from a situation deemed dangerous for her health."[160]

2. From Clinical Medicine to Public Health

The system of la médecine du travail in France is not perfect, and its current challenges must not be ignored. There is active disagreement about the direction occupational medicine should take in the future, particularly with regard to the doctor's role. The doctor's role is being reconsidered in part because there is a "demographic crisis" in médecine du travail: Today, 51 % of all of the workplace doctors are over the age of 55 and nearing retirement.[161] 75% are over the age of 50,[162] and as of 2004, it was predicted that approximately 3,000 of the 7,000 médecins du travail in France would retire in the following ten years.[163] The doctors are not being replaced at a rate that would sustain the system of médecine du travail mandated by the employment code. The specialty is simply not drawing enough medical students.[164]

In 2008, the Economic and Social Council adopted the opinion that the French system of occupational medicine was not reaching its full potential to identify risks and prevent harms to workers.[165] Consistent with the 2007 report on the reform of occupational medicine by a government agency researching social affairs, the Economic and Social Council was critical of the unique French requirement of regular checkups to confirm the employee's aptitude.[166] Over the last decade, occupational medicine has come to be seen as part of public health policy, in addition to a means of regulating the workplace.[167] In light of this recognition,

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[160] Statement of Marie-Christine Soula, quoted in Bourgeot & Blatman, supra note __, at 396.

[161] Réunion du Comité d'Orientation sur les Conditions de Travail sur la réforme des services de santé au travail, Discours de Xavier Darcos, 4 décembre 2009.

[162] Id.

[163] Claire Aubin et al., Le bilan de réforme de la médecine du travail 7 (Inspection generale des affaires sociales 2007), available at http://www.ladocumentationfrancaise.fr/rapports-publics/074000708/index.shtml

[164] Id. at 8.

[165] Conseil économique et social, L'avenir de la médecine du travail, Avis préenté par M. Christian Dellacherie 11 (2008).

[166] See Le bilan de réforme de la médecine du travail, supra note __; L'avenir de la médecine du travail, supra note __.

[167] L'Avenir de la médecine du travail at 17.

proposed reforms would focus the checkups on prevention of health risks and adaptation of work, rather than on the aptitude determinations.[168] This would mean making the schedule of visits more flexible and personalized to the employee, rather than following a strict schedule of once every two years.[169]

The desire to modify the current requirement of aptitude checkups every two years stems largely from the understanding that more of the doctors' time should be spent on the "third-time" activities of studying workplace health risks and making policy recommendations to the employer to reduce them.[170] To that end, there are proposals to strengthen the doctor's recommendations, by require the employer to provide written reasons when it rejects the recommendations, to be submitted to the health and safety committee or to other employee representatives.[171] Another possibility is to require the recommendations to be kept on file with the Labor Inspector or with the social security offices.[172]

Another important proposal is to broaden the range of health professionals represented in the "workplace health services," formerly known as workplace medical services. The reformers are proposing that the workplace health services become more "multidisciplinary," including, in addition to doctors and nurses, ergonomists, psychologists specializing in workplace issues, toxicologists, epidemiologists, and industrial hygienists.[173] It is understood that medical professionals cannot identify workplace health risks and make adaptations using medical expertise alone, especially since the preventive role of workplace doctors requires them to propose solutions other than medical treatment.

The current criticisms of the French system of médecine du travail are not an indication of the system's failures, but rather, of the awareness of the need to adapt the system to the new demands of a changing workplace. Whether the system focuses on individual medical exams or workplace policy, there is a deep understanding that the law's approach to health at work has significant consequences for the health of French citizens.

V. Employment Law and the Future of Healthcare Reform

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[168] Id at 25.

[169] Id. at 25-27.

[170] Id. at 23, 27.

[171] Id. at 28.

[172] Id. at 28.

[173] Id. at 34.

