WG2 "ACTION FOR ADVANCING OCCUPATIONAL MEDICINE (OM)",
SECTION OF OCCUPATIONAL MEDICINE OF THE EUROPEAN UNION OF MEDICAL SPECIALISTS (UEMS)
WORKING PAPER
PREPARED AS A BASIS FOR DISCUSSION, BY DR THEODORE BAZAS, REPRESENTATVE OF THE PANHELLENIC MEDICAL ASSOCIATION AT THIS SECTION, INITIATOR OF WG2, 31.10.2018
ON DRAFT POSITION STATENT OF UEMS OM SECTION ON

"ROLE OF SPECIALISTS IN OM AND OF PHYSICIANS HOLDING SPECIALTIES OTHER THAN OM PRACTICING OM INCLUDING THOSE PRACTICING OM ON AN EQUAL PAR (EXECUTING ALL OM TASKS, BY LAW) WITH THEM"

A. CURRENT PRACTICE OF OM IN EUROPEAN UNION (EU) COUNTRIES

There is no European Union Directive stipulating that the specialty of occupational medicine **(OM)** should be practiced exclusively only by specialists in OM, or the circumstances and conditions under which, certain or all of its constituents could be practiced by physicians holding specialties other than OM (hitherto referred to as "non-OM specialists") or by other occupational health **(OH)** professionals (e.g. OH nurses). Thus, current OM practice (that has developed since the framework European Directive on Health and Safety at Work was issued in 1989) varies widely among and within European countries (European Union member States, Norway and Switzerland).

According to legislation in force **at present and henceforth** (i.e. disregarding previous, currently obsolete transitional legal provisions, which have allowed physicians with inadequate OM knowledge and experience to practice OM in the past, but, in certain European countries, also to continue to do so), in European countries:

1. All OM tasks (as allowed for by law) can be executed: **(a)** always by specialists in OM only and sometimes also by trainees specialising in OM (or non-OM specialists complementing their training to become OM specialists) under supervision of OM specialists, in all public and private enterprises of any size or occupational health risk or in the [State] National Health Service only, **(b)** always by "physicians with special knowledge in OM" or by "competent" as regards OM (**competence being recognized** not necessarily by holding the specialty in OM only, but alternatively also on the basis of different **criteria** in different counties, such as training in general OM or specific parts of OM ranging from a few weeks up to three years , or long experience in performing OM, or working in OM up to a maximum number of hours (e.g. 20 hrs per week after having attended a short, e.g. seven weeks long course in OM**, competence being either specifically stipulated by law, or defined in general terms and then examined and challenged in retrospect** on inspection of OM services by occupational health inspectors) , in all public and private enterprises of any size or occupational health risk.

2. Certain specific OM tasks (as allowed for by law), can be executed : **(a)** always by specialists in OM only and sometimes also by trainees specialising in OM, under supervision of OM specialists (or by non-OM specialists complementing their training to become OM specialists, under supervision of OM specialists), in certain types of enterprises where specific occupational "exposures" (OH hazards resulting in OH risks) exist on account of the nature of work activities (stipulated by law in great detail), and/or where the size of enterprise is large (large size indicating a need for provision of complex OM services), **(b):** i. mainly at University or Hospital OM Departments, or other

special “Departments for the Diagnosis of Occupational Diseases”, or ii. at enterprises by specialists in OM.

