Final Report

Occupational and Environmental Medicine at the crossroads: visions for the future

For the Australasian Faculty of Occupational and Environmental Medicine, Royal Australasian College of Physicians

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Report preparation

This report was prepared by Human Capital Alliance (HCA) Staff Consultants Debbie Stanford and Carla Cowles and HCA Principal Lee Ridoutt for the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) in December 2015.

Disclaimer

HCA prepares its reports with diligence and care and has made every effort to ensure that evidence on which this report has relied was obtained from proper sources and was accurately and faithfully assembled. It cannot, however, be held responsible for errors and omissions or for its inappropriate use.

Acknowledgements

We would like to acknowledge and pay respect to the First Peoples of Australia and New Zealand.

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Human Capital Alliance

HCA is a management and research consultancy firm specialising in helping clients align their human and capital resources to their (organisational, occupational, industry, national) objectives. As part of this broad expertise, HCA has developed highly valued evaluation and review expertise employing strategic and analytical approaches.

HCA was established in 1989 and has consulted to public, not-for-profit and private sector organisations employing well-researched, innovative and effective methodologies. Two important themes that run through all of HCA’s work has been a commitment to:

- understanding and acting upon client needs through a strategic rather than operational research approach; and
- employing the best possible (within budget constraints) research methodology to find answers that meet unique client needs.

For further information about HCA go to www.humancapitalalliance.com.au
Abbreviations

AFOEM  Australasian Faculty of Occupational and Environmental Medicine
AHPRA  Australian Health Practitioner Regulatory Authority
AIHW  Australian Institute of Health and Welfare
AMA  Australian Medical Association
CRC  College Review Committee
DSP  Disability Support Pension
HBGW  Health Benefits of Good Work
HCA  Human Capital Alliance
MCNZ  Medical Council of New Zealand
NDIS  National Disability Insurance Scheme
NZACC  NZ Accident and Compensation Corporation
OEM  Occupational and Environmental Medicine
OEP  Occupational and Environmental Physician
RACP  Royal Australasian College of Physicians
WHS  Workplace Health and Safety
Executive summary

Background

In the modern era the means of production of services and products and the environment in which this transpires changes at a rapid rate leading to changes in work roles, occupations and work practices. Occupational and Environmental Medicine (OEM) is not immune to these changes and requires ongoing development to adequately support the needs of stakeholders because of their pivotal role at the intersection of health and the workplace.

To understand how OEM and Occupational and Environmental Physicians (OEPs) can meet the demands of new and evolving workplaces, the Australian Faculty of Occupational and Environmental Medicine (AFOEM) initiated the project 'Definition of Occupational and Environmental Medicine and the role of the Occupational and Environmental Physicians' with the primary aim of obtaining a revised definition of OEM and the role of OEPs.

Project scope and methodology

The project was carried out in three stages. Stage 1, undertaken by the AFOEM Council and Faculty staff, involved a series of data collection activities that included a survey (Survey A) of AFOEM Members, focus groups and a literature review.

Stages 2 and 3 were undertaken by consultancy firm Human Capital Alliance (HCA). Stage 2 focussed on an analysis and synthesis of the Stage 1 data. The main source of data for analysis was Survey A for which a total of 69 responses were obtained; these results were described in an initial discussion paper in September 2015. This information obtained from Survey A and the focus groups in Stage 1 and 2 strongly informed methodology for Stage 3 as an opportunity to further explore these issues.

Stage 3 focussed on conducting further investigations with AFOEM Members as well as stakeholders of OEM with the following objectives:

1. to seek a consensus (or at least majority perspective) on the definition and concept of the role of OEM and the OEP in it
2. to understand likely future Australasian OEM workforce and service delivery characteristics and patterns
3. to discover the views of key Australasian OEM stakeholders on the role and contribution of OEPs in their business and constituency interests to better understand what is valued from the OEP contribution
4. provide advice on the way forward to promote the OEP profession.

An additional survey (Survey B) was conducted with AFOEM Members to investigate objectives 1 and 2. Survey B was distributed via email to 469 Members (Australian and New Zealand Fellows and trainees) and received a response rate of 14.3% (67 completed responses). To investigate objectives 3 and 4, 14 semi-structured interviews (17 were invited to participate) were conducted by HCA with key OEM stakeholders in Australia and New Zealand. Stakeholder groups included employer representative bodies, work safety regulators, employee representative bodies (unions, peak bodies, etc.), government health authorities and insurers.
Findings

Professional title
The findings from Survey A indicated that there was a need for a uniform and accepted title as inconsistency was considered to undermine the promotion of the profession by reducing clarity in meaning of the role, especially as presented to key stakeholders. However, results from Survey A revealed that there were still diverging views among OEPs in regard to a definition, including still in relation to the use of ‘environmental’ in the occupational title.

The results from Survey B showed a stronger preference for the title ‘Consultant Occupational Physician’ which ranked most highly with respondents (average score of 5.8 out of 8). Similarly a preference for one definition for the profession was obtained, but again the difference was marginal. The following definition ranked most highly (4.3 out of 6):

A physician who specialises in providing medical services to the community and industry in managing the health and wellbeing of people to enhance their health at work and prevent harm to health from occupational and environmental factors.

The minor differences in preferences suggest that further exploration and engagement with Members will be required on the part of AFOEM to obtain an agreed title and definition of the profession. True consensus, however, may be an elusive goal, because of the varied nature of work, environments and stakeholders of OEM.

Role and practice of OEM
In considering the future of OEM and the role OEPs, a number of new areas of practice, and also challenges, were raised. There was strong acknowledgement that change was needed and this would involve taking on new areas of work, but also letting go of old and less relevant practices. The psychosocial health of workers (including medical practitioners), supporting the under- and unemployed and an ageing workforce (including medical practitioners) were considered by many to be new frontiers of OEM work. Many also felt that there was a place for OEM to carefully consider the ethics of the profession, to increase the profile of and advocate for OEM and OEPs to ensure greater access and more equitable access to OEM expertise. Ongoing education and training was universally supported and there was also a call for an increased focus on quality assurance activities to ensure ongoing improvement OEM more broadly.

In terms of how respondents are employed, a majority (n=26, 43.3%) were ‘self-employed’; looking at ‘self-employed’, ‘Private practice’, and ‘Group private practice’ collectively, then 63% of the total Survey B respondents appear to be working in clinical, direct patient related roles. Most OEPs are also currently working in clinical areas with the top three areas of practice being ‘diagnosis and assessment’ (56 or 84%), ‘medico-legal opinions’ (48 or 72%) and ‘rehabilitation’ (46 or 67%). Just under 60% of respondents indicated a desire to change their area of practice, with ‘Advocating workplace change’ (26.5% of all respondents), ‘Workplace hazards / risk assessment’ (23.4% of all respondents), and ‘Research and analysis’ (26.5%) being the most common. Respondents were also offered an opportunity to indicate new or emerging areas of practice they might like to work in the next five years; interestingly consulting with ‘GPs and other medical specialist and HSE workers’ ranked most highly (57.8%), followed by ‘Preventive health interventions’ (45.3%), ‘Mental health assessment / workplace risks’ (43.8%), and ‘Advocating change in workplace legislation / policy’ (37.5%).

Stakeholder consultation process
Stakeholder interviews in Stage 3 were used to obtain more qualitative data and to explore some of the areas of contention raised in Stages 1 and 2. They were also seen as an essential strategy to look ‘outward’ to assist the profession to honestly reflect on its current and future scope and direction.
With few exceptions, the wide range of selected stakeholders responded with enthusiasm to the opportunity to provide their views on past, current and future professional goals and activities of the AFOEM and its membership and indicated that they were impressed at the expression of openness and forward thinking that this initiative demonstrates.

Whilst not all comments were 100% positive, all were constructive and the majority of respondents were strong supporters of the benefits that can be derived from high quality, evidence-based, ethical and contextually relevant professional interventions by Occupational and Environmental Physicians (OEPs). Many of the views expressed in terms of optimal roles and future directions were also strongly in alignment with the views expressed by Faculty Members in Survey A in late 2014 but the report elaborates several areas that could warrant further internal reflection and investigation as AFOEM refines its strategic directions.

**Two key themes** stood out as overarching strengths and benefits in the practice of OEM: 1) the power of a comprehensive, consumer-focused assessment process underpinned by evidence-based knowledge to achieve fair outcomes for both workers and employers, and 2) the need to continue to be vigilant in relation to perceptions of unfairness and bias.

**Early intervention**

The early intervention principles and positive focus on capacity for work outlined in the Health Benefits of Good Work framework for action were strongly supported by all stakeholders, even those organisations who did not agree to become signatories to the published document. Although most respondents noted the particular and unique skills that an OEP brings to finding solutions in more complex and intractable cases, there is a strong shared sense that there are many cases that become more complex than necessary if they do not have the benefit of a comprehensive OEM assessment in the early “window of opportunity” phase of a new and potentially work-related illness or injury. And, as for all assessment situations, this intervention will be most effective if there is a good understanding of the work context and structure on the part of the OEP.

**Relationship with GPs**

Stakeholders noted and acknowledged a range of difficulties with achieving this optimal model of engagement. These barriers include: perceived lack of awareness of the potential impact, an uncertainty on the part of GPs regarding Medicare subsidies and referral procedures for OEM, the role of GP as patient advocate and support agent, the current low level of Medicare rebates compared to the time required to undertake an effective OEM intervention, the unavailability of OEPs (especially in regional and rural areas) to accept referrals in a timeframe that meets early intervention thresholds, and competition in the health service marketplace from some GPs for potentially work-related illness and injury assessments (including via the “InjuryNet” service model).

Several respondents were interested to discuss the range of ways that barriers related to OEP supply issues. Looking at possible ways of strengthening GP skills and awareness, (particularly in relation to early intervention and the potential for better outcomes) was a well supported strategy but a number of respondents with a more sophisticated understanding of the work/health-related systems acknowledged that there are structural issues in the GP/patient relationship that seem to mitigate against behaviour change, despite good intent and understanding.

