

Anchoring Wellness at Sea: Exploring Filipino Seafarers' Lived Experiences and Perceptions of Pre-Employment Medical Examinations in Maritime Health and Safety

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ABSTRACT

The current study entitled "Anchoring Wellness at Sea: An Assessment of the Experience of Filipino Seafarers and their Perception of Pre-Employment Medical Examination (PEME) in Maritime Health and Safety" aimed to examine the experience of Filipino seafarers with respect to how they have been able to give meaning to PEME, which is both a maritime health and safety measure as well as an employment requirement for international employment. This research is needed because qualitative data on Filipino seafarers' PEME experiences are limited, particularly regarding health protection, employment pressure, family responsibility, and trust in the duty to complete PEME. The quantitative research used descriptive phenomenology. It involved 22 purposively sampled Filipino seafarers who completed PEME within 24 months

and are seeking or already engaged in international maritime jobs. We conducted individual semi-structured interviews with participants via Zoom after obtaining consent through Google Forms. We recorded the interviews, transcribed them, and verified the transcripts against the original recordings to ensure accuracy. Participants participated in interviews using English, Filipino, or both. We used Colaizzi's descriptive phenomenology method to analyze the interview transcripts. Six interrelated themes emerged after completion of the research: 1) A Necessary Passage- PEME as an Employment Gateway and a Health Safeguard; 2) Preparing to Pass- Self-discipline, Experience and Pre-Anxiety; 3) The Physical Journey- Organization and Discomfort; 4) Flow of Things- Consequences- Referrals, Cost, Delay and Livelihood of Family; 5) Dignity Shape Disclosure; 6) Making PEME Work for Seafarers- Support and Education. The core structure indicated PEME work as a health-employment threshold. The study indicates that PEME is important for assessing health status and ensuring fitness to work. It also creates stress for seafarers if exam findings lead to repeat tests, referrals, delays, or unclear communication. The results indicate that a seafarer-centered approach should be used for sailors who adhere to clinical standards, while improving workflow, communication, privacy, health education, dignity, and follow-up care.

Keywords: *Filipino seafarers, Pre-Employment Medical Examination, PEME, maritime health and safety, lived experiences, descriptive phenomenology, nursing administration*

INTRODUCTION

The maritime industry remains a major foundation of global trade and economic connectivity. Through international shipping, essential goods, raw materials, fuel, food supplies, manufactured products, and commercial commodities are transported across countries and continents. Behind this global movement are seafarers whose physical readiness, technical competence, psychological strength, and work discipline sustain naval operations. In this workforce, Filipino seafarers continue to hold a significant position. The International Chamber of Shipping

(n.d.) recognizes the Philippines as a major supplier of seafarers serving on internationally trading merchant ships. In the Philippine context, preliminary data from the Department of Migrant Workers recorded 589,179 deployed Filipino seafarers in 2025 and 76,339 in January 2026, with the agency noting that the 2025 and 2026 data remain preliminary and subject to final evaluation (Department of Migrant Workers [DMW], 2026). These figures demonstrate the continuing relevance of Filipino seafarers not only to global maritime operations but also to the Philippine labor economy.

Although seafaring provides livelihood, career mobility, and financial support for Filipino families, it is also an occupation defined by complex health and safety demands. Seafarers work in a setting where the workplace is also the living space, where access to immediate medical care may be limited, and where physical or psychological unfitness can affect the safety of the individual, the crew, the vessel, and the marine environment. Their work frequently involves prolonged separation from family, irregular work-rest cycles, fatigue, social isolation, multicultural crew interaction, confined living spaces, heavy physical tasks, and exposure to changing weather and operational pressures. These realities make seafarer health a central concern in maritime safety.

Recent maritime health literature has increasingly emphasized that seafarer wellness should not be limited to physical fitness alone. Psychological well-being, work stress, fatigue, loneliness, anxiety, depression, and coping capacity are also important dimensions of readiness for sea service. Brooks and Greenberg (2022) reported that maritime personnel are exposed to occupational stressors that may affect mental health and psychological condition. Baygi et al. (2022) likewise found that mental health status is associated with life satisfaction among seafarers, while Sarinas et al. (2022) identified stress, fatigue, and separation from family and friends as major factors affecting the mental health of Filipino seafarers. These results indicate that seafarer health is multidimensional and closely connected to occupational safety, performance, and long-term employability.

In response to the risks associated with maritime work, medical fitness assessment has become an essential requirement before deployment. The joint guidelines of the International Labor Organization (ILO) and International Maritime Organization (IMO) explain that medical examinations for seafarers are intended to determine whether seafarers can safely and effectively perform routine and emergency duties at sea, whether they have conditions likely to be aggravated by sea service, and whether their health status may endanger others onboard (International Labor Organization [ILO] & International Maritime Organization [IMO], 2013). In the Philippines, the Pre-Employment Medical Examination (PEME) serves as a standardized medical screening procedure conducted before deployment to determine whether a seafarer is physically and mentally fit for work at sea. The Department of Health defines PEME as a medical examination conducted before overseas employment to assess workers' physical and mental fitness, including seafarers (Department of Health [DOH], 2013).

Both international and national policies reinforce the importance of PEME. The Maritime Labor Convention requires seafarers to hold a valid medical certificate attesting that they are medically fit to perform their duties at sea (ILO, n.d.). In the Philippines, DOH-MARINA Joint Memorandum Circular No. 1, Series of 2022 provides guidelines for recognizing and monitoring medical practitioners who conduct PEME and issue medical certificates for Filipino seafarers (DOH & Maritime Industry Authority [MARINA], 2022). Republic Act No. 12021, also known as the Magna Carta of Filipino Seafarers, further recognizes the rights, welfare, and protection of Filipino seafarers working onboard ships plying international waters (Republic Act No. 12021, 2024). These policies show that PEME is not simply a routine employment requirement; it constitutes part of a broader occupational health and maritime safety system.

Despite PEME's regulatory importance, a significant gap remains in understanding how Filipino seafarers experience and interpret the process. Existing discussions on PEME often focus on standards, medical fitness, certification, compliance, and regulatory implementation. Studies such as Huerte et al. (2023) provide valuable information on health risk classification patterns among Filipino seafarers in a pre-employment clinic. Still, they do not completely capture the subjective meanings, anxieties, concerns, and perceptions of seafarers who undergo PEME. Thus, while the medical and administrative functions of PEME are documented, Filipino seafarers' lived experiences remain insufficiently explored.

This gap matters because seafarers' experiences of, and engagement with, PEME may depend not only on the medical procedures involved but also on trust, understanding, willingness to disclose health concerns, and

perceived employment consequences. A seafarer who views PEME as a meaningful health safeguard may feel more comfortable discussing health concerns, following medical advice, and valuing prompt diagnosis. In contrast, a seafarer who experiences PEME primarily as an employment obstacle may tackle the process with fear, anxiety, or reluctance to disclose concerns. Apprehending these perceptions remains therefore important for designing communication, counseling, health education, and service systems that support both maritime safety and seafarer dignity.

The Filipino context makes this issue more complex. For many Filipino seafarers, maritime employment is closely tied to family responsibility, economic survival, social mobility, and long-term career security. Passing PEME may therefore be experienced not only as a health requirement but also as a condition for deployment, income, and family support. Fear of being declared temporarily or permanently unfit may discourage some seafarers from fully disclosing symptoms, mental health concerns, or previous medical conditions. This tension between health protection and employment pressure creates an important area for qualitative inquiry.

This study, titled “Anchoring Wellness at Sea: Exploring Filipino Seafarers’ Lived Experiences and Perceptions of Pre-Employment Medical Examinations in Maritime Health and Safety,” sought to explore how Filipino seafarers experienced, understood, and gave meaning to PEME. It examined whether PEME was perceived as a genuine health and safety safeguard, a procedural employment requirement, a source of anxiety, or a combination of these meanings. Using a descriptive phenomenological approach, the study prioritized Filipino seafarers’ voices and generated insights grounded in their individual accounts. The findings provided a participant-centered basis for improving PEME practices, strengthening maritime health education, supporting nursing administration, and promoting more humane, ethical, and seafarer-centered health screening procedures.