Thus, the central lesson of the French experience is that the law of occupational health and safety, which is largely considered a failure in the United States, has tremendously important implications for healthcare reform. Everyone knows that American healthcare is too expensive. The high cost of healthcare explains why so many Americans are uninsured. We spend more than most other advanced countries, and do not have better health outcomes to show for it. A growing public health literature confirms that the United States has much higher rates of preventable chronic diseases than many countries that spend far less on healthcare. It also suggests that the United States' skyrocketing healthcare costs are largely attributable to the medical treatment of these avoidable chronic conditions.[174]

But healthcare reform cannot be achieved by focusing exclusively on insuring the uninsured.[175] Rather, the underlying problems that plague the U.S. healthcare system will not be alleviated unless we figure out some ways of delivering preventive care in a systematic way.[176] Thus, the legal landscape of healthcare needs to be conceptualized more broadly to include workplace health and safety regulation, broadly construed. Instead of countering chronic diseases with expensive medical treatments after these diseases have progressed significantly, we need to find an effective and efficient way to modify behaviors and environmental factors, which, over the long term, cause and exacerbate chronic diseases.[177] The French experience shows how the workplace doctors can deliver preventive care, through regular checkups of individual employees, as well as through workplace-specific policymaking that minimizes risks and accommodates working conditions to avoid the exacerbation of existing health problems. The French model is a long shot for the United States, but the emerging company clinics provide an opportunity to open up a new path for American healthcare reform, with an ounce of French inspiration.

A. The Workplace as the Appropriate Venue of Preventive Healthcare

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[174] See, e.g. Ross deVol & Armen Bedroussian, An Unhealth America: The Economic Burden of Crhonic Disease 15-22 (Miliken Institute October 2007); Kenneth E. Thorpe, The Rise in Health Care Spending and What to Do About It, Health Affairs (Nov.-Dec. 2005).

[175] See Kenneth E. Thorpe, Reframing the Debate Over Health Care Reform: The Role of System Performance and Affordability, Health Affairs (Nov.-Dec. 2007).

[176] Id.

[177] See id.

The workplace is the most sensible place to do preventive care, for a variety of reasons. First, we already have a healthcare system in which most Americans receive healthcare through their employers in the form of health insurance benefits.[178] Employers are increasingly balking at the rising costs of providing health insurance to their employees, and this is precisely why they are increasingly providing company clinics[179] as well as workplace wellness programs.[180]

Second, since full-time employees spend a majority of their waking hours at work, delivering preventive care at the workplace makes it more likely to reach more people. People are more likely to go for regular checkups to manage one's health and risk factors for chronic diseases if they can do so on-site at the workplace, as compared to off-site at a doctor's office or hospital. There is a literature that suggests that workplace smoking cessation programs have been effective at lowering rates of smoking.[181]

The new healthcare bills encourage people to seek preventive care by requiring qualified healthcare plans to provide preventive services with no cost-sharing.[182] But when it comes to seeking out preventive health, most people probably need a stronger nudge. In a 1965 study, Yale seniors were given persuasive education about the risks of tetanus and the importance of getting a tetanus shot at the Health Center. Most students reported that they were convinced by the lecture, and planned to go to the Health Center to get the shot, but only 3 percent actually went and got the shot. In another group of subjects, the students were given the same lecture, and then told to look in their calendars, look at a map of campus, and make a plan for when they would get the shot and how they would get

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[178] Sixty percent of Americans receive health insurance through their employer. See Kaiser Family Foundation & Health Research & Educational Trust, Employer Health Benefits 2008 Annual Survey 46 (2008).

[179] See supra Part II.

[180] Kaiser Family Foundation report.

[181] E.g. E.M. Barbeau, L. Wallace, & R. Lederman et al, Recruiting Small Manufacturing Worksites that Employ Multiethnic, Low-Wage Workforces into a Cancer Prevention Research Trial, Prev. Chronic Dis. 1: A04, available at http://www.cdc.gov/pcd/issues/2004/jul/03_0020.htm; G. Sorenson, E. Barbeau, A. Stoddard et al., Promoting Behavior Change Among Working-Class, Multiethnic Workers: Results of the Health Directions – Small Business Study, 95 Am. J. Public Health 1389 (2006).

[182] The Affordable Healthcare for America Act, H.R. 3962, § 222. This section defines the "essential benefits package" in all qualified plans under the bill. The "essential benefits package" must provide preventive services without cost-sharing. The Senate bill requires employer group plans to provide preventive care with no cost sharing. See Patient Protection and Affordable Care Act, H.R. 3590, § 2713.

there. In this group, 28 percent got the shot. As Richard Thaler and Cass Sunstein observe, studies such as these suggest that people need to be "nudged" into making choices that they want to make, particularly in matters of health.[183] Delivering preventive healthcare at the workplace, by making checkups a regular part of every job, could provide that nudge.