**Team-based work**

Stakeholders also noted that there is a reasonably complex web of medical, allied health, case management and administrative roles surrounding work-related illness and injury management and there is no doubt scope for streamlining of some of this activity, which may identify opportunities to streamline the involvement of OEPs to achieve efficiency without losing effectiveness. The option of considering the development of a “physician assistant”-type role was posed as a possibility, even if it only involved an adjustment of other existing roles within the current service network.
Focus on capability
In addition to this focus on prevention and recovery from illness and injury, there is an emerging opportunity for OEPs to participate positively in the roll out of an increasingly positive and proactive focus on capability and capacity for work within the population that experiences some form of barrier to employment as a result of a disability. Respondents in this area were very enthusiastic about the potential for partnership and raised awareness of potential in this group to contribute to society and the economy.

Emerging issues
In terms of other areas for future focus, the as-yet-untested impact of reliance on an ageing workforce and responding fairly to an increasing burden of chronic disease in the working population were posed by a number of respondents as pressing issues of concern and challenge with which Faculty Members would be well placed to assist.

Ethics
It is unlikely to be surprising to Faculty Members that many stakeholders reported concerns that issues of bias depending on who pays the fee may be at play in some situations and also reported other perceived quality of care issues. Most respondents were not aware that this is an issue that has been a long-standing priority for concern within the Faculty and its overseas counterparts and one respondent noted with dismay that the current AFOEM document is now 20 years old. Several respondents had actively sought to complain about issues of perceived poor OEP practice (some of which were likely to be attributable to GPs working in the occupational health arena) but reported with dismay that they could find no suitable avenue to raise these concerns. This was particularly frustrating for these respondents in situations where clear patterns of behaviour appeared to be forming and could have been potentially averted if an appropriate mechanism for oversight were in place.

Summary
In summary, the strategic directions outlined by the Faculty membership in their responses to Stage 1 of this project have generally been endorsed by the key OEM Australian and New Zealander stakeholders who have contributed to Stage 2 consultations. Despite some reported negative experiences along the way, there is a strong desire on the part of unions, employer organisations, compensation and insurance bodies and other consumer representatives to work together to take advantage of the positive contribution that can be made by OEPs in relation to the broad field of occupational and environmental health. The guiding principles that are likely to ensure good progress in this discussion are a continuing commitment to evidence-based clinical practice within a systems-based framework of assessment, ethical involvement of patients/consumers in the assessment and solution-building processes, and an ongoing willingness to become and remain knowledgeable about the specific health issues that can arise in various work settings.
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1. Introduction

Background

Occupational and Environmental Medicine (OEM), and Occupational and Environmental Physicians (OEPs) are at the intersection of health and the workplace. OEM provides the knowledge and the authority that enable these arenas to interact and collaborate. OEPs consider the multidimensional environment and are able to facilitate discussions and provide strategic direction because they are at the interface between government, employers, workers and health professionals.

The official definition of the role of the OEM and the possible role of OEPs has not changed for many years, yet clearly the work of OEPs has continued to evolve. To understand how the work and the definition can be better aligned the AFOEM initiated the project ‘Definition of Occupational and Environmental Medicine and the role of the Occupational and Environmental Physicians’.

Project scope and methodology

The aim of the project was to obtain a revised and accepted definition of OEM and the role of OEPs that is adapted for a modern world of work and is relevant and sustainable.

The project was undertaken in three stages; the first conducted by AFOEM Council, and the second and third stage undertaken by HCA.

This report describes the findings from all three stages of the project, the findings from each stage building on the findings from the previous stage.

Stage 1: data collection and literature review

The initial stage of the project, undertaken by the AFOEM Council, consisted of a number of qualitative data collection activities. The activities included:

- a survey of Members of the Faculty
- a literature review
- regional focus groups with OEPs.

These activities were conducted with the aim of exploring the definition and concept of the role of OEM and the OEPs in it — clarifying its purpose and the value it plays in the wider community.

The 12 question survey was administered by email to all current AFOEM Members using the online survey tool SurveyMonkey (copies of the survey instrument are available on request). The purpose of the survey was to explore and obtain thoughts about the definition and role of OEM and OEPs as well as gaining an understanding of the type of work being carried out by OEPs, the type of settings and contexts they are working within and with whom/for whom they are working. A total of 69 Members responded to the survey. This survey is referred to in findings below as ‘Survey A’. Details of the respondent population are difficult to provide since few demographic questions were asked in the survey.

Regional focus groups, facilitated by Dr David Beaumont, AFOEM President, were conducted across Australia and New Zealand to gain a deeper understanding of perspectives of Members around the current and future definition and role of OEM and OEPs.

A literature review was also conducted by AFOEM to gauge the current understanding of the OEM and OEPs internationally and to support and inform the analysis of the survey data, especially in regard to OEM definition, current scope of practice and OEP roles.
Stage 2: analysis and synthesis of stage 1 data

Stage 2 of the project involved analysing and synthesising the data collected in Stage 1 which was conducted by HCA, the consultancy firm contracted by the AFOEM Council. The data was processed by HCA with the following objectives:

1. to explore the definition and concept of the role of OEM and the OEP in it, and to explore the value OEM plays in the wider community from the findings of the survey, regional consultations and literature review
2. use the findings to provide a degree of clarity for AFOEM Members to understand their purpose in the medical and health arena where there is a degree of ambiguity
3. use the findings to ensure that stakeholders and customers external to AFOEM understand the role of OEPs and how they contribute to health in the workplace.

Analysis of this data indicated that further investigation was required with Faculty Members and stakeholders of OEM to seek more clarity and stronger [quantitative] evidence to inform future direction.

Results from Stage 2 were described in an initial Discussion Paper which was shared with Faculty Members in October 2016.

Stage 3: survey of Members and interviews with stakeholders

This stage was conducted by HCA and focused on gathering data both internally (from Members) and externally (from other stakeholders) to explore and refine the views and information obtained from Stage 1 and 2. The objectives for this stage were to:

1. seek a consensus (or at least majority perspective) on the definition and concept of the role of OEM and the OEP in it
2. understand likely future Australasian OEM workforce and service delivery characteristics and patterns
3. discover the views of key Australasian OEM stakeholders on the role and contribution of OEPs in their business and constituency interests to better understand what is valued from the OEP contribution
4. provide advice on the way forward to promote the OEP profession.

To meet these objectives HCA undertook two original data collection activities:

- a survey of Members
- interviews with external stakeholders of OEM.

Survey of Members

The survey contained 14 questions (including fixed-response and open-ended questions) and was administered via SurveyMonkey. The survey was designed by HCA in consultation with the AFOEM staff and President and was reviewed by AFOEM Council members. The survey was then assessed and approved by the College Review Committee (CRC) of the RACP.

Faculty Members were given a period of four weeks (19 October to 15 November) to complete the survey. A total of 78 responses were received for the survey and 67 of these were completed in full. A summary of the respondent characteristics can be found in Appendix A. This survey is referred to in the findings below as ‘Survey B’.
Interviews with stakeholders

Stakeholder groups for the interviews in Stage 3 were informed by the findings from Stage 1 and 2. Identification of the stakeholders of OEM was an area of ambiguity for OEPs who responded to Survey A. While it was relatively straightforward to identify the different types or groups of stakeholders, ambiguity arose in relation to the difficulty in distinguishing who the ‘customer’ is. That is, where does the duty of care or loyalty of the OEP lie? For some OEPs the boundaries for the OEP as medical practitioners are hard to define or see, particularly when the ‘paying’ customer is not necessarily the patient but the employer of the patient in question.

Nevertheless a list of Australian and New Zealand stakeholders were identified and constructed in liaison with the AFOEM President and Council members.

An interview schedule with six questions was designed and reviewed by AFOEM President, staff and Council Members; it was then assessed and approved by the CRC.

Initial contact with nominated stakeholders was then made by email from the AFOEM President. Follow-up emails and phone calls were made by HCA with stakeholders to arrange an interview time. Interviews were mostly conducted with individuals but several interviews involved more than one representative of the stakeholder organisation. Most interviews were conducted by phone with some being conducted in person. Seventeen stakeholders were invited to participate and a total of 14 interviews were conducted with the following organisations:

- Ministry of Social Development, New Zealand (MSDNZ)
- Australian Chamber of Commerce and Industry (ACCI)
- Australian Metal Workers’ Union (AMWU)
- Safe Work Australia (SWA)
- WorkAon New Zealand (WorkAonNZ)
- Business New Zealand (BNZ)
- Worksafe New Zealand (WNZ)
- National Disability Services (NDS)
- New Zealand Disability Network (NZDN)
- E tu New Zealand (EtuNZ)
- Shop, Distributive & Allied Employees’ Association (SDA)
- Comcare
- Insurance Council of Australia (ICA)
- Australian Medical Association (AMA).

Other organisations were invited to offer their perspective but for one reason or another were not interviewed. These included:

- Royal Australian College of General Practitioners (RACGP)
- Royal New Zealand College of General Practitioners (RNZCGP)
- NZ Accident and Compensation Corporation (NZACC).

2. What is in a name? Occupational title

Current terminology

A number of similar but slightly different titles are used by Australian and New Zealand professional, regulatory or funding bodies. Arguably the three most important occupational titles are:
Based on the findings from Survey A, most of the Members of AFOEM currently call themselves an occupational physician (42%) or an occupational and environmental physician (27.5%). A range of other titles are used by the remaining 30% (see Table 2), but nearly all incorporate the word ‘occupational’, generally in conjunction with the term ‘consultant’ or ‘specialist’ in order to either draw a distinction in the marketplace with general practitioners, some of who can ‘specialise’ in the workplace setting, or with other Members who might not undertake clinical work.

