

Training in Occupational Medicine: Jurisprudential Malfunctions in the Italian System and European Perspectives

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Abstract

Background. To practice occupational health in Europe, a medical doctor must qualify in occupational medicine. This requires a period of postgraduate specialist medical training lasting a minimum of four years, in conformity with European regulations, to obtain a certificate of completion of training which is then mutually recognized within the entire European Union.

Discussion. In 2002 an Italian law allowed doctors specialized in public health medicine and legal/forensic medicine to also practice as consultants in occupational medicine in the country. However a subsequent law in 2008 determined that only physicians specialized in occupational medicine could freely practice as consultants in this discipline. The other two categories (consultants in public health medicine and consultants in legal/forensic medicine) were required to undertake additional training (a Master course) to qualify as consultants in occupational medicine.

Conclusions. Doctors who entered postgraduate training in public health or legal/forensic medicine before 2008, with the option to practice also as consultants in occupational medicine upon completion of their training, suffered an unprecedented and legally questionable retroactive application of this new law which stripped them of previously acquired rights. Moreover, even after qualifying by undertaking this extra training in occupational medicine, the latter two categories of doctors do not have their training recognized in other member states of the European Union. To disallow the rights of doctors qualified in occupational medicine to work as consultants in the latter medical discipline elsewhere within the European Union seems a clear violation of professional rights and, as such, legal action could be taken to submit this issue to European attention.

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Background

According to the most recent figures the Italian population totals almost 61 million residents, of which 64.78% are of working-age (about 40 million individuals). The employment rate in the working-age population is 55.4% (22 million people circa), with the self-employment rate being 25.1% of this segment (about 5.5 million people) (1, 2). Unlike self-employed workers (vendors, craftsmen, entrepreneurs, etc.), employed individuals are subject to health and safety at work (HSW) regulation (3), the area with which occupational medicine is concerned.

This medical branch - occupational medicine - is established to protect the health of workers from several different perspectives: health protection; occupational hygiene, workplace health promotion; assessment of duty-specific fitness for work; counselling for employers/employees; diagnosis/screening of occupational diseases and work related injuries (4). With regional variation, the Italian government allocates an overall yearly budget of almost 5 billions € on public health activities, with 13.3% of this lump dedicated to HSW (5). In fact, there is evidence that HSW has a positive impact on the efficiency and competitiveness at work, stimulating the smart and sustainable development of high/middle income countries (6). Furthermore health surveillance of workers (by pre-employment and periodic medical checks) significantly contribute to reduce the burden of occupational diseases, work related injuries and sickness absence (6).

All over Europe this surveillance activity is conducted by doctors qualified in occupational medicine, having successfully undertaken a period of postgraduate specialist training lasting a minimum of four years, in conformity with European regulations (7).

In Italy, the postgraduate specialist training in occupational medicine is four years (8).

The current European legislation entails reciprocal recognition of qualifications and free circulation of the health professional workforce across all European Union (EU). If a medical doctor qualifies as an occupational medicine consultant (OMC) in any EU member state, the specialist diploma is then reciprocally recognised within the entire EU (7).

Depending on the political, social and technical development, occupational medicine has been going through considerable changes over the past decades (9) (Table 1). The evolution of the role of the OMC has been boosted by the need to improve occupational medicine as a discipline, considering the unquestionable value of health protection and health promotion - and the multi-factorial risks of work related injuries and occupational diseases, for which environmental exposures also play a major role (10). The importance of health examination of workers has declined over time, in favour of a new professional approach of the OMC, which is now more oriented towards preventative medicine. This process has been accompanied by the growth of new competencies with which doctors are not always familiar, such as community surveillance and multi-disciplinary work. In this way prevention of individual risk factors has become of diminished importance (9).