Literature Review

Maritime Health and Safety Among Seafarers

Seafaring is a safety-sensitive occupation in which individual health can affect not only the worker but also the crew, vessel operations, emergency response, and the marine environment. The ship is simultaneously a workplace and living environment, often characterized by long periods away from home, rotating work-rest schedules, physical demands, noise and vibration, restricted living space, limited shore access, and delayed access to definitive medical care. These conditions make prevention, early identification of health problems, and fitness-for-duty assessment central components of maritime safety.

Recent reviews consistently describe seafarer health as multidimensional. Brooks and Greenberg (2022), in a systematic review of maritime personnel, found recurring psychological concerns associated with isolation, long working hours, fatigue, restricted shore leave, and demanding occupational conditions. Abila and Acejo (2021), in a narrative review focused specifically on Filipino seafarers, likewise concluded that the evidence base on mental health remained limited and uneven, with important gaps in seafarers’ experiences, systems of care, and mental health needs. Their review is particularly relevant because it shows that the Filipino seafarer literature has historically concentrated more on adverse outcomes and medical events than on how workers understand and navigate health services.

Quantitative evidence reinforces the need for a holistic view of fitness for sea service. Baygi et al. (2022) found that mental health and perceived health status were associated with life satisfaction among seafarers, while Sarinas et al. (2022) identified stress, fatigue, and separation from family and friends among the leading concerns reported by Filipino seafarers. Although these studies do not examine PEME as a lived experience, they demonstrate why medical fitness cannot be reduced to the absence of a single physical disease. Readiness for sea duty includes physical capability, psychological functioning, health behavior, and the ability to work safely under demanding conditions.

Taken together, this literature establishes the health and safety rationale for medical fitness assessment. It does not, however, explain how seafarers experience the assessment itself. The distinction is important: evidence that screening is clinically necessary is not the same as evidence that the process is understood, trusted, or experienced as supportive by the workers who undergo it.

Filipino Seafarers and the Occupational Context of Health Decisions

Filipino seafarers' health decisions occur within a distinctive employment context. International seafaring is commonly contract-based, deployment-dependent, and closely connected to family income. For many workers, continued fitness for duty is therefore tied to more than occupational identity; it may also determine the continuity of remittances, household expenses, debt payments, children's education, and other family responsibilities. This context does not mean that all Filipino seafarers respond to health concerns in the same way. Still, livelihood consequences are an important factor to examine when health status can affect deployment.

Earlier Filipino phenomenological research provides important context for understanding seafarers' health experiences. Gregorio (2012) used descriptive phenomenology with 12 Filipino seafarers and conducted in-depth interviews at an industrial clinic during their annual medical examinations. The study documented health conditions, access to and satisfaction with health services and facilities aboard international shipping vessels, and coping mechanisms. Although data collection occurred in a clinic setting during medical examinations, the phenomenon under study was the seafarers lived experience aboard vessels rather than the PEME encounter itself. Its relevance to the present study is therefore twofold: it demonstrates the value of phenomenological inquiry for Filipino seafarer health, while also leaving the specific lived meaning of PEME as a health-, employment-, and livelihood-related process insufficiently examined.

Guillot-Wright (2021) provides some of the strongest qualitative evidence for this issue. In a one-year photo-ethnography involving 14 male Filipino migrant seafarers, the authors generated data through semi-structured interviews, observation, photovoice, and field notes. Participants described situations in which they underreported or concealed illness, injury, and unsafe conditions because they feared a record of sickness could jeopardize future contracts. The study did not investigate PEME, but it shows a mechanism directly relevant to medical screening. When workers believe disclosure may threaten future employment, economic insecurity can complicate access to healthcare and truthful reporting.

A related concern appears in recent research on seafarers' mental health and health promotion. Abila et al. (2023), using mixed methods, described a persistent 'ship first' orientation in which safe operations and work demands could take precedence over seafarers' own mental health needs. Their findings also showed that seafarers considered health interventions more meaningful when they had visible benefits for their families. This reinforces the importance of examining PEME within the broader realities of work, family, and perceived consequences rather than treating it as an isolated clinical encounter.

Current post-pandemic evidence also shows that employment stability and family separation remain important to seafarers' well-being. Carrera-Arce et al. (2025) sequentially combined semi-structured interviews with 12 seafarers and a survey of 804 multinational seafarers. Contract instability, family separation, workload, insufficient attention to well-being, and working conditions were among the factors associated with reconsidering a career at sea. Although this study addressed retention rather than PEME, it supports the wider argument that seafarers' health experiences are embedded in employment and family systems.

These findings justified examining PEME as both a health procedure and an occupational event. A medical finding may carry several meanings at once: protection from harm, evidence of a health problem, possible deployment delays, financial uncertainty, and concern for family obligations. A phenomenological approach was appropriate because clinical records alone could not reliably infer these meanings.

Pre-Employment Medical Examination as a Medical Fitness Requirement

PEME is a core mechanism for determining whether a seafarer is medically capable of carrying out routine and emergency duties at sea. The joint ILO/IMO guidelines on medical examinations of seafarers emphasize that medical assessment should consider whether a worker can safely perform assigned duties, whether an existing condition may be aggravated by sea service, and whether the condition may create a risk to other persons onboard (ILO & IMO, 2013). The Maritime Labor Convention likewise requires a valid medical certificate attesting to fitness for sea service. These standards position medical fitness as a preventive safety measure rather than a simple administrative clearance.

In the Philippine setting, PEME is implemented within national health and maritime regulatory arrangements. DOH Administrative Order No. 2013-0006 provides the regulatory framework for overseas workers' medical examinations, while the DOH-MARINA Joint Memorandum Circular No. 1, Series of 2022 sets guidelines for recognizing and monitoring medical practitioners responsible for conducting medical fitness assessments for Filipino seafarers. MARINA and DOH continue to emphasize standardized assessments and consistent issuance of medical certificates for sea service.

The most directly relevant Philippine empirical study is Huerte et al. (2023). Using a retrospective observational design, the authors reviewed the records of 11,831 seafarers who underwent physical and medical examination at a Philippine pre-employment clinic from 2018 to 2022. Fit-to-work seafarers were classified into medical risk categories, and risk classification was significantly associated with the time from PEME to fit-to-work determination. Higher-risk categories generally required longer periods before clearance. The study demonstrates that PEME can identify clinically meaningful risk patterns and can affect the timing of deployment-related medical clearance.

Huerte et al. (2023) is important precisely because it also shows the boundary of current evidence. The study explains the distribution of risk classifications, demographic and occupational patterns, and time to fit-to-work status. Still, it does not reveal how seafarers felt while waiting, how they interpreted additional testing, whether they understood the findings, how they experienced communication with clinic personnel, or what being placed in a higher-risk category meant for them and their families. Clinical records can describe the medical pathway; they cannot by themselves describe the lived meaning of that pathway.

The regulatory context has also developed since the passage of Republic Act No. 12021, or the Magna Carta of Filipino Seafarers. Its Implementing Rules and Regulations were signed in January 2025. The IRR affirms seafarers' rights to appropriate medical care and, for overseas seafarers, access to the results of medical examinations conducted on them (Department of Migrant Workers & Maritime Industry Authority [DMW & MARINA], 2025). This is relevant to the present study because transparency, explanation of findings, and access to one's medical information are not merely service preferences; they are closely connected to informed participation and seafarer welfare.

Thus, the current regulatory and empirical evidence clearly supports the necessity of PEME. The unresolved question is not whether medical fitness assessment should exist, but how Filipino seafarers experience the process when their health status is evaluated. Their deployment may depend on the outcome.

Physical Health, Medical Risk Classification, and Repatriation

Physical fitness remains fundamental because shipboard work may involve climbing, lifting, prolonged standing, watchkeeping, machinery operation, emergency response, and work in confined or physically demanding spaces. Cardiovascular disease, hypertension, diabetes, obesity, musculoskeletal conditions, respiratory problems, visual or hearing impairment, and other illnesses may affect safe performance depending on severity and job demands. For this reason, PEME functions partly as a risk-control measure before exposure to the conditions of sea service.

