EDITORIAL

OCCUPATIONAL MEDICINE IN THE NEW MILLENNIUM

It is a privilege to serve as your editor at such a unique time of a New Year, the last year of a century and at the doorstep of a new millennium. New Year is a time of resolution too often balancing good and bad intentions. This particular New Year will have great temptations readily at this time of the year as they join with so many other commentaries to peer into the future to see the road ahead. Many questions will be asked and this editorial will be no exception. The answers will not be easy. They are needed time to perhaps, one of our successors in the year 2999 will ask similar questions and have the wisdom to look back on today and see how accurate our predictions might have been.

Occupational medicine in the 1990s in the UK saw considerable changes, often characterised by a reduction in the number and extent of provision of in-house services. The principal drivers for this state of affairs was a lack of any infrastructure for occupational health services in the UK and the orientation of British industry towards performance management. The latter is not incompatible with occupational health services. The dilemma is, however, the demonstration of value to the organisation.

The 21st century will see the development of new forms of service delivery. Just as banks, the law and even restaurants have seen massive changes in service delivery mechanisms, the face of occupational health will increasingly change as these innovations take root. The growth of the independent service provider will not be restricted to medium and large organisations; increasingly individual physicians will develop portfolios of part-time appointments. The weak point here must be the non-service user, who, at the end of the day, regards a doctor as a doctor and will confuse cost and quality. The market is likely to remain difficult, particularly for the individual service provider until such time as standards are put in place and some attention is paid to the quality of service provided. The average employer prepared to pay for quality in areas of activity which they often regard as fringe.

The title of 'occupational physician' is not protected in the same way as, say, the 'registered medical practitioner'. The distinction between various forms of medical work and the training and qualifications necessary to carry them out effectively, is too complex for the usually naïve service user or indeed purchaser. There are many solutions e.g. a code of practice produced by the regulator, adoption of charter status in common with the biologists, engineers and psychologists. If such measures are to achieve their purpose, the protection of working men and women and future users of the occupational health services, must be accorded explicitly our highest priority and not simply trade protectionism.

The future approach to occupational health in the UK is currently being decided in the corridors of Government. The stated aim is to widen access to occupational health services and no occupational health professional would argue with this. But it is difficult to see how the strategy as currently existing can be delivered with the present level of resourcing. The primary care sector may well contribute but merely increasing their knowledge of work-related disease or occupational health practice is not sufficient. They must understand how industry works in order to deliver solutions that serve the interests of both employer and their employees.

Drop-in centres, already a feature of the medical skyline may well contribute to 'procedural' occupational health practice such as statutory medical examinations or to advise about the risks of working with say, lead. They will not be able to offer the principal currency of occupational medicine which rests heavily on an intimate knowledge of an employee's workplace, something that does not come too easily when they remain in their centres or surgeries to deal with occupational health problems. They are less likely to be able to influence employers to take preventative action and to learn from their experience.

Telemedicine might assist in extending access to occupational health services. The costs of a telemedicine link are now relatively low and hardware easily available. These applications are set to make an impact as they already have in such specialties as cardiology, dermatology and even psychiatry.

If advice is our principal currency, one of our raw materials is information. No longer can we rely on experience with so many gateways to electronic databases available on our desk tops and through the Internet. The use of information in practice will widen considerably and the process of accessing, updating and disseminating information is more likely to become automated with various information technology solutions as they become available. Such databases with suitable end-user interfaces and suitable quality filters can make the use of information by non-professionals easier and safer. Similar databases are being developed, for example, to widen community access to legal services in a consultative mode rather than for specific services such as divorce or conveyancing. Evidence-based medicine is advocated by many and certainly by some. Nonetheless, it is here and we are likely to hear more of it. Or are we? It is easy to see a role for it in resolving questions of causation or diagnosis but not in dealing with routine questions which depend so much on occupational setting in which they arise.

Moreover, the central focus of evidence-based medicine is the randomised controlled trial and occupational medicine does not have a tradition of such evidence. Given the difficulties of carrying them out in the workplace, occupational medicine is unlikely to develop a great store of such literature. Less effective forms of evidence may need to be relied on. Whatever happens, the role for evidence-based approaches to occupational medicine is likely to be limited.

The telephone, a device on all our desks, has carved out a niche in occupational medicine. Important as it is for liaison with the general practitioner and even manager, 'help-lines' have become positioned as effective means of interfacing surface providers with their customers. Access to a telephone line is a useful product to sell to customers. Occupational health practice relies heavily on a patient's history and even access to a telephone line will increasingly become the means of delivering occupational health advice to the workplace. There are already examples of this in operation.

Recently, I returned to Helsinki after an interval of just over a decade. On the first occasion, it was to attend the conference on new developments in occupational health services. On this occasion, the theme was much the same and many of the participants hailed from the same countries. In stark contrast to that first meeting, on this occasion there was an overwhelming uniformity of purpose, irrespective of their parent country and broad similarities in the participants' shared experience of the problems which they encountered in day-to-day practice. In the face of EU employment policies, there remains a likelihood of European intervention in the provision of occupational health services and we, as a profession must be prepared for this, ready to influence these proposals.

In June 1999, ministers of public health from the WHO explicitly accepted the contribution of occupational health to the public health strategy, expressed in letters of collaboration. The position has been recognised in various forms in the UK and during the discussions of the new occupational health strategy. It is true to say that occupational health has never been in a better position. This will raise the standing of the specialty but will bring with it responsibilities. We must also begin to explore the synergies between our sister specialties. There may also be implications for our public health work. As Europe grows to 27 members, its role as the main driver of occupational health will also change. As we enter a new Millennium, the time is right for reflection and renewal.

In traditional Chinese medicine, thunder is a symbol of new birth, a sign of a new era. If advice is our principal currency, one of our raw materials is information. No longer can we rely on experience with so many gateways to electronic databases available on our desk tops and through the Internet. The use of information in practice will widen considerably and the process of accessing, updating and disseminating information is more likely to become automated with various information technology solutions as they become available. Such databases with suitable end-user interfaces and suitable quality filters can make the use of information by non-professionals easier and safer. Similar databases are being developed, for example, to widen community access to legal services in a consultative mode rather than for specific services such as divorce or conveyancing. Evidence-based medicine is advocated by many and certainly by some. Nonetheless, it is here and we are likely to hear more of it. Or are we? It is easy to see a role for it in resolving questions of causation or diagnosis but not in dealing with routine questions which depend so much on occupational setting in which they arise. Moreover, the central focus of evidence-based medicine is the randomised controlled trial and occupational medicine does not have a tradition of such evidence. Given the difficulties of carrying them out in the workplace, occupational medicine is unlikely to develop a great store of such literature. Less effective forms of evidence may need to be relied on. Whatever happens, the role for evidence-based approaches to occupational medicine is likely to be limited.

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Dr Denis D’Auria
Honorary Editor