In view of the above, various bodies - the Faculty of Occupational Medicine (FOM) of UK, the WHO, the International Commission on Occupational Health (ICOH) and the Commission of the European Communities - have recently defined updated training competencies expected from an OMC (11):

- *Communication*: appropriate communication (reading/writing/speaking) with patients, managers and other healthcare professionals; ability to write up a report;
- *Fitness*: assessment of injuries, disability and fitness for work;
- *Law*: advising on occupational health law and ethics;

Table 1 - The evolution of occupational medicine over the years [9]

	DECADES			
	1950-60	1970-80	1990	2000
Goal	Diagnose/preventing disease	Preventing disease/risk	Preventing hazard and risks	Promoting individual health and maintaining work ability
Needs	Legal requirements	Legal requirements	Legal requirements	Stakeholder's satisfaction (including legal requirements)
Focus	Worker	Worker	Worker	Working individual
Approach	Medical diagnosis	Medical diagnosis and risk based	Medical diagnosis and risk based	Risk based and consumer satisfaction
Tools	Medical examination/laboratory exams	Medical examination and bio-monitoring	Medical examination; bio-monitoring; epidemiologic surveillance; information	Questionnaire, bio-monitoring, epidemiologic surveillance, counseling, medical examination (if needed)

- *Hazards*: health assessment in relation to occupational hazards; liaison with other doctors/nurses; assessment of first aid facilities; advising on worksite risk reduction;

- *Promotion*: worksite health promotion;

- *Exposures*: advising on impact of environmental and occupational exposures;

- *Research*: using research methods (analyse/interpret data; literature search);

- *Management*: identify the occupational health needs of an organization; managing an occupational health service.

A survey administered to employees and employers of various private/public organizations has ranked the importance of the above skills as follows: 1) Law and Ethics; 2) Occupational Hazards; 3) Disability and Fitness for Work; 4) Communication; 5) Environmental Exposures; 6) Research Methods; 7) Health Promotion; 8) Management (9, 11).

The above common ground underlying the EU directive 89/391 on HSW – already carved in stone back in 1962 in the Official Gazette of the European Economic Community (EEC) (12) - has been adjusted by each EU member on the basis of individual tenets. As a result, some variation exists between

countries in the role of OMCs and in several aspects of the training curricula to qualify as OMC (13, 14).

In most Northern European countries (Sweden, Ireland, Finland, UK, The Netherlands, Denmark) and Spain, OMCs have the same duty of care towards individual patients/workers as any other clinical specialty. Therefore in addition to preventative activities - such as HSW, risk assessment, fitness for work evaluation, counselling of employers/employees – OMCs also play a role in curative care of employees, including clinical activities such as diagnosis of occupational diseases, vaccination coverage of employees, work adaptation and rehabilitation of workers with illnesses and disabilities (15-19). Occupational specialists in the US also cover similar functions (20). In all other EU countries, particularly in Southern Europe (Germany, France, Greece, Slovakia, Slovenia, Switzerland, Italy, Austria, Belgium, etc.), OMCs work primarily in a preventative capacity (15, 21).

Notwithstanding, the reciprocal recognition of medical specialties within the EU members makes it necessary for OMCs to acquire adequate competencies to enable each EU member state to award a

certificate of completion of training (CCT) in occupational medicine reflecting shared training curricula across the EU (13).

Occupational Medicine in Italy

Considering the above changes, many Italian occupational medicine departments have gone through considerable cuts in recent years (9, 22). Accordingly, hospital wards for occupational diseases have been suppressed even in big trusts, with the clinical management of occupational diseases now being the responsibility of other medical specialists (dermatologists, pulmonologists, etc) and with OMCs being accountable for diagnosis or screening only. Very few referral centres for occupational medicine exist in the country - normally within big University hospitals - to provide second level ambulatory consultancies for particularly complex occupational cases. Similarly, in Sweden OMCs – different from occupational health consultants (OHCs) – work in university hospitals dealing with the clinical management of complex referral cases and performing research/teaching activities. The Swedish OHCs are rather employed in corporate health centres dealing with HSW as well as primary, secondary and tertiary prevention (18). A specific sub-section of OMCs called “*Medico Competente*” (MC) – with similar functions as Swedish OHC - was introduced in Italy to define Italian doctors responsible for HSW (23). However, whilst in Sweden and most European countries OHCs are hired or employed by health & safety firms providing the clients with a combined preventative health service, Italian MCs are instead usually self-employed doctors, hired by individual firms and employers (1, 18, 24).