Table 2: Distribution of Survey A population by occupational title employed (n = 69)

<table>
<thead>
<tr>
<th>Title currently employed</th>
<th>Number</th>
<th>Proportion of total responses (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Physician</td>
<td>29</td>
<td>42.0</td>
</tr>
<tr>
<td>Occupational and Environmental Physician</td>
<td>19</td>
<td>27.5</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>8.7</td>
</tr>
<tr>
<td>Occupational Medicine Specialist</td>
<td>5</td>
<td>7.2</td>
</tr>
<tr>
<td>Occupational Physician Trainee / Registrar</td>
<td>5</td>
<td>7.2</td>
</tr>
<tr>
<td>Consultant Occupational Physician</td>
<td>3</td>
<td>4.3</td>
</tr>
<tr>
<td>Occupational Medicine Consultant</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>69</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

A number of respondents to Survey A noted that, due to the varied nature of their work and roles, they might use a number of different titles. For example, they might use ‘physician’, where they are in a treating role, and ‘consultant’, where they are providing advice.

**Opinion on a common title**

Despite the variety of titles in use, most respondents (62%) to Survey A believed there should ideally be a single title used by all Members (another 17% were undecided) in order to promote the sense of a more uniform ‘product’ or identified ‘brand’. However, opinion on what the title should be was as equally divided as the current title use.

This perception of the degree of difference of opinion no doubt prompted many respondents to Survey A, even those who thought consensus on an agreed title was desirable, to suggest that there

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*The consultant practising in his or her specialty of occupational medicine can claim against MBS Group A12 item numbers (Item numbers 384-389).*
was, or is, little scope to mandate the use of a specific title. A significant number of respondents (n=19) indicated that they would accept a single title if it was nominated and endorsed by the Faculty. One respondent suggested that the Faculty recommend to Members the adoption of a Faculty-endorsed title and publish a policy paper in support of that position.

There was considerable discussion about use of the term “consultant” – on the one hand, it was considered an accurate description of one aspect of the broader OEP role played by many Members but concern was expressed that this title is being used for work that is narrow and strongly focused on medico-legal reporting activity. A small number of respondents were less worried about a single title for Members, but expressed concern about the use of the title “occupational physician” by some GPs and wondered if this could be stopped.

Some respondents suggested that it would be useful if all key stakeholder groups (including the Faculty, Australian Health Practitioner Regulatory Authority (AHPRA), Medicare and Department of Human Services, medical defence organisations, regulators, AMA, unions, insurers, Medical Council of New Zealand (MCNZ), ACC etc.) were to adopt the same title, even if Members themselves did not. They argued inconsistency of title use by these interests undermines the meaning of the role.

One respondent pointed to the usefulness of exploring within OEM an increased scope for focus on sub-specialty interests/expertise without a requirement for formal sub-specialisation (similar to the model that is used by orthopaedic surgeons who may develop specialised expertise in hand, knee, spine etc.). A number of respondents were concerned at including the term “environmental” in their title as they do not regard themselves as sufficiently expert in that aspect of occupational health. These respondents suggested that further training in this sub-specialty area would be required (in addition to the base specialty training) in order for them to feel and be considered as suitably expert in this area of practice.

A potential common title

One of the objectives of Survey B was to work towards obtaining a consensus, or at least a majority perspective, for a title for OEPs. In Survey B Members were asked to rank eight possible titles (including the option for ‘Other’) for their profession. Analysis of this data was by adding all the scores for a particular title and calculating an average score (by dividing by 67, the number of effective respondents). Figure 1 displays the average ranking for the options indicating that the most favoured title was ‘Consultant Occupational Physician’, closely followed by ‘Consultant Occupational and Environmental Physician’, ‘Occupational and Environmental Physician’ and ‘Occupational Physician’ (in descending order). The differences between these four most preferred titles was marginal, indicating that the Faculty membership is no closer to agreement on a single title than it was for Survey A. The term ‘consultant’ appears to be much preferred to ‘specialist’, perhaps reflecting the business environment in which most Members mix.

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b At this point of the survey the response rate dropped to 67 as 11 respondents did not continue with the survey.
It is worth noting that although the title used by the AHPRA is ‘Specialist occupational and environmental physician’\(^1\), this only ranked at number 5. However, five of the respondents who chose ‘Other’ stated that their preferred title was for ‘Specialist Occupational Physician’.

A small number of respondents also noted that ‘medicine’ should be included in the title, but by and large titles with the term ‘medicine’ were poorly ranked. Trainees and new Fellows of the Faculty (joined since 2000) similar favoured the same four titles, although ‘Consultant Occupational and Environmental Physician’ was more poorly considered.

Respondents were also asked whether their preferred title differed from their current title; 38 (57%) respondents indicated it was not different, 29 (43%) indicated that it was different.

28 (97%) of the 29 respondents who said their preferred title was different to their current title, indicated that they would be willing to adopt a new title if recommended by the Faculty. While overwhelmingly positive, the results to this question should be taken with some caution as it relates to the specific title they selected as their preferred title, and not necessarily to what might actually be the majority preference.

\(1\) Source: Survey B data

\(2\) Figure 1: Average ranking of preferred title for OEPs (n=67)
3. Definition of the profession

Current definitions (Australasian and international)

Similar to the case of the occupational title, a number of formal definitions of the specialty area already exist. Most prominent among the definitions of course is that developed and advocated by AFOEM and provided in full Box 1.²

**Box 1: AFOEM definition**

“Occupational Medicine is a medical specialty where highly-trained specialists focus on the effects of work on health and (conversely) health on work. It understands the full range of workplace and environmental hazards (chemical, physical, biological & psychosocial), associated risks of exposure to such hazards, and how these may cause an adverse impact on biological health, such as injury or illness. It covers all occupational/work groupings, and understands the nature of such work in terms of inherent task requirements, environment, and human ergonomics. Environmental Medicine is one important competency of training and practice for an Occupational and Environmental Physician (OEP). Although environmental health is an integral part of the scope of practice of OEPs, AFOEM defines environmental medicine in the context of that practised by OEPs as following: "Environmental medicine is the prevention, research, investigation, assessment and treatment of human health impacts of industrial activities (including primary industry) on the environment beyond the confines of the industrial site."

In the United Kingdom (UK), the equivalent professional body, the Faculty of Occupational Medicine of Royal College of Physicians, offers a much more succinct definition in Box 2.³

**Box 2: UK definition**

“Occupational Medicine works to identify, isolate and eliminate preventable injury and illness caused or aggravated by work.”

In the United States of America (USA), occupational medicine is also aligned more directly with preventive health, and covered professionally by the American College of Preventive Medicine. In this regard, preventive medicine is considered to have three specialty areas with common core knowledge, skills, and competencies that emphasise different populations, environments, or practice settings viz.: aerospace medicine, occupational medicine, and public health and general preventive medicine. In Box 3 occupational medicine is defined as focusing on⁴:

**Box 3: USA definition**

“... the health of workers, including the ability to perform work; the physical, chemical, biological, and social environments of the workplace; and the health outcomes of environmental exposures. Practitioners in this field address the promotion of health in the work place, and the prevention and management of occupational and environmental injury, illness, and disability.”
Royal College of Physicians and Surgeons Canada, perhaps more similar to AFOEM, emphasises the preventive element of the occupational medicine role but still acknowledges more explicitly to clinical aspect of work in their definition (Box 4)⁵:

**Box 4: Canadian definition**

“Occupational Medicine is that branch of medicine that emphasises prevention, and deals clinically and administratively with the health needs of both individuals and groups with respect to their working environments.”

As with the UK, USA and Canada, Occupational Medicine, as defined by the MCNZ, does not include ‘environment’ in the specialist title. The definition provided by the MCNZ (Box 5) focusses on the preventive and clinical aspects of the specialty⁶:

**Box 5: New Zealand definition**

“…the study and practice of medicine related to the effects of work on health and health on work. It has clinical, preventive and population-based aspects. Occupational physicians practise to ensure effective prevention of, and appropriate management of people with, illness and injury due to work and industry, and the appropriate rehabilitation of people with facilitation of their return to work.”

**Future definitional considerations**

Respondents to Survey A offered a substantial set of options for consideration in response to the question of definition, providing a rich body of insight as to how best to describe the OEP in the 21st century. Despite the broad spectrum of opinion, there were clear themes and decision points that were able to be highlighted from Survey A data analysis. The key elements for consideration in establishing a final preferred definition would necessarily include:

- reference to the specialist medical element of the role — e.g. specialist; specialist physician; consultant physician; physician who consults and specialises in …; one who deals in …
- the breadth of expertise and range of roles — e.g. OEM; medical services
- the overall aim or focus of OEM — e.g. recognition, treatment and prevention of diseases; protecting humans from toxic exposures; relationships between work, the workplace environment and medicine; chemical, physical, biological, ergonomic and psychosocial hazards; enhance health at work; prevent harm
- impartiality/ethics of practice
- the degree of prominence of the term environment and whether it can take its place with other key priority areas of OEM practice and sub-specialty interest (see below).

**Agreement on a new definition**

A list of five definitions was crafted from suggestions provided by Survey A respondents and in reference to the elements noted above. The five options presented were:

1. A physician who specialises in providing medical services to the community and industry in managing the health and wellbeing of people to enhance their health at work and prevent harm to health from occupational and environmental factors.
2. A physician with expertise in: a) medical conditions caused by work, b) medical conditions caused by environmental exposures, and c) vocational rehabilitation of people with work-related and non work-related medical conditions.
3. A physician who deals with the recognition, treatment and prevention of diseases associated with work and the work environment.

4. A physician who provides specialist knowledge to ensure a healthy, productive workforce and connect a workplace with the diverse range of health services necessary to optimise the health and wellbeing of workers. OEPs work with governments, regulators, employers, workers and other health professionals to ensure positive health outcomes for workers and employers.

5. A physician specialising in working towards a healthier, safer and more productive workforce.

These five options, along with an opportunity to suggest an alternative, were presented to respondents to Survey B, and a request made to rate them similarly to the way the professional titles had been rated. The relative ratings between options were calculated in the same way.