3. Certain other OM tasks, such as pre-employment medical examinations (as allowed for by law) or medical examinations of employees on entry into an enterprise pension fund, can be and are executed (**a):** by non-OM specialists (or even physicians without any specialty title), with some training in OM (in the framework of “continuous medical education/professional development”), or without any training in OM at all (but even so, “certified “to fulfill these OM tasks), or even by qualified OH nurses or other OH professionals (entailing lower remuneration for their services), depending on the availability of such OH professionals in a country, which also varies widely among European countries. In several European countries non-OM specialists are being trained in elementary aspects of OM. **3. Certain specific OM tasks concerning specific occupations** and related examinations e.g. pertaining to hyperbaric medicine, or aviation medicine, are preferably performed either by specialists in OM or by non-OM specialists; the former and the latter must have received post graduate training in these specific fields. **4. Certain primary health care (general practitioner’s) tasks** are performed by specialists in OM in certain European countries, whereas these tasks can be performed by specialists in OM to a very limited extent in certain other European countries. **N.B.** Physicians practicing OM (Specialists in OM and also Physicians holding specialties other than OM who execute OM tasks) collaborate with physicians holding specialties other than OM (such as ophthalmologists, orthopedic surgeons, psychiatrists, Ear-Nose-Throat specialists, dermatologists). The latter, are not considered to be practicing in the field of OM per se. In some EU countries even though (a) there is generally no specific legal requirement that an enterprise employs a specialist in OM, it is common practice for large enterprises employ full time specialists in OM, or (b) physicians holding specialties other than OM have the right to work in enterprises of smaller size, none of them do so.

B. <u>CURRENT PLANS AND ACTIVITIES IN SOME EU COUNTRIES TO IMPROVE CERTAIN OM TASKS BEING EXECUTED IN VIEW OF SMALL NUMBERS OF OM SPECIALISTS</u>

In some European countries, where there is a shortage of specialists in OM:

1. Short training courses in OM are organized by societies of OM, for non-OM specialists, already providing certain OM services to companies, to teach them the basic principles and elements of OM and to reinforce their networking with specialists in OM, or
2. Multi disciplinary work is promoted by task shifting in occupational health (e.g. transferring some tasks regarding health surveillance to nurses) and general clinical medicine and particularly in disability assessment medicine, encouraged by the professional societies, so as to address the skills gap and lack of available trained practitioners.
3. Proposals have been made for plans to establish additional training in OM that would enable physicians holding specialties other than OM (having in common with the specialty in OM a small or large part of their subject matter) to complement their training so as to acquire the specialty in OM.
4. Shortening of a five year training required to obtain the specialty of OM is being considered, especially for those physicians who already hold another specialty (e.g. in internal medicine).
5. No plans to cope with this situation are put forward or are under way.

C. QUESTIONS THAT HAVE TO BE DISCUSSED, AND EITHER BE ANSWERED BY CONSENSUS OR INDICATE WAYS WHEREBY THEY COULD BE STUDIED FURTHER IN EUROPEAN COUNTRIES).
(NB. SOME ANSWERS MAY APPEAR OBVIOUS. THEY WILL BE THE BASIS OF THE TEXT OF PART C):

1. A physician specialized in general surgery knows elements of orthopedic surgery and an orthopedic surgeon know elements of general surgery. Would a woman trust a medical microbiologist to diagnose a treat her for a specific gynecological disease and to what extent? The necessary changes having been made (mutatis mutandis) **could, and perhaps should certain OM tasks (and which ones) be left to non-OM specialists (who should have received a minimum amount of training in basic aspects of OM), who would perform them at a lower cost?** Would that situation be resulting in reduced occupational health care in a country, compared with a situation where all OM tasks are exclusively performed only by specialists in OM in all circumstances?
2. If so (see 1, above), which would these tasks be and under which circumstances (duration and content of postgraduate training, size of enterprise and magnitude and type of OH risk ["noxious (i.e. harmful) exposure"]), could these non-OM specialists execute these OM tasks?
3. If so (see 1, above) , do we acknowledge that (a) **cost** (in terms of cost of training specialists in OM and in terms of higher remuneration for specialists in OM providing their specialist service) is an important factor to be taken into account, and (b) **specific criteria should apply** when allowing non-OM specialists to execute certain OM actions?
4. If so (see 1, above) , would allowing (by law or at the discretion of the employer) non-OM specialists (as above) be regarded as an interim arrangement until there are enough specialists in OM in a country, or would it be accepted as permanent mode of provision of occupational medicine services in a country? If this situation is perpetuated, would that be optimally conducive to worker's health and safety and promoting safety and health at work in enterprises? Up to what extent, if any, should the cost-effectiveness principle apply, rather than the benefit-effectiveness principle?
5. What is the "optimum" number, if any, of specialists in OM would be considered to be adequate in a European country? What would be the criteria for assessing whether such number is adequate (taking into account the number of other OH professionals, related administrative and laboratory infrastructure, and the existing employment and productivity model in a country) ?
6. Should specific criteria be set in a **new European Directive** which should be used for determining "competence" of non-OM specialists that are employed in enterprises in the public and in the private sector to fulfill specific or general OM tasks, and what should these criteria be?
7. Should there be provisions in a **new European Directive** stipulating that OM should be practiced by specialists in OM only, and all non-OM specialists (including non-OM specialists but "competent in OM" ones and those with merely postgraduate studies in OM not leading to the OM specialty title) should complement their training so as to acquire the specialty of OM title?