The Huerte et al. (2023) clinic study provides direct Philippine evidence of the prevalence of medical risk categories among seafarers who ultimately obtained fit-to-work status. Risk Class C represented the largest category in their sample, indicating that a substantial proportion of workers had chronic conditions or medical issues requiring control or specialist evaluation before being cleared. Importantly, the study did not equate a medical condition with permanent exclusion from work; many health problems required management before fitness could be established.

Medical repatriation studies further demonstrate why pre-employment assessment matters. Abaya et al. (2023) reviewed 6,526 medical repatriation cases among Filipino seafarers from 2015 to 2019, based on 464,418 deployments, and calculated an overall repatriation rate of 1.4%. Musculoskeletal disorders, gastrointestinal problems, and traumatic injuries were among the most common causes. The authors emphasized continued health profiling and stronger health protection as important for occupational health planning. These findings support the

preventive intent of PEME, because identifying and managing health risks before deployment may reduce avoidable illness, contract interruptions, and medical emergencies at sea.

However, epidemiologic data do not fully capture the consequences of illness. Villa and Paraggua (2024) used a narrative qualitative approach with eight medically repatriated Filipino seafarers and documented effects on life, career, and finances, as well as coping and recovery. Seven participants were eventually declared fit to work after treatment and received re-employment opportunities from their previous manning agencies. Their findings are useful because they show both sides of medical fitness decisions: illness can disrupt income and career continuity, yet treatment and follow-up can also support safe return to work.

This body of evidence suggests that the phrase 'fit to work' carries clinical, occupational, and personal meanings. For healthcare providers, it is a medical judgment about capability and risk. For seafarers, it may also signify readiness to deploy, continuity of income, and relief from uncertainty. Conversely, a pending or unfit result may be experienced as a health warning, a temporary interruption, or a threat to future work. These meanings warrant direct exploration rather than assumption.

Mental Health and Psychosocial Well-Being of Seafarers

Mental health is increasingly recognized as integral to maritime safety. Seafarers may face social isolation, fatigue, disrupted sleep, prolonged family separation, limited privacy, demanding schedules, organizational pressure, and uncertainty about crew changes or contracts. Brooks and Greenberg (2022) concluded that maritime personnel face substantial psychological stressors, while Abila and Acejo (2021) emphasized the continuing need for stronger evidence and mental health education among Filipino seafarers.

Recent mixed-method evidence shows that support systems matter. Tang et al. (2022) first conducted qualitative interviews with 26 maritime stakeholders, including 14 seafarers, and then surveyed 817 seafarers. The study identified 22 forms of mental health support and found that communication with family, timely crew changes, vaccination-related support, and a positive, collegial onboard atmosphere were among the most helpful measures. The qualitative findings also showed that support from companies, crew members, families, welfare organizations, and other stakeholders operates as an interconnected system rather than as isolated interventions.

Timilsina and Baygi (2023) provide particularly useful qualitative evidence concerning workers' experiences of formal health requirements. Their study used in-depth interviews and qualitative content analysis with 10 ocean-going seafarers and three managers from international shipping companies. Participants generally followed COVID-19 health guidance when it was available and communicated through trusted organizational channels. Some reported reduced anxiety because clear procedures gave structure to an uncertain situation, but the guidelines did not adequately address psychological needs, repatriation difficulties, or all sources of distress. Although COVID-19 guidelines differ from PEME, the study illustrates a transferable principle: the perceived value of a health requirement depends partly on communication, trust, relevance, and whether the procedure addresses the worker's actual concerns.

Carrera-Arce et al. (2022) similarly examined seafarers' well-being using quantitative and qualitative components among 105 active seafarers. Participants identified rest, communication with the outside world, relationships onboard, and organizational conditions as important to well-being. The study argued for a healthier psychosocial work environment rather than relying exclusively on individual coping. This is relevant to PEME because health screening can identify vulnerability, but organizational and social conditions continue to shape health after a worker is declared fit.

More recent Filipino-focused research has also highlighted barriers to mental health help-seeking. Abadicio et al. (2025) reported that financial limitations, privacy and digital-security concerns, infrastructure constraints, stigma, limited awareness of services, and distrust could affect Filipino seafarers' engagement with mental health support. Telemental health was viewed as potentially useful because of convenience and privacy, but acceptance was not automatic. These findings strengthen the need to examine whether seafarers see PEME as a setting where they can disclose mental health concerns safely and have them taken seriously.

The implication for PEME is not that every psychological concern should lead to restriction from sea service. Rather, the literature shows that mental health is part of occupational readiness and that stigma or fear

may discourage disclosure. A screening system intended to protect health is weakened if workers believe that revealing psychological difficulty will automatically result in punishment, loss of employment, or loss of dignity.

Health Disclosure, Employment Pressure, and Fear of Disqualification

Accurate health disclosure is essential to medical fitness assessment because clinicians rely partly on information about symptoms, medical history, medications, previous diagnoses, and current concerns. Yet disclosure becomes more complicated when the person being assessed believes that an unfavorable finding may delay deployment or reduce future employment opportunities. In this setting, the decision to disclose can involve a perceived trade-off between immediate livelihood and longer-term health protection.

Guillot-Wright's (2021) photo-ethnography directly illustrates this conflict among Filipino migrant seafarers. Participants described self-treatment, delayed healthcare seeking, and concealment of injuries or illness because of concern about being labeled medically problematic or becoming too costly to employ. This study is valuable to the present research not because onboard healthcare and PEME are identical contexts. Rather, it shows that employment insecurity can shape health behavior among Filipino seafarers, making fear of future work consequences a legitimate issue to investigate during pre-employment screening.

Turner et al. (2024) provide a closely related comparison from maritime occupational health. Using interviews, focus groups, and a participatory workshop with commercial fishers in Cornwall, United Kingdom, the authors examined the effects of compulsory medical certification. They found that an intervention introduced to improve safety also created unintended consequences, including reduced access to healthcare, a perceived mismatch between regulatory requirements and workers' lived realities, and mistrust. The population and legal context differ from Filipino international seafarers, so the findings cannot be transferred directly. Nevertheless, the study is conceptually important because it shows that mandatory medical certification can be experienced as both a safety intervention and a potential threat to livelihood or autonomy.

Villa and Paraggua (2024) add a Philippine perspective by showing that medical illness and repatriation can affect finances and career continuity. Their findings do not establish that seafarers intentionally conceal illness during PEME, but they help explain why the possibility of a medical problem may carry significant personal consequences. This distinction matters for careful interpretation: employment pressure is a plausible influence supported by related qualitative evidence, but its specific operation within Philippine PEME must be established from participants' own accounts rather than assumed in advance.

The Health Belief Model and Theory of Planned Behavior are useful sensitizing frameworks for this tension. A seafarer may see clear benefits in PEME, such as early detection and protection at sea, while also facing barriers like cost, delays, anxiety, or potential income interruption. Attitudes, subjective norms, and perceived behavioral control may also shape whether the worker feels able to ask questions, disclose health concerns, comply with additional tests, or follow medical advice. In this qualitative study, these concepts informed the inquiry but did not serve as predetermined categories for the themes developed from participants' narratives.

Communication, Trust, Confidentiality, and Seafarer Participation

The quality of a medical screening program depends not only on the technical accuracy of tests but also on how the process is communicated and experienced. Seafarers need to understand what is being assessed, why additional examinations may be requested, what a finding means for fitness, and what steps are available when treatment or follow-up is required. Unclear communication can transform a preventive procedure into a source of uncertainty, even when the clinical decision itself is appropriate.

Timilsina and Baygi (2023) found that access to trusted organizational information improved seafarers' acceptance of health guidance, whereas inadequate information encouraged reliance on less reliable sources. Tang et al. (2022) likewise demonstrated that regular information and support from companies, families, and crew members were important to perceived well-being. These studies focus on pandemic health measures rather than PEME, but both suggest that compliance and psychological reassurance strengthen when communication is timely, credible, and responsive to workers' concerns.

Trust is also shaped by whether workers perceive the system as fair. Turner et al. (2024) found that mistrust developed when compulsory medical certification was experienced as insufficiently aligned with fishers' working realities. Guillot-Wright (2021), meanwhile, showed how fears about health records and future employability could discourage Filipino seafarers from seeking care. Together, these studies suggest that a seafarer may evaluate a medical process not only by its clinical purpose but also by whether the worker expects respectful treatment, reasonable explanation, confidentiality, and fair consequences.