As with the profession title, the purpose of Survey B was to work towards obtaining a consensus, or majority perspective, for a definition for the profession. But, as also with the profession title, the differences between each preferred option were marginal and a clear agreement did not emerge from the analysis. Figure 2 indicates that the top three preferred options were 1, 2 and 3, respectively.

12 respondents who selected ‘Other’ as their first preference provided a suggested definition, a list of which is provided as Appendix B. Four of these respondents suggested the definition, “A physician specialising in the effects of work on health and the effects of health on work”.

The issue of ‘environment’ within the definition of the OEP

It was noted earlier that only 19 of the 69 Survey A respondents (27.5%) currently self-identify with a profession title that includes the word ‘environment’. Yet, when asked if there should be the
definition of environment within the role of the OEP, the majority (42 or 61%) indicated this to be appropriate. In a similar way, Survey B respondents rated most favourably those profession titles that included the word ‘environment’ (two of the top three preferred titles).

In Survey A, some respondents even expressed frustration that the issue of including environment in the profession title should be canvassed again when there is already a consensus-based decision among Members that reference to environmental medicine be incorporated into the Faculty’s definition and description. It was widely understood among survey respondents that the term “environment” in this context was limited to the “place of work” environment and any impacts of that environment on the surrounding physical or social environment.

Nevertheless, even among those who agreed with its inclusion, there was significant discussion about some outstanding issues that needed clarification, such as:

- Is the functional boundary between public health physicians (as well as public health practitioners and occupational hygienists) and OEPs well understood, both within the Faculty and among OEM’s various stakeholder groups – e.g. infectious disease focus vs chemical and physical hazards?
- Is it widely agreed that the psychosocial environment of a workplace is encompassed in the definition and is that in turn well understood by stakeholder groups?
- Is the practice of environmental medicine sufficiently prominent in current and anticipated occupational medicine practice in Australia and New Zealand as to warrant its inclusion in the profession’s name?
- A number of Members expressed concern that their level of skill and knowledge in “environmental medicine” did not warrant its inclusion in their professional title and in fact created what they feel is a somewhat false claim, despite their otherwise broad field of expertise; and,
- Are adequate opportunities offered by the Faculty at present for current Members to develop sufficient skill and knowledge in this field (or sub-specialty) in order to be properly considered an expert and, if so, are these opportunities being taken up to a satisfactory extent?

4. OEPs’ role in the workplace

Current scope of practice

It was very clear from the Stage 1 Survey A data and consultation meetings that the roles for which OEPs are trained and then develop subsequent experience are very broad and wide-ranging – both in type of role and in subject matter.

In AFOEM’s literature review, based on a survey of membership in 2009, the main roles played by Members (in descending order of proportion of OEPs in the role type) were:

- clinical (patient related consultation – supported generally through third part payment, e.g. workers compensation insurer or less likely through the MBS) (54.5%)
- consulting (non individual patient related involving research, managing, advising) (26%)
- administration (8.5%)
- teaching (2.7%)
- research (2.7%).

\( ^c \) see Appendix C for details of the MBS items for ‘Consultant Occupational Physicians’ and Appendix D for data on the Medicare item claims actually made.
Another way of perceiving the role of OEPs is to understand the contexts in which they work. Based on 2012 data collected through the Australian Institute of Health and Welfare (AIHW) Medical Workforce survey (administered in conjunction with registration renewal) the main context in which OEPs work (61.5% of OEPs) is in solo or group private practices (see Figure 3). This is not inconsistent with the information provided above in regard to the proportion of OEPs in clinical roles. Just over one tenth (10.3%) of OEPs work in commercial businesses, and a similar proportion (8.3%), work in government departments.

![Figure 3: Distribution of registered OEPs working in 2012 by work contexts](image)

Source: Published AIHW Workforce Survey data

Analysis of Survey A text data showed that OEP roles tended to be considered mostly within a primary, secondary and tertiary intervention framework — with the roles ranging potentially from prevention to treatment. Within this framework, the following broad roles were identified:

- diagnosis
- treatment
- rehabilitation
- risk management
- surveillance/ monitoring
- health promotion
- research/ analysis.

A typical response that illustrates this perspective of the OEP role provided by one Survey A respondent was:

“i) The primary prevention of illness and injury. ii) The promotion of health and wellbeing among the workforce through promoting a healthy and supportive social work environment and physical environment. iii) The secondary prevention of illness for those with injuries or chronic disorders, including providing appropriate employment for those with reduced work capacity.”
Some of the specific activities undertaken by Survey A respondents consistent with these broad roles included being a:

- source of knowledge about workplace hazards and risk
- provider of clinical assessment of workers for employment/pre-placement and/or return to work
- provider of advice – to patients, other clinicians, employer, insurer
- source of evidence-based contribution to Workplace Health and Safety (WHS) policies and procedures
- part of senior management team for preventing and minimising harm from risk
- manager of absences due to ill health and/or absenteeism
- means to specify causative associations between ill health and work
- policy contributor to government decision-making processes and developmental activities
- independent medical examiner
- research/worker health and incident surveillance/trend analysis
- source of advocacy.

A small but significant number of Survey A respondents highlighted the central (potentially leadership) role of OEPs in the area of workplace health, setting direction or guarding against direction being biased in favour of a particular stakeholder. Some likened their role to a ‘bridge’, an issue raised also in the consultations with Council. This sentiment is captured in the comments of the following three respondents:

“[an OEP is an] … Expert Advisor to stakeholders in the workplace, on issues of health, safety and the work environment. Executive Function in managing Occupational Health in relation to exposures to pathogens including chemical, biological, physical and psychological at work. Medical Advisor to workers and employer.”

“The role can be very broad. I see the OEP as a trusted partner to the business, providing leadership in the area of health assessment, health management and the opportunities to protect and promote health. They do not just provide advice, but real advocacy for improvement of health outcomes. They also need to have business knowledge and display an understanding of business imperatives, so they can provide feasible and realistic recommendations.”

“The OEP’s role is to act as an umpire, keeping all parties honest, including government, insurers, claims agents, employers and employees, who all are subject to moral hazard effects in what is usually an insurance system or an issue of risk management where risks may be borne by others to the profit of the agent in question. An insurer or employer relies on a doctor to provide ex-post information after injuries to better understand prognosis, diagnosis, and causation.”

Data from Survey B provides another indication of the ways in which OEPs are currently employed. The largest portion of respondents (n=26 or 43.3%) were self-employed (Figure 4) and of these
seven were also employed in one or more additional areas the most common being ‘State or territory public sector agency’. If ‘self-employed’, ‘Private practice’ (presumably salaried), and ‘Group private practice’ are considered together, then 63% of the total Survey B respondents appear to be working in clinical, direct patient related roles. This is very close to the 61.6% found to be working in private practice through the AIHW Workforce Survey.

![Figure 4: Ways in which OEPs are employed (n=60)](image)

Source: Survey B data

**Figure 4: Ways in which OEPs are employed (n=60)**

Seeking a more detailed understanding of current practice, Survey B asked respondents to identify their current areas of practice from a list of comprehensive primary, secondary and tertiary prevention practice options. Figure 5 below shows that currently, the top three areas OEPs are working in are diagnosis and assessment (56 or 84%), medico-legal opinions (48 or 72%) and rehabilitation (46 or 67%) — all firmly of a clinical nature. Some preventive actions feature in the top 10, including ‘Workplace hazard / risk assessment’ (56.3% of OEPs), ‘Health promotion’ (42.2%), and ‘Surveillance / monitoring’ (also 42.2% of OEPs). Only 14% of OEPs indicated they currently practice environmental assessments, which seems consistent with earlier findings.

Many external stakeholders support the emphasis of OEP practice in clinical areas, but lament the tardiness with which workers get to see an OEP. For these stakeholders, early intervention is seen as a prime opportunity for OEPs to contribute to the planning and management of cases — there is an acknowledged window of opportunity for a high likelihood of getting good outcomes but OEPs are often not brought in until too late to influence this phase. Early engagement of OEM expertise would have a good flow-on and practical learning effect for GPs — as a demonstration of what is achievable as a result of timely and comprehensive assessment and planning that includes engagement with the workplace (even if the GP can find other ways to ensure this is done if not by them). Early comprehensive assessment and response planning also sets a better basis for case managers and rehabilitation providers to put an effective plan in place. One government agency stakeholder strongly supported the Faculty’s position, based on evidence, that the timeliness of OEM input is critical in order to achieve the best social and economic outcomes for people who have become ill or injured, whether at work or by other means. This stakeholder noted that there is a large group of people in the non-compensable population that could benefit from a professional OEM assessment and suitable workplace adjustment processes as part of their recovery planning but that...
unfortunately there are few avenues available at present to promote and fund this service. This is an area of potential policy investigation and would benefit from further research and analysis in order to explore and elaborate the likely return on investment. The AFOEM submission recently to the Medicare Review Committee could be the start of part of that policy development.

Source: Survey B data

Figure 5: Current areas of practice (n=64)

A work cover insurer noted that unfortunately there is very little sense among employers and others in the use of OEPs in the early intervention phase at present. Where used, they tend to be brought in once a complex situation has developed. Even then though, OEPs tend to be more useful at that point because a) they tend to do a more comprehensive assessment and write a more comprehensive report, and this level of exploration is very valuable, b) they take into account the particular issues arising from the specific workplace, and c) they take a more holistic and rounded
view of the situation and keep an eye out for patterns (see more discussion of independent medical examinations below).

One stakeholder from a regulator expressed disappointment overall in the narrow focus of OEPs on clinical processes, particularly when these were so individually focused. This stakeholder was of the opinion that OEPs, who could be leaders in HSE by dint of their status and expertise, were missing this opportunity through being too specialised. Thus, reports from OEPs tended to focus on single cases, and failed in this stakeholder’s opinion to extract generalised meaning from single or related cases to deliver guidance on hazards and controls — the heart of meaningful and strategic change. The question was asked, “Who translates technical advice from OEPs into more useful recommendations (for preventive action)?” The OEP needs to be given permission through a change in culture to develop tangible plans from their clinical practice, otherwise others, probably less capable, will fill the breach and claim leadership.