The occupational health surveillance conducted by Italian MCs should be distinguished from the function of vigilance and inspection of worksites, which is responsibility of OMCs employed by public

health departments, and whose task is to supervise the observation of national policies of HSW in the workplaces located within the territorial area of each local health unit (LHU). Public health departments are also responsible to supervise and investigate MCs for their activity in health surveillance of workers and in support of the employer; areas subject to criminal accountability (3).

Considering that the background of MCs covers the core competencies described above (11), an Italian law which came into force in 2002 determined that medical doctors allowed to practice as MCs included not only those specialized in occupational medicine, but also consultants in public health medicine and legal/forensic medicine (25). The rationale of this political decision was grounded on the postgraduate curricula of the latter two categories of doctors, which include key HSW skills, such as extensive training in epidemiology, environmental risk assessment, health surveillance and health management (25).

However a recent law, the Legislative Decree 81/2008 (D.Lgs. 81/2008), promulgated in 2008 (3), then changed the scene. On one hand the D.Lgs. 81/2008 reinforced the importance of surveillance, workplace prevention and HSW, on the other it restricted the eligibility to freely practice as MC in Italy only to physicians with the specific post-graduate specialist qualification in occupational medicine. For the other two categories (consultants in public health medicine and consultants in legal/forensic medicine) an integrative training (a one year Master course in occupational medicine which was planned after the D.Lgs. 81/2008) is now required. This Master course must be organized only by Italian universities with departments in occupational medicine and with professors and academic educators in that discipline. The first Master course in occupational medicine was set up in 2011, 3 years after

the D.Lgs. 81/2008 above quoted. Leaving aside the serious delay in the application, the above mentioned law was detrimental for the previous two categories of specialist doctors to qualify as MC and thus to be able to practice in the country.

Discussion

Italian universities are free to organize these Master courses and it is up to the respective deans in occupational medicine at each academic centre to decide whether to organize them or not, and this has inevitable negative consequences from a logistical point of view. In fact, mostly universities in Southern Italy have been active in setting up these Master courses thus far. The only exception in the North of the country is the University of Pavia, which established a Master course in 2011. Some authors have argued that these logistical barriers are likely the aftermaths of corporative obstructionism. Limiting business competition may be interpreted as a means to protect a lucrative revenue source for the medical profession (12, 26, 27).

Nonetheless, a deep reflection is recommended not just regarding formal academic regulations of this integrative training (subjects treated, contents, teaching time, final dissertation, etc.), but rather the factual acquisition of the competencies necessary to practice as a MC. Although this topic is too long and complicated to be discussed here, it is important to stress that the program of these master courses is designed to integrate the existing curriculum of consultants in public health medicine and legal/forensic medicine with the required elements to qualify also as a MC. Furthermore, for particular categories of MCs, such as those employed in healthcare institutions, consultants in public health - whose training portfolio already covers areas of health protection related to biological

and chemical hazards - may find this extra training provided by the above Master course in occupational medicine to be redundant (28, 29).

All in all, the economic damage has concerned a category of doctors who had entered postgraduate training in public health or legal/forensic medicine before 2008, and therefore before the D.Lgs. 81/2008, particularly those who were still in specialist training at the time the above quoted law was issued. These doctors, who had the option to practice also as a OMC upon completion of their postgraduate specialist training, were stripped of legitimate previously acquired rights, thus suffering from the unprecedented retroactive application of this new law (D.Lgs. 81/2008). Indeed, it can be reasonably assumed that these physicians had chosen to specialize in public health or legal/forensic medicine on the basis that they would then be eligible to work also as an OMC. For this reason, a number of doctors decided to bring this case to court, with controversial and inconclusive outcomes that were reached only after 4-5 years of legal dispute (30, 31).

