

Farhan: Dr John Schneider, thank you for joining us. Please tell us about your earlier years including your training and journey.

John: I was born in Brisbane but did my early schooling in Sydney, then moved back to Brisbane where I finished my primary and secondary education. I worked in the Commonwealth Public Service for 3 years and at the same time was involved in the Naval Reserve where I spent nearly 8 years. I then attended University of Queensland completing MBBS in 1976.

I then worked as an intern at the Mater Hospital in Brisbane, then in Roma (Western Queensland) and finally as a senior resident in Mackay. I settled there establishing a general practice where I worked for about 15 years. While working in general practice I became involved in occupational rehabilitation, establishing the first multidisciplinary occupational rehab program in Queensland, outside of Brisbane. I first became aware of occupational medicine at our 10 year reunion when I found that 6 of my cohort were working in occupational medicine.

Farhan: Tell us about the years when you qualified as an occupational physician including the opportunities you had initially and before you joined JCU.

John: When I joined the faculty in 1995 there were 3 other occupational physicians in rural Queensland and probably less than a dozen in Brisbane. Practicing in regional Queensland involved significant travelling to worksites as work mainly came from industry or workers' compensation insurers referring workplace rehabilitation cases rather than medical colleagues

I spent a lot of time away from home traveling to mining and worksites from Cairns to Brisbane and west to Mt Isa, running workshops and clinics. It was becoming hectic and I was burning out. I saw a position at the United Arab Emirates University for an occupational physician in the Department of Community Medicine, was offered the job, signed a 4 year contract, but ended up staying for 8 years.

Farhan: How was your experience working with the RCP - the Physicians College in Ireland and in the Middle East? What were you trying to achieve in terms of undergrad and post-grad training? What's your experience been like in Australia now?

John: Employment opportunities for occupational physicians differ. In the Middle East, very few practiced as private independent consultants. In the UK, most of the NHS hospitals had Departments of Occupational Medicine employing occupational physicians to provide staff with OH services as well as occupational medical consultation for management of hospital patients. Colleagues become familiar with consulting with occupational physicians regarding workplace

contribution to injury and illness and return to work issues. This provides a significant awareness largely lacking in Australia.

In the Middle East the majority of the workforce are expatriates, and the employer is required to provide medical care to their workforce and their families if present. As a consequence, there is a greater awareness of the link between health and productivity. Emirates Airlines for instance used to run medical services for the cabin crew and their families. They employed about a dozen primary care practitioners, an occupational physician and 2 or 3 aerospace and aviation medical specialists. (Indian Railways; employs ~2,500 general duty medical officers & specialist doctors as well as ~1,000 senior/junior residents and house officers but no specialist occupational physicians)

The big difference which I found between occupational medical practices in Australia and the Middle East, and also to some extent, Europe and America was co-location with primary care and/or hospital practice. Ownership of occupational health was maintained within the organization and not subcontracted to an independent provider. Positions are available within industry and, they are involved directly in the workplace, providing proactive health maintenance and management advice, as well as involvement in health surveillance, and safe return to work programs following surgery or treatment following treatment of an accident or illness. In Australia most of the referrals and involvement of occupational physicians seem to be for reactive management eg medico-legal assessments, reviews for insurers, and fitness for work assessments following injury at work.

These policies and practices provided an opportunity for post graduate training of company employed primary care practitioners, as well as our University's commitment for undergraduate education and OHS research activity. The former promoted an interest among company employed general practitioners for formal peer assessed qualifications in occupational medicine, and expatriate practitioners seeking employment by large employers operating company health clinics.

The Irish Faculty of Occupational Medicine is entrepreneurial with probably a bigger international footprint than the English Faculty. The Irish College of Physicians runs exams in several international centres and while I was working with UAEU we assisted the Irish Faculty of Occupational Medicine to establish an examination centre in the UAE. They have 3 level of association, Fellowship (exit exam and experience), Membership (exit exam) and Licentiate (entry exam). The latter can also be recognized as basic occupational medicine training for non-specialists, which attracted candidates from the Middle East, Africa, the UK, Australia, and the Indian sub-continent. As a consequence of this the University also provided pre-examination occupational medical courses for potential candidates for the Irish Faculty exams.

Farhan: What's your message for trainees and fellow peers?

John: Don't practice occupational medicine sitting in your consulting rooms. Get out into the workplace and don't be scared to have a look at it. You don't have to do it all the time but do it early in your career so you learn to know what you're looking at and how to talk to people.

Don't just rely on referrals coming from insurers. Try and find employers who are interested in preventing problems in the workplace. Promote yourself to them. If possible and the opportunity arises try to establish communication with union representatives interested in OH&S not political careers.

I think the big threat in occupational medicine at the moment is the corporatization of practices which are being run by accountants and solicitors rather than physicians. What worries me is that occupational medicine may be getting stamped as a medico-legal specialty, and bureaucratic collaborator rather than a preventive medicine specialty. Unfortunately the consumers are generally uneducated and unaware of quality comprehensive occupational health services.

In hindsight our absorption into the College of Physicians does not appear to have increased the awareness of our specialty within the medical community, industry, workplace or society in general. At one stage, there was a proposal for Rehab Medicine and Occupational & Environmental Medicine to collaborate in holding joint conferences, which is probably a good idea and may assist in promoting our specialty.

Trainees need to realize that there are plenty of opportunities in occupational medicine. There are only 5 occupational physicians resident in northern Australia, and not all working full time. If you become too frustrated in Australia, there's overseas, as long as you have internationally recognized training.