A similar but slightly contradictory opinion from a business stakeholder was:

“A good OEP opinion is based on appropriate evidence, takes a diagnostic approach, is related specifically to the worker, work and workplace in question, and is solutions/capacity-building in its focus.”

In general, external stakeholders believe OEPs are most effective when they have an understanding of the specifics of a work environment – for example as in the more traditional “company doctor” and workplace health management systems advisor role – but there is a perception that many opinions are being given in recent times without the benefit of insight into an individual’s workplace (see independent medical examination discussion below).

**OEPs’ role in providing independent medical examinations**

The specific issue of involvement of OEPs in independent medical examinations generated a wide-ranging set of views in the Survey A responses. The greatest concern in relation to OEPs in this role (offered by OEPs themselves) is the potential for bias in favour of the paying party (most often an employer or insurer) and the current absence of transparency / disclosure to the patient / worker in terms of assurances of independent and fair assessment outcomes. This hazard is perceived by many as even more pronounced because of how relatively lucrative a role it is compared to other available roles.

External stakeholder perspectives on this issue, as one might expect, varied enormously. The variation in opinion tended to follow expected lines of argument depending on what side of the employer – employee concern the stakeholder represented. According to New Zealand stakeholders, OEPs are widely used by insurers and self-insured employers to provide “qualified, independent, evidence-based opinion” on employee claims. They are generally brought in after the initial 8 week period where reliance on the GP assessment alone is not providing a comprehensive enough insight into the capacity for work of the claimant. According to these stakeholders the OEP assessment offers a better understanding of:

- the extent, significance, impact of co-morbidities
- individual work capacity and a focus on ability
- clarification of general wellness status
- the impact of age on claims.

While in these stakeholders’ opinion OEPs are more likely to be able to identify potential for work this can still be controversial, particularly where workers (and sometimes their GP) have developed “fixed views” about their abilities and their potential for return to work.
On the other side of the debate, it has been controversial in New Zealand that the NZACC relies on a panel of assessors (reportedly mostly OEPs) around whom there is a perception of being too closely aligned with the NZACC. The accusation is that the panel has developed a reputation for making recommendations aligned with the interests of the NZACC.

In Australia the lightning rod for such concerns has been with the large, self-insured companies. They are accused of a range of tactics prejudicial to the interest of workers, but a key claim has been around the use of panel doctors, whose medical examination findings deliver recommendations that appear (from the union perspective) to follow a pattern of favouring an employer-friendly outcome. The qualifications and specialisation of these panel doctors is unclear but most, according to union stakeholders, appear to be GPs, but some ‘mud’ has still been apportioned to OEPs. Of course, while panels draw considerable ire from some quarters, other stakeholders point out that a preferred provider arrangement can actually assist in identifying patterns in an organisation or part of an organisation through repetition of contact across a number of individuals which is potentially helpful.

One of the union stakeholders went so far as to say that the area of medical examinations has created a lack of trust with the Faculty, despite the fact that there remain a small number of trusted and experienced individuals providing valuable services. There remains, though, scope for collaboration with unions on the development and promotion of best practice guidance. Union respondents commented positively on two documents specifically – one was a guide for Vocational Rehabilitation Conferencing, and the other was an AMA guide for Independent Medical Examiners. The core points of intersection of interest between OEPs and the people they are assessing are for an independent, evidence-based approach to the assessment, and for a meaningful and respectful dialogue to be allowed and encouraged in order for the assessment to reach its effectiveness potential.

The inability sometimes to distinguish between GPs and OEPs in the conduct of independent medical examinations is problematic. One more independent stakeholder, though, offered an opinion on the difference, noting that an OEP focusses on progressing someone to recovery by asking them the right questions, and sees return to work as part of the solution not part of the problem. Alternatively, they opined, a GP will often take a more cautionary approach, thinking they do so in the best interest of the patient. And even unions appreciate the skills of OEPs, when applied fairly, and believe they could be more widely used in a proactive way to suggest different strategies in certain settings.

Many Survey A respondents held concerns of another sort in regard to undertaking medical examinations, particularly if these became the dominant area of practice of an OEP. They called for greater efforts on the part of OEPs (individually and collectively) to find more pathways to incorporate both assessment and treatment of workers into their professional practice. Many felt that a practice strongly directed to providing medico-legal opinions to third parties would be likely to lead to a dissipation of clinical skills over time, leaving the relevant OEP less capable of what most respondents reported as the core roles of OEM – protecting workers from harm and assisting them to recover from work-related injury or illness. A number of respondents also indicated that they believed their own capacity to prepare balanced and constructive medico-legal reports had benefited significantly from experience gained in a wide-ranging body of OEM practice and they suggested that newly qualified Members should be encouraged to explore these broader opportunities before incorporating too high a proportion of medico-legal reporting work into their practice.
Future role potential

In a recent article on the role of the OEP it was noted:

“The OEP is uniquely qualified in this role. However, it is a seductive field for us to work in as it can be extremely lucrative. Practitioners (are) often seen as hired guns, (and often are). It should not be the majority of work done by OEP's, and best avoided until the OEP truly is an expert with experience in the field as well as qualification.”

There was widespread acknowledgement among respondents to Survey A that it was not possible to rely on the OEM role remaining the same as it was in previous decades, for a wide range of reasons. Many called for an attitude of openness and reflection on what is required in the present and near future in terms of OEM interventions, with a will to take up new challenges and a willingness to let old, less relevant practices take lower precedence or disappear. Some of the comments in Survey A typical of this regard were:

“We need to encourage diversity in the nature of our practices to maintain relevance in the longer term.”

“[OEPs] need to develop an awareness of emerging trends and new industrial developments so as to be in the forefront of intellectual issues affecting Work Health and Safety. There are likely to be fewer employed OEPs -- and many more working as independent consultants.”

“OEPs need to emerge from their protected and comfortable work environment and become informed of the mental, social and physical health needs that exist in our society and take responsibility to help promote optimal independence and function among those with health needs.”

To investigate the areas of practice into which OEM could expand, respondents to Survey B were also asked to identify what areas of practice they desired to perform in the future. Just under 60% (38 of 64 respondents) indicated a desire to change their areas of practice, but how radically is not known. Almost all respondents took a desire to change to mean what areas of practice they are currently not performing would they like to perform in the future. Figure 6 shows the number of respondents identifying each of the areas of practice. In general, preventive and more strategic areas of practice [for instance ‘Advocating workplace change’ (26.5% of all respondents), ‘Workplace hazards / risk assessment’ (23.4% of all respondents), and ‘Research and analysis’ (26.5%)] were identified for expansion, although providing medico-legal opinions and some areas of clinical practice were also featured. Unfortunately because of the way the question was interpreted and mostly answered, it is difficult to say which current areas of practice might be decreased in levels of performance to allow a shift of OEP workforce to desired areas of practice.

The data in Figure 6 reinforces the earlier findings from Survey A that there is tension within the profession around the focus of practice between prevention and treatment encapsulated to some extent in the following quotes from Survey A respondents:
“[we should be] discouraging continuance of preventive activities that were once relevant but are no longer so, in favour of spending the preventive dollars where they will be most effective.”

“[there needs to be] a greater role in secondary and tertiary prevention in relation to worker health, rather than primary prevention.”

One of the union stakeholders was clearly in favour of OEPs working within a preventive framework, and noting that there is considerable power in the skill set of an epidemiologist in the occupational health arena, wondered if this might be a suitable role for an OEP (perhaps with dual fellowship with the Australian Faculty of Public Health Medicine).

![Figure 6: Desired areas of practice (n=38)](image)

Unlike the areas of practice above, which are already being performed by some OEPs but are desired to be performed by more OEPs, there are other areas of practice that are rarely if ever performed by OEPs — but potentially could be. For instance, a practice direction advocated by Harper¹⁰, and with which there is some agreement from Survey A respondents, is to focus more on psychosocial elements of health:
A range of such ‘hypothetical’ or rarely travelled areas of practice for OEPs was put to respondents to Survey B to seek their level of interest in practicing in these areas within the next five years. Figure 7 shows their response.

The most commonly identified area of future practice that Survey B respondents wanted to increase was in their relationships with other HSE providers (57.8% of respondents). At the head of this list would be general practitioners, who could be very useful partners in dealing with workplace health issues (and probably sometimes are), but appear too often to be more in competition or at least a barrier to patients whose health is being effected by their work getting appropriate care. Other new areas of practice that respondents to Survey B wanted to explore were quite strategic in nature, and an attempt to place OEPs in the role of change agent rather than the current more reactive role. This included ‘Preventive health interventions’ (45.3% of respondents), ‘Mental health assessment / workplace risks’ (43.8%), and ‘Advocating change in workplace legislation / policy’ (37.5% of respondents).

Source: Survey B data

Figure 7: New and potential areas of work for OEPs (n=64)
In regard to psychosocial health, psychiatrists are currently the identified experts in this space but some external stakeholders reported too strong a propensity on the part of psychiatrists to individualise and “medicalise” the treatment and rehabilitation process, a fault sometimes laid at the door of OEPs too. Generally though, and by comparison, despite concerns by some respondents about whether their skill base was adequate for engagement with mental health issues, OEPs were seen as more likely to be able to detect patterns of injury within organisations because of an increased sensitivity and awareness of the impact of systems and the interrelationships between individual players.

In Survey A also a number of respondents (unquantified) saw the need for the OEP role to be more proactive in engaging with other medical and allied health professionals who are working with the same target populations. Rather than relying on vigorous defence of traditional OEM territory, these respondents called for positive engagement and professional relationships, including the potential for expanding into a training and mentor role that would help to bring the standard of occupational medicine experienced by the average Australian and New Zealander to a higher standard than has been achievable to date. This area of practice is discussed more in Section 6 below.

Typical comments supporting this view included:

“She need to support our colleague doctors, including GPs and other specialists.”