The 2025 IRR of the Magna Carta of Filipino Seafarers strengthens the importance of communication by giving overseas seafarers the right to receive the results of medical examinations conducted on them (DMW & MARINA, 2025). The present study therefore has a practical reason to ask how findings are explained and whether seafarers feel adequately informed after PEME. The issue is not simply satisfaction with service; it concerns meaningful participation in one's own occupational health assessment.

Confidentiality is particularly important when screening involves sensitive diagnoses or mental health concerns. The reviewed literature does not establish how Filipino seafarers specifically understand confidentiality during PEME, which itself constitutes a gap. Exploring their expectations about privacy, who may access results, and whether confidentiality affects willingness to disclose can generate evidence for more seafarer-centered health communication.

Social, Cultural, and Economic Influences on PEME Experiences

Social context shapes health behavior. For Filipino seafarers, family relationships, peer experiences, manning-agency requirements, employer timelines, and financial obligations may influence how PEME is approached. These influences should not be reduced to fixed cultural traits. Rather, they should be treated as contextual conditions whose importance may differ from one participant to another.

Family is consistently visible in recent seafarer research. Sarinas et al. (2022) identified communication with family as an important coping strategy, while Tang et al. (2022) found family communication among the most highly valued forms of mental health support. Abila et al. (2023) further observed that seafarers could perceive health interventions as more useful when the benefits extended to their families. Carrera-Arce et al. (2025) also identified family separation and contract instability as important concerns in decisions about remaining in seafaring. These findings support asking how family responsibilities shape the emotional significance of passing, delaying, or repeating a PEME.

Economic considerations may include transport to a medical facility, time away from other activities, additional testing, treatment costs when not covered, delayed deployment, and income uncertainty. The reviewed studies do not show that these burdens occur uniformly across PEME clinics or companies. Therefore, they should be investigated as possible experiences rather than presented as established features of every PEME. This distinction is essential for phenomenological rigor and for avoiding assumptions about participants before data collection and analysis.

Peer and organizational influences may also affect expectations. Stories from other seafarers about medical findings, repeated tests, clinic practices, or previous deployment delays may shape anticipation before a medical examination. Manning agencies and employers may influence the timing and urgency of PEME through deployment schedules. The Theory of Planned Behavior provides a useful lens for examining these social pressures, but the direction and strength of their influence must emerge from participant accounts.

Regulatory and Policy Context of PEME

PEME is situated within overlapping international and Philippine regulatory frameworks. Internationally, the Maritime Labor Convention and medical examination guidelines establish the basic expectation that seafarers should be medically fit for their duties and should have access to health protection. In the Philippine system, DOH Administrative Order No. 2013-0006 and the DOH-MARINA Joint Memorandum Circular No. 1, Series of 2022 govern medical examinations and the recognition of medical practitioners conducting medical fitness assessments for Filipino seafarers.

Republic Act No. 12021 and its 2025 IRR add a broader rights-and-welfare framework. The IRR covers Filipino seafarers serving on ships plying international waters and emphasizes safe working conditions, appropriate medical care, welfare protection, and access to relevant employment and medical information. These provisions place PEME within a larger system of seafarer protection rather than treating it only as a prerequisite for deployment.

Policy compliance, however, should not be assumed to produce a uniformly positive experience. A procedure may comply with standards while still being perceived as rushed, poorly explained, intimidating, or difficult to navigate. Conversely, a rigorous medical process may be experienced positively when staff explain findings, preserve dignity, offer realistic treatment options, and communicate clearly about the path to fitness. Qualitative inquiry is therefore valuable because it examines the human experience of encountering policy.

The study did not seek to determine whether clinics or practitioners complied with the law, nor did it compare individual medical facilities. Its focus was narrower: how Filipino seafarers experienced the PEME process within the existing regulatory environment and what their narratives suggested about communication, trust, disclosure, support, and participation.

Nursing Administration and Seafarer-Centered Maritime Health Services

The topic is directly relevant to nursing administration because PEME is not only a medical decision but also a health-service process. It involves patient flow, instructions, history taking, vital signs and other screening activities, documentation, coordination of laboratory and diagnostic procedures, referral, privacy, health education, communication of next steps, and follow-up. Even when an authorized physician makes the final fitness determination, the service environment can influence how the seafarer understands and engages with the process.

Recent seafarer research repeatedly points to communication, organizational support, and access as modifiable aspects of health services. Tang et al. (2022) showed that support was most useful when it was accessible and relevant to seafarers' needs. Timilsina and Baygi (2023) demonstrated the value of trusted information and worker participation in implementing health guidance. Turner et al. (2024) showed that mistrust can develop when occupational health rules are disconnected from workers' lived realities. These findings support a nursing-administration focus on service design rather than viewing the seafarer only as the recipient of a fitness decision.

For nursing leaders, potential improvements may include clearer pre-examination instructions, organized patient flow, appropriate privacy during history taking, sensitive communication about mental health, clear explanations of repeat testing or referrals, timely updates, and health teaching that frames PEME as prevention rather than mere clearance. These issues required empirical examination from the perspective of Filipino seafarers. The study's value was that its recommendations were grounded in participant narratives rather than imposed based on assumptions about what clinics should change.

A seafarer-centered approach does not require lowering medical standards. On the contrary, transparent communication and respectful care may strengthen screening integrity by increasing understanding, trust, and willingness to disclose relevant health information. From a nursing administration perspective, clinical rigor and humane service delivery are complementary goals.

Synthesis and Research Gap

The reviewed literature establishes a clear foundation for the present study. First, seafaring exposes workers to significant physical and psychosocial demands, making medical fitness assessment a legitimate component of maritime safety. Second, Philippine clinic-based evidence shows that PEME identifies meaningful risk classifications and that higher-risk cases may require longer pathways to fit-to-work status (Huerte et al., 2023). Third, evidence on medical repatriation shows that illness and injury continue to interrupt sea service and can affect occupational health, career continuity, and finances (Abaya et al., 2023; Villa & Paraggua, 2024). Fourth, qualitative and mixed-method studies show that seafarers' health experiences and behavior are shaped by shipboard conditions, employment insecurity, family relationships, communication, organizational support, trust,

stigma, and perceived consequences of illness (Gregorio, 2012; Guillot-Wright, 2021; Tang et al., 2022; Timilsina & Baygi, 2023; Abila et al., 2023; Turner et al., 2024; Carrera-Arce et al., 2025).

These studies also define the limits of existing knowledge. Gregorio (2012) used descriptive phenomenology with Filipino seafarers and conducted interviews during annual medical examinations. Still, the study focused on health experiences aboard international vessels rather than on the lived meaning of PEME itself. Huerte et al. (2023) describe the medical risk classifications used in a Philippine PEME clinic but not how seafarers experience the examination. Guillot-Wright (2021) explains healthcare avoidance and concealment among Filipino migrant seafarers but focuses primarily on healthcare access during employment rather than pre-employment screening. Tang et al. (2022), Timilsina and Baygi (2023), and Carrera-Arce et al. (2025) examine health support, organizational response, or well-being in maritime work rather than the PEME encounter. Villa and Paraggua (2024) focus on the consequences of medical repatriation after illness, while Turner et al. (2024) examine compulsory medical certification in a different population and regulatory setting.

Accordingly, the principal research gap is experiential, contextual, and process-specific. Across the literature reviewed for this study, no peer-reviewed qualitative investigation focused specifically on how Filipino seafarers experience and make meaning of the Philippine PEME process before, during, and after the examination. The literature does not adequately describe their preparation and expectations, emotional responses while awaiting results, encounters with clinic personnel, understanding of tests and medical findings, experiences of repeat testing or referral, perceptions of confidentiality, or the meanings attached to being declared fit, pending, temporarily unfit, or otherwise requiring further management.

A second gap concerns the interaction of health and employment. Related studies show that employment insecurity can influence healthcare seeking and disclosure. Still, evidence is insufficient on whether and how fear of delayed deployment, disqualification, or income interruption shapes disclosure specifically during PEME among Filipino seafarers. Likewise, family responsibility, peer influence, employer or manning-agency expectations, and perceived behavioral control have not been examined together within the lived PEME experience.