8. Should there be provisions in a **new European Directive** stipulating that in EU Member States (before a set deadline or adhering to a time frame and to a time line) OM should be practiced only by specialists in OM and by trainees in the specialty of OM under the supervision of specialists in OM?
9. Should there be provisions in a **new European Directive** which would stipulate that certain specific OM tasks should be performed ad hoc, in the private and public enterprises?
10. **Which are the specific tasks that only specialists in OM can and should perform (with or without collaborating with other OH professionals, as appropriately), because these tasks distinguish the specialty of OM from other medical specialties?** For example, could an indicative non exhaustive list include the following? (a) Assessing health effects of work, i.e. diagnosing occupational diseases, and exacerbation of non occupational diseases by occupational factors, (b) performing (or coordinating, or contributing to, or definitively interpreting the results of) occupational health risk assessments i. in large enterprises, ii. in circumstances where work ["exposures"] are complex or potentially very unhealthy, and iii. when insuring an enterprise (i.e. the employer) against OH risk (c) assessing and ultimately and definitively give an expert opinion on working people medical fitness to work i. in circumstances where work ["exposures"] are complex or potentially very unhealthy or requiring special physical or mental health characteristics, and ii. on return to work after "serious" illness or injury, (where work might possibly affect work performance or health), (d) design, coordinate, assess and interpret the results of occupational epidemiologic studies (such as intervention studies, operational studies to reveal occupational health effects, studies to reveal new occupational health hazards), (e) interpret the sickness absence rates values and patterns, at an enterprise, (f) identify priorities in annual occupational action plan at an enterprise, (g) contribute to major accidents preparedness and to provision of emergency health care in circumstances arising from major or specific health hazards.
11. Are there such specific, exclusively OM tasks, or could all OM tasks be performed by other non-OM specialists and other OH professionals?
12. Which are the tasks that physicians holding specialties other than OM can perform that Specialists in OM should also be allowed to perform.
13. **Can we, National Representatives at the UEMS OM Section agree** on the following short, preliminary Position Statement, which would be recorded in the Minutes of the Bilbao, Meeting of the OM Section of the UEMS?
    "In European countries, a physician who **does not hold and is not fully trained** in the specialty in occupational medicine (OM) must not be allowed to execute **all** the tasks which are **specific** to OM, in **all** enterprises of **any** size and magnitude and **any** type of occupational health risk ("exposure"), as if he were a specialist in OM. This practice should not be allowed by law, because it results in a situation of reduced and inadequate protection of workers' health and decreased concomitant enterprises' productivity compared with the level of protection and productivity achieved when a specialist in OM performs the specific OM tasks."

D. <u>RECOMMENDATIONS</u> (addressed to OM Societies, National Medical Associations, University Medical Schools, Ministries of Health, Ministries of Labour [Employment], Employers' Federations, Workers' Trade Unions, UEMS in Brussels)