VIEWPOINT

The renewed mission of the occupational physician: To be or not to be a doctor?

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INTRODUCTION

A recent editorial pointed out that the 'adding-value' feature of occupational physician (OP) activity as compared to allied professionals in preventing occupational risks is the clinical skill. It was argued that, apart from clinical skills, no difference exists between the risk manager and the OP in dealing with risk characterization and risk management.

On the other hand, it is stressed that the practice of occupational medicine must be based on a sound professional competence including a basic clinical knowledge. Should the educational process of the specialist in occupational medicine include the acquisition of adequate clinical competence? Several reports dealing with education and training of OPs in Europe underline the need that this figure be a skilled clinician.

This is necessary to investigate the occurrence of occupational and work-related diseases and to evaluate and control health status of workers who might be exposed to harmful factors. Elsewhere clinical skills are less emphasized or neglected. Outside Europe, the American College of Occupational and Environmental Medicine states that the mission of the OP is devoted to the prevention and management of occupational and environmental injury, illness and disability, promoting the health and safety of individuals and focusing diagnosis of illnesses and their rehabilitation.

European legislation on occupational health and safety leads to a change of the OP mission

The progressive implementation of European directives concerning occupational health and safety into national legislations is leading to changes in the role OPs will assume in the future. Although the European Union framework directive does not provide any guidance about the required competence of the involved health professionals, namely of OPs, the activity of the OP must comply with the renewed rules. In spite of some differences existing in each national legislation, OPs (or even non-specialists in this field) are required to practice health surveillance according to article 14 (Health Surveillance) of European directive 89/391.

The participation of OPs in other activities (such as evaluation of fitness for work, certification of occupational diseases and accidents, education of workers and participation in risk assessment) is less focused. These needs arising from the legal rules are involving a change in the mission and in the role of this figure.

The importance of the consulting role of the OP within the multidisciplinary service (including occupational nurses, work psychologists, ergonomists, industrial hygienists and safety experts) is emphasized. The stronger involvement in consulting and management activities, however, would undoubtedly lead to the gain of different competencies and to a loss in the ability to both focus on clinical aspects of diseases and cope with workers' health problems. Should the future OP have more management competence and less clinical skill? Whether this would represent an improvement or a threat to the traditional mission of OPs (both prevention and diagnosing activities) is not easily foreseen. In any case, an OP whose activity is limited to workers' health surveillance would lead to an irreversible shifting of OPs role and tasks.

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The fall in occupational disease and the declining clinical skill of the OP

Some people believe that OPs have progressively lost their clinical skills due to the declining number of occupational diseases and consequently to the progressive lack in confidence with clinical pictures. Whether this is true or not, a question to answer is: who will investigate and diagnose new epidemics of occupational diseases in the future? Epidemiologists have no medical background to investigate effects on an individual basis. Medical specialists have no specific competence in establishing links between diseases and risk factors and their involvement could be, if not adequately addressed, unsatisfactory. Is the general practitioner able to investigate whether a clinical picture is caused by an occupational cause? It is commonly believed that general practitioners are overwhelmed by a variety of duties and that they have no time to adequately investigate occupational hazards. Further, practitioners have an insufficient knowledge of occupational medicine, and most physicians and medical students consider this topic not relevant.5

Practitioners should be aware of the possible relationship between disease and occupation, addressing any suspect to a well-educated and trained OP. But, is the OP well educated and trained enough to perform this thoughtful job? And to what extent should his clinical skills be developed?

What clinical competence should the OP have? The needs-based competence

What competence should an OP have, and to what extent should an OP be experienced? There is a growing interest for this topic. A number of educational, scientific and professional societies (including the European Association of Schools of Occupational Medicine, the American College of Occupational and Environmental Medicine, the European Network of Societies of Occupational Medicine and the Occupational Medicine Section of the Union of European Medical Specialities) are dealing with this. The evaluation of the extent to which competence should be acquired is under the control of the Schools of Occupational Medicine which have the responsibility to adapt their curriculum to comply with these needs. To be competent in dealing with a great variety of tasks, the OP must be well-educated and trained in many fields. A survey carried out in several European schools of occupational medicine shows that competence-based curricula should include the ability to carry out a clinical examination proficiently, to diagnose work-related ill-health and provide advice on prognosis, to advise on impairment and disability and on rehabilitation and redeployment.5 The ACOEM report1 mentioned earlier stresses the need for OP training to be suitable for acquisition of general clinical competence and some specialty competence. Furthermore, the OP is expected to competently assist employees to make complete and rapid recovery from illness and injury and in assessing work capacities in order to allow a safe employment.

Although no OP is expected to be an expert in all areas, most OPs are supposed to have the ability to provide a broad spectrum of services, according to well-established competencies. In spite of the need to comply with a number of tasks, clinical knowledge and skill are stressed as a multifaceted competence allowing provision of high quality, cost-effective medical care in diagnosing and treating occupational injuries and diseases.

What is in the future?

Any service is based upon client-need satisfaction. In a rapidly changing world where there is an increasing need to foresee and to anticipate any health improvement request, it is necessary to improve and hasten the analysis of health needs. This will allow a prompt and flexible action to satisfy these needs. The task of scientific institutions (involved in research activity) and educational institutions (involved in education and training of OPs) should be intimately linked in order to better integrate knowledge, know-how, values, attitudes and behavioural patterns. Scientific institutions should be aware of their responsibility in assuring an up-to-date and critical evaluation of occupational health risks. Educational institution should provide up-to-date training programmes through the implementation of recent knowledge acquisitions into sound learning objectives.

The curriculum of OPs should enable professionals to cope with problems and situations which might be encountered during their professional life. At least the following clinical skills should be gained: (1) the ability to diagnose the most common occupational diseases and to treat and rehabilitate patients; (2) the ability to diagnose the most common job-related injuries and to treat and rehabilitate patient; (3) the ability to establish the causal relationship of occupational diseases and to evaluate disabilities; (4) the ability to contribute to patient redeployment and resettlement and (5) the ability to recognize the occupational cause of diseases in the following fields: cardiology, pulmonary, dermatology, emergency medicine, otolaryngology, haematology and oncology, infectious diseases, musculoskeletal diseases, neurology, ophthalmology, psychiatry and reproductive medicine.

Future educational programmes probably will not provide the degree of knowledge and skills required for the role of OP in every field of the discipline. However, the occupational physician will have learnt the approach to solve occupational health problems. In addition to the ability to assess the workplace with respect to hazard and risk and to the capacity of communicating with management, workers and their representatives, the OPs will keep and improve his clinical competence and will continue to be a 'doctor'.
REFERENCES