A third gap is methodological. Much of the Philippine evidence closest to PEME is based on medical records, risk classification, epidemiology, or survey data. These approaches are valuable for determining prevalence, patterns, and associations, but they cannot provide the depth required to understand subjective meaning. The existing qualitative studies address adjacent phenomena such as healthcare access, mental health support, medical repatriation, or compulsory certification in other contexts. Descriptive phenomenology therefore addresses a methodological need by allowing the shared structure and meaning of PEME to be described from the accounts of Filipino seafarers who have directly undergone it.

The study responded to these gaps by exploring Filipino seafarers lived experiences before, during, and after PEME; the meanings, beliefs, and attitudes they attached to the examination; the challenges and barriers they encountered; and the ways health beliefs, social influences, employment pressures, and perceived behavioral control shaped engagement with the process. The Health Belief Model and Theory of Planned Behavior served as sensitizing frameworks rather than fixed coding categories, while descriptive phenomenology kept participants' experiences at the center of the analysis. The resulting themes provided a participant-grounded basis for recommendations concerning communication, confidentiality, health education, mental health sensitivity, workflow, counseling, seafarer participation, and maritime health and safety.

METHODS

Research Design

This study employed a descriptive phenomenological design. This design was appropriate because the study sought to explore and describe the lived experiences and perceptions of Filipino seafarers who had undergone Pre-Employment Medical Examinations. Descriptive phenomenology focuses on how individuals experience a phenomenon and how they describe its meaning. In this study, the phenomenon was the PEME process as lived and perceived by Filipino seafarers.

A qualitative design was suitable because the study did not aim to measure variables, test hypotheses, or produce statistical generalizations. Instead, it aimed to generate rich, detailed, and meaningful descriptions of participants' experiences. The descriptive phenomenological approach was appropriate because the study sought to describe the essence of the PEME experience from the seafarers' perspective.

The Health Belief Model and the Theory of Planned Behavior served as sensitizing frameworks in framing the inquiry and interpreting the findings. Their concepts informed relevant research questions and interview topics, but analysis remained open to meanings and experiences beyond those concepts. The researcher developed significant statements and formulated meanings from participants' accounts before discussing the resulting themes in relation to the theories. The study did not test either theory statistically or require the themes to fit a predetermined theoretical coding structure.

The researcher practiced bracketing and reflexivity throughout the research process. Bracketing involved identifying and setting aside personal assumptions, expectations, or biases about PEME and seafarer behavior. Reflexivity involved continuous awareness of how the researcher's background, values, and decisions could influence data generation and analysis. These practices helped preserve the authenticity of participants' descriptions and supported the study's scholarly rigor

Research Locale

The study was conducted among Filipino seafarers who had undergone PEME as a requirement for international maritime employment. Because the participants were geographically dispersed and engaged in international maritime work, the researchers conducted data collection through individual online interviews via Zoom or Google Meet rather than at a single physical research site. Participants were recruited through maritime networks, professional contacts, seafarer groups, and referrals, subject to the inclusion and exclusion criteria.

The online semi-structured interview format was selected to accommodate the geographic dispersion and variable schedules of Filipino seafarers, particularly those managing time-sensitive pre-deployment requirements before joining a vessel. Zoom or Google Meet enabled synchronous interaction without requiring participants to travel to a fixed research site. At the same time, the semi-structured format allowed the researcher to ask follow-up probes and clarifying questions when needed to deepen the participants' descriptions of their PEME experiences.

The study was not conducted during the actual PEME procedure or active medical assessment to avoid any perception that participation could influence a participant's medical clearance, deployment, or employment. This arrangement protected voluntary participation and reduced possible pressure or coercion.

Participants and Sampling Technique

The study involved twenty-two (22) Filipino seafarers who had undergone PEME as a requirement for international maritime employment. The final sample comprised twenty-two participants. This number was considered appropriate for a descriptive phenomenological study because the purpose was to obtain depth, richness, and meaningful description rather than statistical representation.

The final sample of twenty-two participants was appropriate because phenomenological inquiry prioritizes direct experience, experiential depth, and rich description over numerical power. Data adequacy was assessed iteratively across the twenty-two interviews by examining recurrence of meanings, consistency of patterns, and whether later interviews contributed substantively new dimensions to the phenomenon. Later interviews largely reiterated the established domains of health protection, employment stakes, waiting and workflow, findings and follow-up, relational trust, and desired service improvements and did not generate an additional overarching theme. Accordingly, thematic sufficiency was judged to have been reached for describing the shared structure of the PEME experience. This judgment was based on interview content rather than a predetermined numerical threshold.

The study used criterion-based purposive sampling. This approach was appropriate because participants were intentionally selected based on predefined eligibility criteria and direct personal experience of PEME. Each participant had undergone PEME and could describe experiences, perceptions, concerns, and recommendations

related to the process. Referrals served only as one recruitment avenue; eligibility for inclusion remained determined by the established study criteria.

Participants were eligible for inclusion if they were Filipino seafarers aged 18 years or older who had undergone at least one Pre-Employment Medical Examination (PEME) within the 24 months preceding participation and were employed in, or applying for employment in, international shipping. Both officers and ratings were eligible to participate. Participants were also required to be willing to complete the electronic informed-consent process, participate in an individual semi-structured online interview, and provide informed consent. The researcher excluded individuals employed exclusively in domestic maritime operations, non-Filipino seafarers, those who had not undergone a PEME, or those whose most recent PEME was more than twenty-four months before participation. The researcher also excluded medical practitioners, clinic personnel, manning agency staff, employers, and other stakeholders who were not eligible seafarers and who described their own PEME experiences. The researcher also excluded individuals who were unwilling or unable to complete the electronic informed-consent process or participate in the semi-structured interview. The researcher identified potential participants through maritime networks, seafarer groups, professional contacts, referrals, and online communication. The researcher ensured that participation was voluntary and that no participant was forced or pressured to join. Participation or refusal did not affect a participant's PEME result, medical certificate, deployment, employment, or relationship with any employer, clinic, or manning agency.

Research Instrument

In this qualitative phenomenological study, the researcher served as the primary instrument of inquiry, supported by a researcher-developed semi-structured interview guide used during individual online interviews conducted through Zoom or Google Meet. The researcher generated the data through direct interaction with participants, follow-up probing, clarification, and reflexive attention to the interview process. The interview guide provided consistency across participants, while its open-ended format encouraged participants to describe their lived experiences in their own words and allowed appropriate probing aligned with the research questions.

The interview guide contained open-ended questions that explored participants' experiences before, during, and after PEME; their perceptions of PEME as a health and safety measure; their beliefs, attitudes, and concerns; the influence of family, peers, employers, and manning agencies; and their recommendations for improvement. Optional probing questions encouraged fuller description and reflection without requiring participants to disclose medical diagnoses or actual PEME results.

Participants could answer in English, Filipino, or a combination of both, depending on their preference and comfort. This flexibility enabled participants to express their experiences more naturally and accurately.

The semi-structured interview guide was organized into the following parts:

Part I: Participant Profile. This section gathered basic demographic and professional information such as age, rank or position, years of seafaring experience, type of vessel, number of PEMEs undergone, and approximate date of the most recent PEME.

Part II: Lived Experiences Before, During, and After PEME. This section explored participants' preparation, expectations, emotions, examination experiences, communication with medical personnel, waiting time, and experiences after receiving results or feedback.

Part III: Perceptions of PEME as a Health and Safety Measure. This section examined whether participants viewed PEME as useful, protective, stressful, routine, employment-related, or necessary for maritime safety.

Part IV: Beliefs, Attitudes, and Social Influences. This section explored how personal health beliefs, family responsibilities, peer influence, employer expectations, manning agency requirements, and maritime culture shaped participants' engagement with PEME.

Part V: Challenges, Concerns, and Recommendations. This section examined barriers such as cost, time, confidentiality, fear of disqualification, additional testing, mental health disclosure, and suggestions for improving PEME.