“The College should involve itself more in standard setting and endorse of knowledge for non specialist or consultant level medical practitioners. (Similar to UK situation offering peer assessed Licentiate endorsement).”

“Act as a conduit between treaters, workers, workplace & balance agendas for an optimal management plan & outcome for worker & workplace.”

Harper has offered an even more sweeping departure from the current role of OEPs than that considered above (in Figure 7), posing the question “What about the unemployed population?” He notes:

“We are aware that good work is good for health and that unemployment can be detrimental. A major public health role for Occupational Medicine is to work with the unemployed and to address their health barriers to meaningful activity. This activity could be paid work, or volunteering, or regular exercise or social participation, any of which would help prevent chronic disability and adding to the community burden of illness.”

Several Survey A respondents supported this radical re-think of the role from only considering people working or at least tied to a workplace, noting:

“In my view there are great and almost untapped opportunities for us. Assisting people [get into the workforce] who are under-employed or unemployed due to un-managed or poorly managed non work-related medical conditions.”

“We need to look beyond influencing the health of people at work and see how we can utilise our skill set to influence the health of the working age population - look at activity, function and independence.”
One of the moderately supported new areas of practice (28% of Survey B respondents, see Figure 7) is in the area of disability. According to stakeholders there are numerous opportunities both in relation to people with a disability and the growing workforce serving those with a disability.

In New Zealand, there is a fast-growing care sector looking after ageing people and those with disabilities. There are significant emerging risks for this largely unskilled workforce – they often work without supervision and support, workers are often older women (with attendant life stage health issues and risk of injury), the nature of the work carries potential psychological burdens. The same situation in Australia is exacerbated where there may be a potential for more injuries to occur with a de-centralised service delivery model (National Disability Insurance Scheme - NDIS).

For people with a disability, there is an emerging opportunity to use OEM skills in the new Disability Support Pension (DSP) panel arrangements, where the Department of Social Services has recently decided to move away from utilisation of GPs in the assessment and review procedures. There is also an opportunity to be explored within the broader context of the NDIS roll out – a cost-benefit case could potentially be developed in terms of future access to work and socioeconomic improvement.

More generally, workers’ compensation stakeholders have begun to consider emerging risks in relation to work of an increasingly aged worker population (physical and mental limitations to consider) and the impact of an increased chronic disease burden in the population on work capacity and limitations.

From the AMA perspective, and several respondents to Survey A also picked up this point, the biggest emerging issues that have relevance to the skills and interests of OEPs are those associated with an ageing medical / health workforce and how to respectfully and safely accommodate the changing needs of practitioners who are often senior in their fields. To date, however, there has not been a lot of policy discussion about this issue so it is one for potential future focus and collaboration. In terms of psychological injury, the biggest work sector of concern for medical practitioners at present lies within the public hospital sector. This policy issue tends to be handled by specialist medical administrators at present but there may be a role for collaboration on identification of best practice strategies to apply in those settings.

5. Issues of ethics

In answering the survey question on how they should fulfil the College vision (“Striving for excellence in health and medical care through lifelong learning, quality performance and advocacy”), respondents to Survey A largely reflected the overarching principles of the Code of Ethics published by the International Commission on Occupational Health (1992, revised 2012)\textsuperscript{10}.
Similar codes have been published by the American College of Occupational and Environmental Medicine (seven core principles, adapted from an international physician-focussed code published in 2002)\(^\text{11}\), the Occupational and Environmental Medical Association of Canada (based on the aforementioned US code)\(^\text{12}\), the Faculty of Occupational Medicine (UK)\(^\text{13}\) and AFOEM’s own publication – “Guidelines on Ethics and Professional Conduct for Occupational Physicians” (1998)\(^\text{14}\).

All of these codes and guidelines acknowledge the very particular challenges faced by those working in the field of occupational health where the rigours of ensuring impartiality, confidentiality and independence are day-to-day challenges because of the multivariate nature of their client group.

Despite unanimous support for these principles and their validity for the practice of occupational medicine, respondents to Survey A reported considerable disquiet about whether these standards were being adequately upheld across the board. In a number of cases, these concerns were paired with calls for greater emphasis within the Faculty on quality assurance activities (peer review and audit processes).

As noted previously, ethical issues have been most canvassed in regard to ‘independent’ medical examinations, with a questioning of the degree of independence in some third party payment or employer payment situations. Issues of consent and privacy, particularly when assessments are being organised and paid for by employers (and especially when organisations are self-administering their compensation arrangements), have attracted attention from many external stakeholders.

In response to public perception of potential for bias through use of OEPs in a panel arrangement to conduct assessments of NZACC claimants around New Zealand, the NZACC has recently set-up a Vocational Medical Services panel to operate as a peer review mechanism and this is likely to bring a fresh focus on the core issues of Fit for Work.

Like any workforce, there appears to be considerable variation in the quality of services provided by OEPs according to the perspective of union, employer, regulator and insurer respondents. This issue of variation leaves practitioners more widely open to perceptions of bias – if the process is truncated and not transparent, suspicion and distrust is apparently more likely to arise.

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**Box 6: International Commission on Occupational Health – Code of Ethics**

“The purpose of occupational health is to serve the health and social wellbeing of the workers individually and collectively. Occupational health practice must be performed according to the highest professional standards and ethical principles. Occupational health professionals must contribute to environmental and community health.

The duties of occupational health professionals include protecting the life and health of the worker, respecting human dignity and promoting the highest ethical principles in occupational policies and programs. Integrity in professional conduct, impartiality and the protection of the confidentiality of health data and of the privacy of workers are part of these duties.

Occupational health professionals are experts who must enjoy full professional independence in the execution of their functions. They must acquire and maintain the competence necessary for their duties and require conditions which allow them to carry out their tasks according to good practice and professional ethics.”
6. Relationships with other providers

A range of issues arose in relation to this topic. Although OEPs and their core customer/stakeholder groups understand the role of OEM and the value it can offer, there is wide scope for better promotion of the expertise of OEPs and their potential for both more specialised input and a contribution to a far broader set of issues.

Role and relationship with GPs

GPs are at the coalface of interaction with the Australian and New Zealand workforce, under-employed and unemployed population – there is a strong collegiate role for OEPs in providing training and education in evidence-based assessment and treatment strategies for core work-related health issues, and this may even extend to the establishment of formal accredited training options for GPs wishing to develop and retain specific expertise in this area. Stakeholders held a wide range of views about current and potential roles for GPs in relation to occupational health issues.

According to many stakeholders, the whole paradigm of GP and specialist involvement in work-related illness and injury needs re-thinking, with issues to be better addressed including:

a) GP appointment and fee structures are by and large set-up to support brief and individualised consultations. This does not include an examination of the patient’s workplace or any in-depth analysis of the work being performed

b) most GPs have little or no visibility of nor background knowledge of work settings

c) very few OEPs are available for clinical referral as a rule, even if this is thought of as an option

d) referral to other clinical specialists (e.g. orthopaedic surgeons) tend to provide a narrow clinical perspective on an individualised basis (very little capacity for identification of patterns)

e) there will always be a large number of pre- or non-compensable conditions seen by GPs alone, so their management of these cases is critical (e.g. application of early intervention practices to achieve optimal outcomes/avoid sub-optimal outcomes)

f) it can be very difficult for GPs in small communities to provide reports that are adverse to the claimants’ interests and expectations – an OEP assessment can assist greatly in this situation.

There is an under-explored professional role for OEPs in accepting referrals from GPs and other specialists (in consultation with GPs) – this is another way in which OEPs could more effectively promulgate their expertise and build greater awareness of the health, economic and social benefits of successful occupational health interventions. At this time, OEPs are simply not used by GPs for a referral like they refer to most other medical specialists.

One compensation provider recently engaged an OEP to assist them in developing a more active engagement with the Health Benefits of Good Work (HBGW) initiative that has been promoted by the Faculty and this project has included a comprehensive consultation process. This respondent noted that, although many GPs are well informed and supportive of the benefits of the HBGW initiative, this awareness does not seem to be translating into more engagement with employers and more active approaches to early intervention. They have found that unavailability of time, unwillingness to engage with employers, structural patient advocacy role, and lack of ready access to OEPs by GPs and their patients are all factors that tend to conspire against change in practice. This stakeholder has formed the view that there is a need for a general re-think of how all of the roles
connect and add value to achieving the best outcomes for each individual case (i.e. GP, OEP, return to work support person/case manager, claims manager, rehabilitation provider etc.).

Relationship with providers other than GPs

As with many other fields of health care, occupational health is increasingly incorporating a range of allied health and other technical roles – some respondents to Survey A noted the threat that this may pose to future use of the more expensive OEP resource and called for action to find ways to demonstrate the value provided by OEPs. Others noted that this is a worldwide trend and that AFOEM needs to look for ways to engage positively with this development (as has occurred in both the UK and the US).

Within this more competitive milieu many OEPs who responded to Survey A expressed concern that an unclear understanding of what OEPs can do and the value they can add, coupled with the need for cost-cutting by stakeholders, leaves the profession vulnerable to a systemic erosion of OEM where OEPs are being replaced by other, cheaper, health professionals. These replacements may not be adequately skilled to carefully and subtly manage the needs of stakeholders:

“Industry (includes workers, unions, employers and industry associations) should want good advice on prevention and dealing with an issue once systems have failed - generally have a good opinion of us; insurers realise we have expertise which differentiates us from orthopods and other medical specialists and can give well-researched and evidence-based opinions - but I think some of us are more evidence-based than others! [The] general community is clueless about our existence; government has got rid of us as we were an expensive option compared with policy officers and other allied health advisors.”

“The role of the OEP has been devolved into regulations and guidelines so much so that HSE Consultants, paramedics GPs and nurses are now providing the bulk of OEP services; their rigid and rule-based (rather than logic or medicine based) application of guidelines without training in medical context can be a detriment to the health of workers and workforces ("Coke machine" medicine).”