Third, many (though not all) of the factors that cause or exacerbate chronic conditions can be controlled or mitigated by the employer. Occupational deaths are the eighth leading cause of death in the United States.[184] Although occupational deaths include deaths from accidents, a significant portion of occupational deaths are attributable to chronic diseases. This is obviously true of various preventable cancers that are caused by the carcinogens to which workers in some industries are exposed. Cardiovascular disease, which is the number one cause of death in the United States, [185] can be caused or exacerbated by various workplace factors, including exposure to toxins noise, sedentary work, and stress. Although cardiovascular disease is obviously caused and exacerbated by a variety of non-workplace factors as well, one study estimates that up to 18 percent of deaths attributable to cardiovascular disease are occupational deaths.[186] Another study suggests that obesity, which is linked to cardiovascular disease and other chronic diseases, is caused or exacerbated by various occupational exposures.[187] For instance, higher rates of obesity are correlated with chronic work stress, heat stress, exposure to certain chemicals, contingent work (which exacerbates poor eating and exercise habits), sedentary work, organization of shift work.[188]

Fourth, as the French model demonstrates, preventive healthcare in the workplace setting need not – and in the French case cannot – include medical treatment. Occupational doctors in France do not prescribe medicines, except in emergencies – they recommend and oversee behavioral and environmental modifications to avoid and reduce health

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[183] Richard Thaler & Cass Sunstein, Nudge: Improving Decisions About Health, Wealth, and Happiness 71 (2008).

[184] See Kyle Steenland, Carol Burnett, Nina Lalich, Elizabeth Ward, & Joseph Hurrell, Dying for Work: The Magnitude of U.S. Mortality From Selected Causes of Death Associated with Occupation, 43 Am. J. Indus. Medicine 461 (2003).

[185] See Centers for Disease Control, National Vital Statistics Reports Vol. 53 No.5 at 5 (2004).

[186] Steenland et al., supra note __., at 475.

[187] P.A. Schulte, G.R. Wagner, A. Downes & D.B. Miller, A Framework for the Concurrent Consideration of Occupational Hazards and Obesity, Am. Occup. Hygiene, July 2008, at 1.

[188] Id. at 3.

risks.[189] Chronic diseases are responsible for higher healthcare costs in the United States not only because the rates of chronic disease are higher, but also because they are addressed through expensive medical technologies and drugs,[190] rather than through behavioral and environmental modifications. In a world where most employees are treated only by their own doctors, without a comprehensive system of preventive healthcare in the workplace, it makes sense for doctors to focus on individual medical treatments which are within the doctor's control rather than on changes to the patient's work schedule or exposure to workplace stress, noise or carcinogens, over which the doctor has no control. The French médecin du travail, on the other hand, can focus on individual behavior modifications (e.g. stop smoking and exercise more) as well as environmental ones, since it can recommend modifications to the employer regarding the employee's individual schedule or worksite, as well as larger changes in production and exposure to health risks.

This does not mean that modifying the behavioral and environmental factors correlated with chronic diseases is costless. The point here is that the American lack of regulation of employees' health in the workplace, as compared with other countries, is at least partly responsible for our higher healthcare costs relative to other countries. According to 2002 OECD data, we spend about $5,267 per capita on healthcare, as compared to the French, who spend $2,736.[191] National healthcare cost calculations include the cost of médecine du travail. In 1999, France spent €132.8 billion on healthcare, or about €2,180 euros per capita. Of the total cost, médecine du travail accounted for only €1.1. billion euros.[192] When we consider the costs and benefits of regulating employers for the sake of employee health and safety, the healthcare cost of non-regulation should be should be taken into account.

B. Self-Regulation of Occupational Safety and Health

The French model demonstrates the ways in which a company doctor can facilitate the self-regulation of the workplace, not only in enforcing health and safety standards, but also on various other issues, such as disability accommodation and harassment. In light of the failures of command-and-control regulation by administrative agencies, the limits of private enforcement through civil lawsuits, and the decline of

[189] See supra Part I.

[190] See Kenneth Thorpe, The Rise in Health Care Spending and What to Do About it, supra note __.

[191] OECD Health Data 2004; see also Gerard F. Anderson, Peter S. Hussey, Bianca K. Frogner and Hugh R. Waters, Health Spending In The United States And The Rest Of The Industrialized World, 24 Health Affairs 903 (2005).

[192] Dyèvre & Leger, Médecine du travail, supra note __, at 27-28.

unionization, American employment law scholars, have embraced employer self-regulation as the road to improving a wide range of working conditions.[193] Company clinics have great potential as a tool of employer self-regulation, particularly when it comes to occupational health and safety.