Data Gathering

The data collection process followed a clear, systematic procedure. Initially, the researcher requested consent from the relevant body and the Institutional Ethics Review Board before initiating data collection. The researcher also obtained permission to recruit volunteers and use the established data-gathering procedures. Volunteer recruitment involved identifying eligible persons according to inclusion and exclusion criteria, and recruitment occurred through shipping networks, professional contacts, seafarer organizations, referrals, and the internet. Referrals helped with identification, but they did not replace the criteria used to select eligible volunteers. No recruitment was conducted during the actual PEME.

Third, potential participants received information about the study objective, participation details, expectations for involvement, confidentiality assurances, the risks and benefits involved, and their legal right to refuse or withdraw. Fourth, the researcher obtained electronic consent through Google Forms before any interview occurred. The consent process informed participants that their involvement was voluntary, that they could choose not to answer any question, and that they could stop at any time without fear of consequences. Before audio-recording the interview, the researcher requested explicit consent to record.

The researcher conducted individualized semi-structured interviews. The researcher followed the approved interview guide and used appropriate follow-up probes and clarifying questions to collect comprehensive descriptions of participants lived experiences with PEME. The limited duration of the focused interview ensured a bounded investigation of a single phenomenon; depth came from investigating, clarifying, verbatim transcribing, reviewing transcripts, and analyzing across the twenty-two interviews rather than from duration alone. With participants' permission, all interviews were audio-recorded to ensure the participant's account was faithfully captured in transcription and analysis.

Sixth, participants could respond in English, Filipino, or a combination of both, based on their preference and comfort level with both languages. The interview format was designed to elicit in-depth narratives of their PEME experiences without requiring medical diagnoses, lab values, or other identifying clinical information.

Seventh, the researcher transcribed the audio recordings verbatim. The researcher compared the completed transcripts with the original audiotape to ensure accuracy and preserve the participant's intended meaning. Interviews conducted in Filipino were initially transcribed in the participant's original language and translated into English only for reporting purposes, while striving to maintain the original meaning.

Eighth, we de-identified the prepared transcripts when compiling data for analysis and reporting. Participants were represented using standardized codes—SF01 through SF22—, and all inadvertently disclosed identifying information was deleted or generalized. The thesis excluded employer names, ship names, clinic names, physician names, and manning agency names.

Ninth, the researcher compiled the completed transcripts sorted by participant code to prepare for phenomenological analysis. The researcher reviewed the completed transcripts multiple times to ensure understanding before deriving significant statements and formulating meanings.

Finally, the researcher stored all electronic consent forms, audio recordings, completed transcripts, reflexive notes, and related research files securely, in accordance with established institutional ethics guidelines and relevant data privacy standards. Access to these documents was limited to the researcher and authorized research ethics or academic reviewers, as needed. The researcher securely disposed of the data after the institutionally approved retention period.

Data Analysis

The researcher analyzed the verified verbatim interview transcripts using Colaizzi's (1978) descriptive phenomenological method. The method provided a systematic process for analyzing lived experiences while remaining close to the participants' actual words. It enabled the researcher to identify significant statements,

formulate meanings, cluster related meanings, develop themes, prepare an exhaustive description, and describe the phenomenon's fundamental structure. The audio recordings served as the primary reference for checking transcription accuracy; the researcher then conducted formal analysis on the verified transcripts. We adapted Colaizzi's method at the final participant-validation step because we did not formally validate the exhaustive description or fundamental structure.

The account below follows Colaizzi's seven-step sequence, with theme clustering and refinement presented together in step 4. We completed steps 1–6; we did not complete the seventh step, formal participant validation. The final entry explains this adaptation and distinguishes researcher verification against transcripts from participant endorsement of the findings:

Familiarization with the Data. The researcher read and reread all verified verbatim interview transcripts to gain a general understanding of the participants' experiences. The researcher also reviewed reflexive notes and the original-language transcripts to preserve context and meaning.

Extraction of Significant Statements. The researcher identified statements directly related to participants' PEME experiences from the verified interview transcripts. The researcher remained open to all relevant statements rather than restricting extraction to predetermined theoretical categories.

Formulation of Meanings. The researcher interpreted significant statements and formulated meanings while staying close to participants' intended messages. The researcher consciously set aside personal assumptions through bracketing and reflexive review.

Organization of Meanings into Theme Clusters and Emergent Themes. The researcher grouped similar formulated meanings into theme clusters. These clusters represented recurring patterns, shared meanings, and important variations across participants' experiences. The researcher refined them into broader emergent themes that captured the essence of the PEME experience. The researcher examined the themes in relation to the research questions while remaining grounded in participants' narratives.

Exhaustive Description of the Phenomenon. The researcher developed a rich and comprehensive description of the PEME experience based on the themes. The description integrated emotional, social, occupational, cultural, and health-related meanings expressed in the participants' verified interview transcripts.

Fundamental Structure of the Experience. The exhaustive description was condensed into a clear statement that captured the central meaning and shared structure of PEME as lived and perceived by Filipino seafarers.

Participant Validation and the Study's Adaptation. In Colaizzi's original sequence, the researcher returns the developed description or fundamental structure to participants for validation. The present study did not undertake this step. Instead, the researcher checked formulated meanings, theme clusters, themes, the exhaustive description, and the fundamental structure against the verified transcripts and reviewed reflexive notes for possible researcher influence. These checks assessed consistency with the source accounts; they did not establish whether participants endorsed the final synthesis. The analysis is therefore reported as an adaptation of Colaizzi's method, and the absence of formal participant validation is retained as a limitation.

The final themes were presented with supporting excerpts from the verified interview transcripts. Short, de-identified quotations were used to preserve participants' voices and show the connection between the findings and the original interview data.

Ethical Consideration

This study followed ethical principles that protected participants' rights, dignity, privacy, welfare, and safety. Because the study involved personal experiences related to health, employment, and medical examinations, the researcher conducted the study with sensitivity, honesty, and respect.

The researcher secured ethical clearance from the Institutional Ethics Review Board before data gathering began. The Philippine Health Research Ethics Board's (2022) National Ethical Guidelines for Research Involving Human Participants guided the study. All participants provided electronic informed consent through Google Forms before any semi-structured interview. Before audio recording began, the researchers confirmed participants' permission to record the interview.

Participants were informed about the study's purpose, procedures, expected effort, possible risks and benefits, confidentiality measures, the voluntary nature of participation, and their right to refuse or withdraw without penalty. They were also informed that participation or refusal did not affect their PEME result, medical certificate, deployment, employment, or relationship with any medical facility, employer, manning agency, or maritime organization.

The study-maintained confidentiality and de-identification throughout. Participants were represented through standardized research codes (SF01–SF22) rather than their names. The study did not report identifying details such as employer names, vessel names, clinic names, physician names, manning agency names, or specific deployment contracts, and removed or generalized any inadvertently provided information. The study did not collect actual PEME results, laboratory findings, medical certificates, medical records, or clinic documents.

The researcher observed data privacy in accordance with the Data Privacy Act of 2012 (Republic Act No. 10173, 2012), which protects personal information and promotes responsible data handling. The researcher password-protected digital copies of the electronic consent records, audio recordings, verified interview transcripts, reflexive notes, and related research files. The researcher kept physical research documents in secure storage. Access was limited to the researcher and, when required, authorized academic or ethics reviewers. The data were retained according to institutional policy and were scheduled for secure disposal after the approved retention period.

The possibility of emotional discomfort was also considered. Participants could decline to answer any interview question or discontinue the interview without penalty. The interview guide did not require disclosure of specific diagnoses or medical test results. The researcher could provide information on appropriate support or referral channels if a participant communicated distress related to the study topic.

The researcher avoided coercion and conflict of interest. Participation was voluntary, and recruitment did not occur during the actual PEME procedure. When referrals were used, the referring person was not informed about who agreed or refused to participate unless a participant independently chose to disclose that information. No participant was promised an employment benefit, PEME advantage, medical clearance, or deployment opportunity in exchange for participation.

Finally, the researcher reported the findings honestly and with integrity. The researcher reported participant accounts without fabrication or changes to their substantive meaning; limited editorial corrections for quotation readability were distinguished from the verbatim source transcripts. Findings were presented truthfully, including variations and contradictions in participants' experiences. Through these safeguards, the study protected participants while ensuring that their voices were represented with fairness, respect, and dignity.