7. OEPs as advocates

Apart from the advocacy roles focussed on promoting the role and benefit of OEM as practised by OEPs, the most significant role proposed via Survey A and consultations is that of advocating to the community more generally on key areas of OEM expertise (e.g. the health benefits of work). A large number of respondents noted the very small portion of the Australasian population (and even smaller proportion of industrialised Third World populations) who get access to the knowledge base held by OEPs. This particularly includes workers in small business enterprises, casual workers, people with work-limiting health or ongoing disability issues, and people who are unemployed.

While there was strong support for further engagement by the OEM profession in these matters, some respondents cautioned against the possibility of becoming too politicised and partisan, which could compromise the important principle of impartiality that underpins normal practice. The literature review undertaken by AFOEM as part of this project, however, highlighted the example of Dr Stephen Levin, an eminent US OEP, who called for less caution on this issue because of extensive imbalance of power that often forms the core of the relationship between workers’ health and the large profits gained by companies as a result of their employment. This is obviously an issue that would benefit from further discussion and debate within the Faculty.
8. Education and training of OEPs

In relation to the specialist training arrangements for OEM, various comments were made by respondents to Survey A with respect to the focus, structure and/or location of training, including:

- the value of hospital-based training for developing a deep understanding of the way the health care system operates and for establishing strong networks and relationships with other future specialists
- as the manufacturing sector in Australasia declines, so too do the number of full-time positions with large companies, and this in turn has an impact on the availability of trainee placements as well as exposure to this key OEM role
- the need for in-depth training in core subject matter so that there can be no doubt that OEPs are the most relevant experts in key occupational health assessment and treatment domains
- whether consideration should be given to adopting a training program that incorporated general physician training, with add-on modules for OEM.

For those who mentioned continuing professional development in their responses, there was unanimous support for its importance and the need for robustness in this area. Some felt that there was scope to develop modules of add-on training for Members who needed to supplement their expertise in certain subject areas, such as environmental medicine, but increased offerings in this realm of training would also be useful for dealing with issues that are emerging as significant, such as psychosocial stress (e.g. in response to bullying) or nanotechnology. Others felt that a Masters degree in public health\(^d\) would provide more robust skills and broader systems understanding that would be of great benefit in effective OEM practice.

A number of OEP respondents called for a renewed and increasing focus by all OEPs on evidence-based practice. This point was relevant in terms of calls for a commitment from all OEPs to lifelong learning and providing patients/clients with the most rigorous and scientifically-based professional service possible. But further to that, a number of respondents called for increased levels of participation in research in order to help build the evidence base that will continue to build the credibility and usefulness of OEPs in the community and the economy. These respondents argued that OEPs are uniquely placed to identify relevant emerging issues and that research undertaken in response to these insights has the potential to allow employers, employees (and their representatives), and governments to achieve greater prevention of harm.

9. Quality assurance

Some respondents to Survey A expressed an urgent need for an increased focus on quality assurance activities within the Faculty, as part of a broader commitment to ongoing improvement within the profession and to ensuring that appropriate standards of professional practice can be relied upon from all specialists who have received the RACP qualification in OEM. Some called for an increased use of audit activities, undertaken within the umbrella of the Faculty, with a quality improvement focus:

“We would benefit by the opportunity to candidly and confidentially discuss our shortcomings and failures with wise and supportive colleagues – a peer support model.”

\(^d\) From the responses it was not possible to discern whether respondents were recommending a Masters degree with or without a thesis.
In some stakeholder responses, frustration was expressed by both employer and employee representatives that there is no adequate recourse for challenging a report’s findings and the professional approach of its author, particularly in situations where there is a strong perception that ethical standards have not been properly upheld (i.e. influence of “hired gun” bias) or there is an inadequate level of detail addressed as part of the assessment process.

For employees, this is usually an issue where an employee has been sent to a particular “panel” doctor, often the doctor has a bundle of documents that are not shown nor discussed with the patient, the assessment is brief, the findings contain opinions on issues that have not been thoroughly assessed nor explained, and there is usually a poor outcome for the worker involved.

There is reportedly also still a propensity for some OEPs to confidently “predict the future” for an individual, often based on very sparse assessment and little engagement with that individual, and little known assessment or understanding of the workplace and its infrastructure/dynamics. This was reported as an issue by both unions and employer representatives.

The AMA published guide for independent medical examinations is supported by the Metal Workers’ Union but unions in general, as well as some business representatives, are frustrated that there is no effective mechanism for reporting apparent poor professional behaviour and lack of adherence to such professional guidance. The AMA does not seem to be able to handle this sort of complaint and Medical Boards are probably a bridge too far as a first port of call.

Both employer and union representatives reported an unfortunate and widespread lack of knowledge and understanding of the relevant legislative frameworks within which many Australian OEPs’ assessment and reporting activities are undertaken – for employers, it means that they can not trust the OEP to properly take into account their legislated responsibilities (therefore increasing the chance that a report can not be acted upon as envisaged by the OEP), and for employees it means that recommendations appear to be made with no or little understanding of the drastic implications that can arise from an opinion that does not carefully consider these issues. Despite this apparent lack of rigour in taking the context into account, according to union representatives such reports can and are pounced on by employers and used to their benefit and as an excuse to “get rid of” an employee rather than remaining engaged and undertaking a more complex adjustment process for return to work.

The literature review process identified the operation of a comprehensive professional revalidation process in the UK, as part of a broader UK approach to assuring quality of medical practice in the UK. This model may be worth examining in more detail for its possible merits in the Australian and New Zealand settings.

### 10. Concluding remarks

The project that the AFOEM embarked upon in 2014 has resulted in a rich body of information, self-reflection and stakeholder feedback, all of which should provide the Faculty with a very useful basis for establishing its priorities for focus in the next 5-10 years. The project has involved two member surveys, a literature review, and a stakeholder consultation process and a large number of Members have contributed extensively to the process to date.

At the conclusion of Stage 2, there was a general sense from AFOEM respondents that the future of OEM is “rosy” but a number of challenges and opportunities had been identified through Survey A responses, focus groups of Members and the literature review. Some of these issues have now been further explored in the follow up Survey B of Members, with a particular focus on the current and
anticipated roles being played by OEPs in Australia and New Zealand and on the issue of the labelling, brand and public identity of the specialty of Occupational and Environmental Medicine.

The results from Survey B showed a stronger preference for the title ‘Consultant Occupational Physician’ which ranked most highly with respondents (average score of 5.8 out of 8). Similarly a preference for one definition for the profession was obtained, but again the difference was marginal. The following definition ranked most highly (4.3 out of 6):

“A physician who specialises in providing medical services to the community and industry in managing the health and wellbeing of people to enhance their health at work and prevent harm to health from occupational and environmental factors.”

The minor differences in preferences suggest that further exploration and engagement with Members will be required on the part of AFOEM to obtain an agreed title and definition of the profession. True consensus, however, may be an elusive goal, because of the varied nature of work, environments and stakeholders of OEM.

In terms of how respondents are employed, a majority (n=26, 43.3%) were ‘self-employed’; looking at ‘self-employed’, ‘Private practice’, and ‘Group private practice’ collectively, then 63% of the total Survey B respondents appear to be working in clinical, direct patient related roles. Most OEPs are also currently working in clinical areas with the top three areas of practice being ‘diagnosis and assessment’ (56 or 84%), ‘medico-legal opinions’ (48 or 72%) and ‘rehabilitation’ (46 or 67%).

Just under 60% of respondents indicated a desire to change their area of practice, with ‘Advocating workplace change’ (26.5% of all respondents), ‘Workplace hazards / risk assessment’ (23.4% of all respondents), and ‘Research and analysis’ (26.5%) being the most common. Respondents were also offered an opportunity to indicate new or emerging areas of practice they might like to work in the next five years; interestingly consulting with ‘GPs and other medical specialist and HSE workers’ ranked most highly (57.8%), followed by ‘Preventive health interventions’ (45.3%), ‘Mental health assessment / workplace risks’ (43.8%), and Advocating change in workplace legislation / policy’ (37.5%).

The information and feedback received from a wide range of stakeholders in Australia and New Zealand (including unions, employer representatives, insurers, regulators, and the disability support sector) was largely very constructive and quite well aligned with many of comments and issues raised by Faculty members. The majority of stakeholder respondents were strong supporters of the benefits that can be derived from high quality, evidence-based, ethical and contextually relevant professional interventions by OEPs. In addition, the project has identified several areas of interest and possible concern that could warrant further internal reflection, investigation and future development as AFOEM refines its strategic directions as the 21st century unfolds.

Two key themes stood out as overarching strengths and benefits in the practice of OEM: 1) the power of a comprehensive, consumer-focussed assessment process underpinned by evidence-based knowledge to achieve fair outcomes for both workers and employers, and 2) the need to continue to be vigilant in relation to stakeholder perceptions of unfairness and bias.

In addition, there was strong stakeholder support for continuation and/or development of the following:

- increasing opportunities for OEM intervention as early as possible in the injury and recovery cycle
- assessment and intervention processes that can be demonstrated as have a positive cost-benefit ratio
- greater clarity and more active promotion of the skills and knowledge (including sub-specialty expertise) that OEPs (collectively and individually) can offer in pursuit of worker health and safe productivity
Occupational and Environmental Medicine at the crossroads: visions for the future

- a commitment to working constructively and efficiently with the range of other professionals involved in contributing to the health and safety of workers
- constructive responsiveness to the emerging requirements of an ageing population, an increasing chronic disease burden and community expectations of greater participation in the workforce by people with disabilities.

Particular challenges that have been identified by both Faculty Members and stakeholder respondents include:

- working collaboratively to find suitable and evidence-based pathways for better including GPs in the management of work-related health issues, acknowledging that the majority of GPs appear to be unwilling to undermine the trust relationship they hold with their patients and have little capacity in the current service and funding arrangements to engage comprehensively with the employer and or the workplace
- continuing perceptions of bias and unfairness on the part of some doctors who are engaged by employers and insurers (and the related issue of how to distinguish the practices of OEPs from other medical practitioners or allied health providers undertaking some form of occupational health assessment)
- the emerging need for more transparent quality management, peer review and complaint handling processes.