The failures and inadequacies of occupational health and safety regulation in the United States are well known. The federal Occupational Safety and Health Act has done little to improve workplace safety. Although workplace fatalities declind 57% between 1970 and 1993, the drop in fatalities was 70% larger in the period between 1947 to 1970, as compared to the rate during the 15 years immediately following the OSHAct's adoption.[194]

Occupational health and safety standards are notoriously underenforced. OSHA is responsible for the health and safety of 115 million workers and 8 million worksites.[195] There are only about 1,100 inspectors, which means that, on average, OSHA officers can inspect a workplace every 117 years.[196] The average fine for an OSHA violation is $900.[197] Some studies of OSHA inspections suggest that inspections have neither an abatement nor a deterrence effect.[198] Other studies have suggested that an inspection leading to a penalty can reduce the injury rate by 20% over the following three years.[199] Nonetheless, one scholar notes that "even the most optimistic reading indicates that . . . more vigorous

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[193] See, e.g., Cynthia Estlund, Rebuilding the Law of the Workplace in an Era of Self-Regulation, 105 Colum. L. Rev. 319 (2005); Susan Sturm, Second Generation Employment Discrimination: A Structural Approach, 101 Colum. L. Rev. 458 (2001); Orly Lobel, The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought, 89 Minn. L. Rev. 342 (2004).

[194] See Thomas J. Kniesner & John D. Leeth, Abolishing OSHA, 18 Regulation 46, 49.

[195] See OSHA Facts – August 2008, at http://www.osha.gov/as/opa/oshafacts.html

[196] See Job Safety Commitment is Lacking, Hazards Increasing, AFL-CIO Reports, 36 O.S.H. Rep. (BNA) 385 (April 26, 2006).

[197] See Orly Lobel, Interlocking Regulatory and Industrial Relations: The Case of Workplace Health and Safety, 57 Admin. L. Rev. 1071, 1085 (2005).

[198] See Wayne B. Gray & John M. Mendeloff, The Declining Effects of OSHA Inspections of Manufacturing Injuries, 1979-1998, 58 Ind. & Lab. Rev. 571 (2005); John F. Burton & James R. Chelius: Workplace Safety and Health Regulations: Rationale and Results, in Government Regulation of the Employment Relationship 253 (Bruce E. Kaufman ed. 1997).

[199] See Wayne B> Gray & John T. Scholz, Do OSHA Inspections Reduce Injuries? A Panel Analysis (NBER Working Paper No. 3774) (1991).

enforcement alone cannot close the gap between US safety conditions and those in other OECD countries."[200]

In addition to underenforcement, the OSHAct's unfulfilled promise is attributable to its inability to promulgate new health and safety standards at a reasonable pace. Most existing OSHA standards are the "interim" standards that were adopted when the OSHAct was initially enacted. These standards were derived from existing standards at the time, and have not been updated to adapt to changes in production and in the workplace.

Thus, it is no surprise that occupational deaths are the eight leading cause of death in the United States. Both OSHA and scholars have called for more modes of employer self-regulation with regard to health and safety standards.[201] One manifestation is OSHA's Voluntary Protection Program, which grants participating employers exemptions from scheduled inspections in exchange for maintaining a good safety record and an effective safety program.[202]

The company doctor can play a significant role in enforcing existing health and safety standards, as well as in developing industry or company specific standards that would reduce risks to employees' health. American company doctors have not done so in the past, largely because they have pursued the employer's interest in avoiding regulation and liability, rather than the optimization of employee health.[203] The new company clinics, because they are outsourced and run by third-party healthcare vendors, may provide better assurances of confidentiality to employees than the company doctors of the past. But another consequence of this outsourcing is that, unlike the médecins du travail in France, the primary care physicians who staff the new company clinics are disconnected from the employer. They do not have a statutory duty to learn anything about the particular risks of the workplaces they service, or the possibilities within that workplace for changes in working conditions that would improve their patients' health.

For the most part, the new company clinics are staffed by physicians who work for a healthcare firm that provides similar clinics to a variety of large employers. In short, they are doing the same job whether they work for Pepsi, Disney, or Toyota, even though the environmental factors that could alter the employees' health are very different between these three companies. The French médecins du travail, even if they work

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[200] Peter Dorman, Markets and Mortality: Economics, Dangerous Work, and the Value of Human Life 196 (1996).