RESULTS AND DISCUSSION

The study explored the lived experiences and perceptions of 22 Filipino seafarers regarding the Pre-Employment Medical Examination (PEME). Using descriptive phenomenology and Colaizzi's method of analysis, the participants' narratives generated six interconnected themes. Collectively, these themes showed that PEME was not experienced merely as a medical examination, but as a critical "health-employment threshold" because its outcome could affect both a seafarer's health readiness and ability to continue working at sea.

Theme 1: A Necessary Passage – PEME as Health Safeguard and Employment Gateway. Participants generally recognized PEME as important for monitoring their health, detecting medical problems early, and confirming their fitness for safe sea duty. At the same time, medical clearance was closely associated with employment because passing PEME allowed them to proceed with deployment, earn income, and continue supporting their families. Thus, PEME carried a dual meaning: it was both a legitimate health and safety measure and a gateway to employment. This dual role became the central finding of the study and explained why participants could simultaneously value PEME and feel anxious about it.

Theme 2: Preparing to Pass – Self-Discipline, Experience, and Anticipatory Anxiety. Before undergoing PEME, participants commonly prepared themselves by monitoring their diet, exercising, avoiding alcohol, complying with medications, fasting properly, resting, and learning from previous PEME experiences. These behaviors reflected their attempt to exercise control over the outcome. Previous experience generally increased familiarity and confidence; however, anxiety remained because participants could not completely control what the examination might reveal. Their anxiety was particularly related to possible unfavorable findings, repeat examinations, additional expenses, and delays in medical clearance.

Theme 3: The Clinic Journey – Organized Systems Amid Queues, Waiting, and Bodily Discomfort. Participants' experiences during PEME were strongly influenced by how efficiently the clinic operated. Clear procedures, organized routing, online appointments, and digital result systems made the process easier and more reassuring. In contrast, long queues, prolonged waiting, repeated visits, delayed completion, and extended fasting contributed to inconvenience and physical discomfort. The findings therefore demonstrated that workflow was not simply an administrative concern; it substantially affected how seafarers perceived the overall quality of the PEME experience.

Theme 4: When Findings Carry Consequences – Referrals, Costs, Delay, and Family Livelihood. Medical findings frequently had consequences beyond health. When additional testing, referrals, treatment, or repeat examinations were required, participants could experience additional expenses and delays in receiving clearance. Delayed medical clearance could also affect deployment schedules and employment opportunities. Because maritime employment was closely connected to family income, a medical finding could become a financial and emotional concern not only for the seafarer but also for the family. Thus, medical risk could quickly expand into livelihood risk.

Theme 5: Dignity Shapes Disclosure – Communication, Respect, Trust, and Privacy. Participants were more willing and comfortable discussing health concerns when healthcare personnel communicated clearly, treated them respectfully, and maintained privacy and confidentiality. Private discussion of findings promoted trust and dignity. Conversely, fear that disclosed information might negatively influence clearance or employment could make some seafarers hesitant to share sensitive information. The findings therefore emphasized that communication and confidentiality directly influence the quality of health disclosure and, consequently, the effectiveness of PEME.

Theme 6: Making PEME Work for Seafarers – Support, Fairness, Efficiency, and Health Education. Participants did not call for PEME requirements or medical standards to be weakened. Instead, they wanted the process to become more efficient, transparent, respectful, and supportive. Their recommendations included faster processing, shorter waiting times, better scheduling, clear communication of findings and next steps, transparent costs and standards, approachable healthcare personnel, health education, and stronger support from families,

manning agencies, employers, and healthcare providers. This showed that a seafarer-centered PEME can maintain clinical rigor while improving the human experience of medical screening.

The discussion of the findings showed that the participants generally accepted and valued the health and safety purpose of PEME. Their complaints, anxiety, or frustrations were not necessarily objections to medical fitness standards. Rather, they were often reactions to the potential consequences of findings, including referrals, costs, delays, uncertainty about deployment, and disruption of family income.

The findings were also consistent with the Health Belief Model. Seafarers recognized the benefits of PEME in detecting health problems and maintaining fitness for duty, while barriers such as cost, waiting time, fear of findings, and employment consequences influenced their experiences. Their preparation before PEME reflected self-efficacy and attempts to manage factors within their control. The findings also reflected the Theory of Planned Behavior, particularly through attitudes toward PEME, social expectations from families, employers and agencies, and the participants perceived control over preparation, costs, disclosure, and follow-up requirements. The study used these theories as interpretive lenses rather than predetermined coding categories.

Most importantly, the study synthesized the experience into the concept of the Health-Employment Threshold. Filipino seafarers crossed this threshold whenever they underwent PEME: on one side was confirmation of health and fitness for safe maritime work, while on the other was access to employment and livelihood. The six themes showed that this threshold was shaped by four major conditions: the legitimate clinical purpose of medical fitness assessment; the importance of employment and family livelihood; process factors such as waiting time, referrals, costs, and clarity of next steps; and relational factors such as communication, privacy, trust, and respect.

In summary, the study found that PEME is both protective and consequential. Filipino seafarers recognize its importance in protecting their health and promoting maritime safety, but their experience becomes stressful when medical findings are associated with uncertainty, additional expenses, delays, and threats to employment or family income. Therefore, improving PEME does not require lowering medical fitness standards. Instead, the findings support a seafarer-centered approach characterized by efficient workflow, transparent communication, confidentiality, dignity, health education, coordinated referrals, and appropriate psychosocial and organizational support. The manuscript itself concludes that workflow, communication, trust, respect, and privacy are substantive parts of the PEME experience, and that strengthening these areas can improve participation without compromising medical standards.

CONCLUSION

The essence of PEME for the participants was a health-employment threshold. Participants did not experience the examination as a purely medical encounter because its outcome could simultaneously confirm health readiness and determine access to maritime employment.

Filipino seafarers generally accepted and valued the health and safety purpose of PEME. Anxiety, frustration, or criticism of specific processes did not necessarily represent rejection of medical fitness standards; these responses often reflected the livelihood consequences attached to findings, referrals, costs, and delays.

Preparation for PEME represented an important expression of agency and perceived control. Participants attempted to manage diet, exercise, fasting, rest, medication adherence, and other controllable factors. Yet, anxiety persisted because the seafarer could not fully control the final clearance decision and the time required for follow-up.

Medical findings expanded beyond the body into the participant's occupational and family life. A pending result, repeat test, treatment, or referral could become a financial, temporal, emotional, and employment concern, particularly when deployment and family income depended on timely clearance.

Workflow, communication, trust, respect, and privacy were substantive components of the PEME experience. They influenced whether participants understood the process, felt comfortable disclosing health information, and perceived the system as fair and supportive.

A seafarer-centered PEME does not require weaker medical standards. Transparent communication, coordinated follow-up, efficient workflow, privacy, and respectful care may support trust, informed participation, appropriate health disclosure, and the perceived legitimacy of the screening process while preserving established medical fitness standards.

Nursing administration has an important role in improving PEME service quality because many modifiable concerns identified by participants involve patient flow, preparation instructions, privacy, health education, communication, interdisciplinary referral coordination, and quality monitoring.

Taken as a whole, the phenomenon can be expressed in the following essential statement: Filipino seafarers experienced PEME as a necessary passage between health readiness and livelihood continuity. Its protective purpose was clearest when the process was organized, understandable, respectful, private, and supportive. Its burden intensified when uncertainty, delays, repeated procedures, unclear referrals, additional cost, or fear of employment consequences reduced the seafarer's sense of control. The essence of the experience therefore lay not in a simple opposition between "health protection" and "employment requirement," but in the continuous negotiation of both realities within the same examination.

Practical Output 1. Health-Employment Threshold Model

The study's first practical and scholarly output is the health-Employment Threshold Model presented in Figure 2. The model synthesizes the participant-grounded themes by showing that the lived meaning of PEME is shaped by four interacting conditions: the legitimate clinical purpose of medical fitness assessment; the livelihood stakes attached to deployment and family support; process conditions such as waiting time, referrals, cost, and clarity of next steps; and relational conditions such as communication, trust, privacy, and respect. These conditions influence whether PEME is experienced more strongly as health protection and reassurance or as burden and employment uncertainty. The model is qualitative and explanatory. It is not a diagnostic instrument, predictive scale, or substitute for clinical fitness standards.