In summary, the strategic directions outlined by the Faculty membership in their responses to Stage 1 of this project have generally been endorsed by the key OEM Australian and New Zealander stakeholders who have contributed to Stage 2 consultations. Despite some reported negative experiences along the way, there is a strong desire on the part of unions, employer organisations, compensation and insurance bodies and other consumer representatives to work together to take advantage of the positive contribution that can be made by OEPs in relation to the broad field of occupational and environmental health. The guiding principles that are likely to ensure good progress in this discussion are a continuing commitment to evidence-based clinical practice within a systems-based framework of assessment, ethical involvement of patients/consumers in the assessment and solution-building processes, and an ongoing willingness to become and remain knowledgeable about the specific health issues that can arise in various work settings. Final recommendations to the AFOEM membership on the issue of professional titles will require further consideration.
11. References


Appendix A: Summary of characteristics of respondents to Survey B

<table>
<thead>
<tr>
<th>Respondent characteristics (n=78)</th>
<th>Count</th>
<th>Proportion (%)</th>
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</thead>
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<tr>
<td>Number of respondents</td>
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</tr>
<tr>
<td>Complete surveys</td>
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<tr>
<td>Incomplete surveys</td>
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<td>17.9</td>
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<th></th>
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<td>Trainee</td>
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<tr>
<td>Fellow</td>
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<td>82.1</td>
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<tbody>
<tr>
<td>Female</td>
<td>21</td>
<td>26.9</td>
</tr>
<tr>
<td>Male</td>
<td>57</td>
<td>73.1</td>
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<table>
<thead>
<tr>
<th>Age</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>34 or under</td>
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<td>6.4</td>
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<tr>
<td>35-39</td>
<td>7</td>
<td>9.0</td>
</tr>
<tr>
<td>40-44</td>
<td>4</td>
<td>5.1</td>
</tr>
<tr>
<td>45-49</td>
<td>8</td>
<td>10.3</td>
</tr>
<tr>
<td>50-54</td>
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<td>16.7</td>
</tr>
<tr>
<td>55-59</td>
<td>16</td>
<td>20.5</td>
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<tr>
<td>60-64</td>
<td>13</td>
<td>16.7</td>
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<tr>
<td>Over 65</td>
<td>12</td>
<td>15.4</td>
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<table>
<thead>
<tr>
<th>Country of primary work</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>72</td>
<td>92.3</td>
</tr>
<tr>
<td>New Zealand</td>
<td>6</td>
<td>7.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year of fellowship (n=63)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1980 – 1989</td>
<td>13</td>
<td>20.6</td>
</tr>
<tr>
<td>1990 – 1999</td>
<td>22</td>
<td>34.9</td>
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<tr>
<td>2000 – 2009</td>
<td>20</td>
<td>31.7</td>
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<tr>
<td>2010 – 2015</td>
<td>8</td>
<td>12.7</td>
</tr>
</tbody>
</table>
Appendix B: Survey respondent suggestions for definition of the profession

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>A doctor who specialises in the effects of a worker’s health on capacity for work, and of the effects the workplace may have a worker’s health (for better and for worse).</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>A Specialist Physician who provides medical services to the community and industry in managing the health and wellbeing of people to enhance their health at work and prevent harm to health from occupational and environmental factors</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>A physician who specialises in impact of work on health and health on work.</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>The first definition is reasonable but most are missing the role of the OP in maximising workforce and public safety from the potential adverse effects of medical and psychological conditions and substance use.</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>A physician trained in the prevention, recognition, and treatment of illness and injury arising from exposure to occupational and environmental hazards and the impact of a persons health on their capacity to work</td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>A consultant physician specialised in the prevention, diagnosis and treatment of medical conditions caused by or aggravated by work or the environment.</td>
</tr>
</tbody>
</table>
| **7.** | This is not a "definition" but it is how we could get to a definition:  

To ensure long-term acceptability of the definition and maximum flexibility to cover all roles undertaken, consistency with international definitions of relevance e.g. ILO UNEP WHO AHPRA (the licensing body which is likely to be the ongoing dominant Government agency for Australia) + UK FOM and USA ACOEM.  

The definition should be (a) short (b) broad (c) fundamentally medical, whilst not excluding technical aspects of medical knowledge which distinguish OEM's from other medical specialists (e.g. occupational hygiene, ergonomics, epidemiology, toxicology). It could be in a short summary form, with and expanded detail addendum. The title Registered Specialist in Occupational and Environmental Medicine, is itself a correct description and definition - and sufficient for perhaps 90% of purposes. It is not necessary, for the purposes stated, to be expanded beyond that, except where detail is required. Then a short expansion, followed by a more detailed set of descriptors, could follow the title.  

Remember the old adage: "it is when I strive for brevity that I become unintelligible" ~Horace  
And another: "Horses for Courses"  |
| **8.** | A specialist doctor who specialises in all aspects of the effects of health on work, and the effects of work on health. |
| **9.** | A medical specialist who manages, and/or advises third parties on management of, the biopsychosocial health and health-related risks of individuals and/or groups in the context of their current or prospective work environment, with the goal of improving the health, safety, participation and productivity of the working age population |
| **10.** | A physician specialising in the effects of work on health and the effects of health on work. |
| **11.** | A physician who specialises in work-related diseases and diseases that may impact upon work. |
| **12.** | A physician specialising in the effects of work on health and the effects of health on work. |
Appendix C: Medicare Benefit Schedule items for Consultant Occupational Physicians

<table>
<thead>
<tr>
<th>CONSULT OCCUPATIONAL PHYSICIAN</th>
<th>CONSULT OCCUPATIONAL PHYSICIAN</th>
<th>GROUP A12 - CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial professional attendance of 10 minutes or less in duration on a patient by a consultant occupational physician practising in his or her specialty of occupational medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para A58 of explanatory notes to this Category)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fee:</strong></td>
<td><strong>Benefit:</strong></td>
<td><strong>Extended Medicare Safety Net Cap:</strong></td>
</tr>
<tr>
<td>$64.20</td>
<td>$54.60</td>
<td>$192.60</td>
</tr>
</tbody>
</table>

| CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - SURGERY OR HOSPITAL (Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a referring practitioner) |
|-----------------|-----------------|
| - INITIAL attendance in a single course of treatment (See para A22 of explanatory notes to this Category) |
| **Fee:** | **Benefit:** | **Extended Medicare Safety Net Cap:** |
| $85.55 | $64.20, $72.75 | $256.65 |

| Each attendance SUBSEQUENT to the first in a single course of treatment (See para A22 of explanatory notes to this Category) |
|-----------------|-----------------|
| **Fee:** | **Benefit:** | **Extended Medicare Safety Net Cap:** |
| $43.00 | $32.25, $36.55 | $129.00 |

| CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - HOME VISITS (Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a referring practitioner) |
|-----------------|-----------------|
| - INITIAL attendance in a single course of treatment (See para A22 of explanatory notes to this Category) |
| **Fee:** | **Benefit:** | **Extended Medicare Safety Net Cap:** |
| $125.50 | $94.15, $106.70 | $376.50 |

| Each attendance SUBSEQUENT to the first in a single course of treatment |
|-----------------|-----------------|
| **Fee:** | **Benefit:** | **Extended Medicare Safety Net Cap:** |

Professional attendance by a consultant occupational physician practising in his or her specialty of occupational medicine:
(a) by video conference; and
(b) the attendance is for a service:
   (i) provided with item 385 lasting more than 10 minutes; or
   (ii) provided with item 386; and
(c) the patient is not an admitted patient; and
(d) the patient:
   (i) is located both:
      (A) within a telehealth eligible area; and
      (B) at the time of the attendance—at least 15 kms by road from the physician; or
   (ii) is a care recipient in a residential care service; or
   (iii) is a patient of:
      (A) an Aboriginal Medical Service; or
      (B) an Aboriginal Community Controlled Health Service;
      for which a direction made under subsection 19 (2) of the Act applies

(See para A58 of explanatory notes to this Category)

Derived Fee: 50% of the fee for item 385 or 386. Benefit: 85% of the derived fee
Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or $500, whichever is the lesser amount
### Appendix D: Medicare item reports for Consultant Occupational Physicians, 2010-2015

<table>
<thead>
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<th>MBS item number</th>
<th>State</th>
<th>Total</th>
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<tbody>
<tr>
<td></td>
<td>NSW</td>
<td>VIC</td>
</tr>
<tr>
<td></td>
<td>$Benefit</td>
<td>$Benefit</td>
</tr>
<tr>
<td>2010/2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>385</td>
<td>11,516</td>
<td>4,401</td>
</tr>
<tr>
<td>386</td>
<td>3,541</td>
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<tr>
<td>388</td>
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<td>0</td>
</tr>
<tr>
<td>389</td>
<td>no claims this year</td>
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</tr>
<tr>
<td>Total</td>
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<td>7,125</td>
</tr>
<tr>
<td>2011/2012</td>
<td></td>
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<tr>
<td>385</td>
<td>12,878</td>
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</tr>
<tr>
<td>386</td>
<td>5,161</td>
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</tr>
<tr>
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<td>388</td>
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</tr>
<tr>
<td>389</td>
<td>54</td>
<td>0</td>
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<tr>
<td>Total</td>
<td>18,093</td>
<td>4,412</td>
</tr>
<tr>
<td>2012/2013</td>
<td></td>
<td></td>
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<tr>
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<td>386</td>
<td>6,819</td>
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<tr>
<td>388</td>
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<td>0</td>
</tr>
<tr>
<td>389</td>
<td>161</td>
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<tr>
<td>Total</td>
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### MBS Item Number, State, and Total Benefits

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<tr>
<th>MBS item number</th>
<th>NSW $Benefit</th>
<th>VIC $Benefit</th>
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<th>SA $Benefit</th>
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