[201] See Estlund, supra note __; Lobel, supra note __.

[202] See OSHA Fact Sheet: Voluntary Protection Programs, available at http://www.osha.gov/dcsp/vpp/index.html.

[203] See supra Part III.

for a variety of employers, are required by law to integrate health and safety standards with specific information about the health conditions of the individuals employed and the special risks posed by the particular environment. The new American company clinics appear to be more independent and thus more likely to respect employee confidentiality than the traditional company doctors. Their ability to do preventive care could be enhanced if this independence could be combined with the power to make workplace policy recommendations to the employer.

C. New Directions in the Healthcare Debate

What can American policymakers, scholars, and lawyers learn from the French practice of médecine du travail? A comprehensive system of mandatory occupational medicine à la Française is hard to imagine in the United States. Yet, there are threads of resemblance between French and American onsite healthcare which provide a starting point for the thinking about ways in which law can optimize employers' ability to deliver preventive healthcare effectively. Given the voluntary rise of company clinics that are focusing on preventive medicine in the United States, employers are obviously interested in onsite preventive care, as they are realizing that it can cut health insurance costs. Congress is considering the Healthy Workforce Act of 2009, which proposes to provide a tax credit to companies offering "effective and comprehensive wellness programs."[204] Tax credits would be available to employers who provide health awareness education and risk assessments and behavioral change programs such as counseling, seminars and on-line programs on topics like nutrition, stress, management, or smoking cessation.[205]

Perhaps further tax incentives should be offered to those employers whose onsite healthcare facilities incentivize employees to use the primary preventive healthcare services regularly. To this end, U.S. law should also provide formal guarantees of the doctor's independence from the employer, as well as sanctions for company doctors' breaches of confidentiality. The confidentiality of employees' medical information should be protected through the legal prohibition of the termination of a company doctor for refusing to violate medical ethics rules. This could be accomplished by statute or by the recognition of a public policy exception to the doctrine of employment at will. Even as the immediate transplant of the mandatory French legal regime of médecine du travail is politically implausible, smaller reforms to improve the efficiency of company doctors and clinics in delivering preventive care are plausible and should be pursued. These reforms are incremental steps towards the

[204] Healthy Workforce Act of 2009, S. 803, 111th Cong., 1st Sess., introduced April 2, 2009.

[205] Id.

improvement of workplace health and safety, broadly conceived, as a key component of healthcare policy.

The obvious barrier to a more robust, mandatory system of occupational medicine in the United States is the deeply rooted resistance to paternalism, shared by employers and workers alike. But, if anything is going to be done to reform healthcare in the future, American healthcare policy will have to overcome its allergy to paternalism. Policies that have traditionally seemed paternalistic need to be reconceptualized as a response to the negative externalities of non-regulation. Several existing features of the House and Senate healthcare bills can be understood in these terms. They both essentially require employers to provide health insurance by way of the "pay or play" provisions: Employers must offer health insurance coverage to its employees, or else contribute to a fund that finances affordable coverage.[206] Both bills also require Americans to get health insurance or face a penalty.[207] Requiring every American to be insured may appear paternalistic, but such mandates are increasingly being justified by reference to the costs borne by society as a result of the choice to remain uninsured, rather than by reference to the harms sustained by the uninsured person himself. Requiring or offering greater tax credits to larger employers to provide onsite clinics (or shared near-site clinics) which in turn incentivize or require all employees to attend confidential regular check-ups may appear paternalistic, but the social costs of America's failure to deliver preventive care is the underlying justification.

CONCLUSION

Moving forward, American healthcare reform needs to focus on cost reduction through the prevention of chronic diseases. The workplace remains one of the most promising venues in which prevention can be pursued, through the delivery of individual preventive care as well as through policies that minimize risks. French employment law, by mandating and regulating the practice of occupational medicine in every workplace, is an important component of French public health policy. The French model should remind American policymakers and scholars of the potential of a robust body of workplace health and safety law, broadly construed, to improve health outcomes and reduce healthcare costs. A consideration of this potential can inject the ailing American healthcare debate with the medicine it badly needs.

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[206] Affordable Healthcare for America Act, H.R.3962 § 413; Patient Protection and Affordable Care Act, H.R. 3590 § 1513.

[207] Affordable Healthcare for America Act, H.R.3962 § 501; Patient Protection and Affordable Care Act, H.R. 3590, § 1501.