Practical Output 2. Proposed Seafarer-Centered PEME Quality Improvement Framework

To translate the findings into an administrative and service-level output, the study proposes a Seafarer-Centered PEME Quality Improvement Framework. The framework operationalizes the Health-Employment Threshold Model into six domains that nursing administrators, clinic leaders, occupational health nurses, physicians, diagnostic units, manning agencies, and other relevant stakeholders can use to review PEME service delivery. It does not prescribe medical fitness thresholds. Instead, it focuses on the quality of preparation, workflow, communication, privacy, health education, and coordination around the medical assessment.

Table 6. Proposed Seafarer-Centered PEME Quality Improvement Framework

Framework domain	Operational goal	Key actions derived from the findings	Suggested service indicators
1. Pre-PEME orientation and safe preparation	Reduce uncertainty and support appropriate preparation before arrival.	Provide standardized plain-language instructions on documents, fasting-dependent tests, medication documentation, appointment sequence, and possible follow-up pathways.	Receipt of pre-PEME instructions; preparation-related clarification requests; participant-reported clarity of instructions.
2. Workflow and queue coordination	Reduce waiting burden, prolonged fasting, and repeat visits.	Balance appointment loads; prioritize fasting-dependent procedures; identify bottleneck stations; provide routing and status updates; coordinate diagnostic units.	Median total processing time; waiting time by station; proportion requiring return visits for completion; participant-reported workflow clarity.
3. Findings and referral navigation	Reduce uncertainty after a finding while preserving clinical standards.	Explain the reason for repeat testing or referral; provide written next steps, required documents, expected timeline when known, and route back	Proportion of referrals with documented instructions; referral-completion time; clarification contacts;

4. Privacy, dignity, and disclosure-supportive communication	Promote respectful participation and conditions supportive of appropriate health disclosure.	to final fitness review; clarify cost responsibility when known. Use private spaces for sensitive history taking; explain confidentiality boundaries; reinforce nonjudgmental communication; provide a clear process for raising service concerns.	participant-reported understanding of next steps. Participant-reported privacy and respect; communication-related complaints; completion of staff communication/privacy training.
5. Health education and preventive support	Use PEME as an opportunity for occupational health promotion rather than only clearance.	Provide brief health teaching based on relevant risk areas and participant questions; reinforce appropriate follow-up, medication adherence, and sustainable health practices.	Receipt of health education; documented follow-up advice; participant-reported usefulness of health teaching.
6. Stakeholder coordination, transparency, and feedback	Reduce preventable employment uncertainty and improve accountability around the process.	Clarify administrative requirements, authorized documentation, and scheduling; communicate referral/cost responsibilities where applicable; collect de-identified service feedback.	Administrative clarification requests; administrative delays; unresolved referral/cost questions; trends in participant feedback.

The framework can be used as a structured quality-improvement checklist. A clinic or occupational health service may review each domain, identify gaps supported by local data or patient feedback, select feasible actions, and monitor service indicators over time. Suggested indicators are intentionally process-oriented because the present study did not evaluate clinical appropriateness or establish performance cutoffs. The proposed indicators are preliminary service-quality measures derived from the qualitative findings and have not yet undergone formal validation. Local institutions should therefore set targets based on applicable regulations, resources, patient volume, and quality-improvement priorities.

Recommendations for Practice

Standardize pre-PEME orientation. Clinics and occupational health services should provide clear, plain-language instructions on required documents, fasting, test sequence, medication documentation, appointment procedures, and what participants should expect if further evaluation becomes necessary.

Strengthen workflow and waiting-time management. Nursing administrators and clinic managers should map the patient journey, identify bottleneck stations, balance appointment loads, prioritize fasting-dependent procedures early in the process, and use practical status updates to reduce prolonged waiting and unnecessary return visits to complete the process.

Establish a structured findings-and-referral communication process. When additional testing, treatment, or referral is required, the seafarer should receive a clear explanation of the reason, expected next steps, required documents, an estimated timeline (when known), and the pathway back to final fitness review.

Protect privacy and support health disclosure. Obtain sensitive health histories in appropriate private settings. Healthcare personnel should explain confidentiality boundaries in understandable terms and use respectful, nonjudgmental communication, particularly for sensitive or potentially stigmatized concerns.

Use PEME as a health-promotion opportunity. Occupational health nurses and other healthcare personnel should provide brief, relevant health teaching on risk reduction, chronic condition management, medication adherence, lifestyle practices, and follow-up based on the participant's needs and questions.

Incorporate seafarer feedback into service quality monitoring. Clinics should develop mechanisms to receive and review de-identified patient feedback on waiting, communication, privacy, staff interaction, referral navigation, and overall process clarity. Use feedback for quality improvement rather than to alter legitimate medical standards.

Recommendations for Policy and Institutional Governance

Clarify administrative requirements and timelines. Clinics, manning agencies, employers, and regulators should communicate applicable documentation, scheduling requirements, and employment-related timelines in clear, consistent terms so seafarers understand what is required and what steps follow if additional evaluation is needed.

Improve transparency around referrals and costs. When possible, under applicable contracts and policies, responsible stakeholders should communicate which follow-up services are medically required, who is expected to cover associated costs, and what options exist to complete required evaluation without unnecessary duplication or uncertainty.

Treat communication, privacy, and navigation as service-quality standards. Institutional monitoring should consider whether seafarers receive understandable explanations, appropriate privacy, clear referral instructions, and timely information about the status of the process in addition to monitoring technical and regulatory compliance.

Strengthen coordination among clinics, manning agencies, and employers without compromising clinical independence. Administrative coordination should support timely scheduling, transfer of authorized documentation, referral completion, and communication of employment-related timelines while preserving the independent medical judgment of recognized practitioners.

Maintain clear channels for questions, concerns, and review of process issues. Seafarers should know where to seek clarification about procedures, documentation, scheduling, billing, or communication concerns. Such channels should distinguish administrative concerns from clinical fitness decisions and should protect confidentiality.

Preserve medical rigor while promoting proportional, transparent implementation. Address participant concerns about perceived strictness through clear standards, consistency, explanation, and fair process rather than by weakening evidence-based medical fitness requirements.

Recommendations for Future Research

Conduct in-person, repeated, or longitudinal qualitative interviews with Filipino seafarers to explore how PEME meanings may develop across successive examination and deployment cycles. Where appropriate, future phenomenological studies may also incorporate formal participant validation of the developed exhaustive description or fundamental structure.

Undertake multi-site studies involving different PEME providers, geographic locations, vessel sectors, ranks, and employment arrangements to examine which findings are transferable and which are context-specific.

Explore the perspectives of occupational health nurses, nursing administrators, recognized medical practitioners, clinic coordinators, manning agencies, and employers to develop a multi-stakeholder understanding of PEME communication, workflow, referral, and confidentiality.

Use mixed-method designs to quantify service factors suggested by this study, including waiting time, repeat visits, out-of-pocket follow-up costs, clarity of instructions, perceived privacy, trust, disclosure comfort, and deployment delay.

Pilot and evaluate the proposed Seafarer-Centered PEME Quality Improvement Framework. Future studies should assess its feasibility, acceptability, and usefulness in real PEME settings and refine the domains and indicators based on implementation evidence.

Conduct longitudinal research to examine how PEME experiences influence subsequent health behavior, follow-up adherence, perceptions of occupational health services, and readiness for later PEME cycles or deployment.

The study underscores the continuing importance of PEME in supporting the fitness of Filipino seafarers and the safety of maritime work. It also shows the value of treating the seafarer as an informed participant rather than only as the subject of a clearance decision. The findings support a balanced direction: maintain credible medical fitness standards while improving the systems through which seafarers prepare, wait, disclose health information, receive explanations, complete referrals, and understand the process's implications. Through this

balance, PEME can function more consistently as both a rigorous occupational health safeguard and a humane, seafarer-centered component of maritime health and safety.

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