Under the current state, a form of professional discrimination still goes on for these doctors specialized in public health medicine or legal/forensic medicine who, after successfully passing the admission test have to undertake - at their own expense - this extra training explained above. Moreover, albeit becoming eligible to work as MCs in Italy, where they hold exactly the same professional rights - both in the private as well as the public sector - as their colleagues with postgraduate specialist training in occupational medicine, no CCT is issued to them by the Italian government. This type of document - approved by an Italian court - is essential to allow inclusion in the specialist register of occupational medicine of all EU member states.

Since the Italian four-year postgraduate training in occupational medicine is mutually

recognized within the entire EU (7), and considering - as explained above - there are alternative recognized routes to qualify as MC, thus achieving exactly the same professional status as an occupational medicine specialist in Italy, an integrative legislative revision is required to fill this gap and eliminate what seems to be a clearly unjustified professional discrimination. Of course this necessary legislative revision should also extend to doctors previously qualified as MC by Art. 55 of the Legislative Decree 277/1991 (D.Lgs. 277/1991), a norm allowing physicians without any post-graduate specialization to qualify as MCs provided they were already practicing occupational medicine by August 1991, when D.Lgs. 277/1991 was issued (32). The rationale of the latter norm relies upon the implicit acknowledgement that the acquisition of the necessary professional competencies to practice as an OMC can also be achieved by practical experience outside formal academic settings. An eloquent example in this view is provided by the United Kingdom, where the FOM similarly confers memberships (therefore full eligibility to practice as OMC) outwith approved specialty training if a doctor provides evidence of four years full-time (or equivalent pro-rata) practical experience in occupational medicine (16).

ConclusionS

The above questionable barriers to shift from one medical specialty into another sister medical branch - not infrequent in the Italian system - can be considered a form of corporate protectionism (23, 27). The main thesis against the "intrusion" of consultants in public health medicine and in legal/forensic medicine into the practice of occupational health has been the difference between their clinical training portfolio as compared to that of occupational medicine

specialists (who go through some rotations in secondary care such as internal and emergency medicine) (15, 26). However, similarly to other countries (e.g. UK, Austria, Ireland, Germany), if there is evidence that the medical practitioner has already achieved some or all the relevant competencies required in a particular medical specialty (by practical experience or by training in another medical discipline with common trunk) this needs to be acknowledged and doctors should be given the opportunity to fulfill the outstanding curricular gaps by undertaking shorter integrative training in order to qualify also for this new specialty (15-17). For instance, additional recognized training in occupational medicine is provided in Germany to other clinical medical specialists, in Austria to general practitioners and in the Republic of Ireland to generalists to enable all these categories of doctors to qualify also in occupational medicine (15, 21). This implicitly demonstrates a rather constructive and inclusive approach by the Austrian Academy of Occupational Medicine, the German Federal Chamber of Physicians and the Irish Faculty of Occupational Medicine. Moreover, as mentioned above the FOM of the UK elects as fellow a doctor with 4 years experience in occupational medicine outside formal academic routes (16). In the Italian system however, changing medical specialty always implies re-training from the start, which does not make sense. The one year Master course in occupational medicine (which includes also elements of clinical medicine) is designed to qualify consultants in public health medicine and legal/forensic medicine also as MCs (by D.Lgs. 81/2008) (3). If this integrative clinical training is still deemed "insufficient" by the occupational medicine unions to equalize these medical consultants with occupational medicine specialists, instead of a meaningless discriminatory approach, focus should be placed on providing training pathways to enable the latter two medical consultants to

perfectly match the professional profile of occupational medicine specialists.

Disallowing OMCs to work elsewhere within the EU is a clear violation of professional rights. As things stand currently, this case as such could be brought to European attention. For doctors recognized as specialists in an area of medicine in one member state of the EU, the same recognition should apply in other member states.

Similar situations in the past have involved another category of Italian doctors, i.e. physicians who were qualified to work as general practitioners in Italy without specific training in primary care, provided they completed medical school before 1994, the year when postgraduate training in primary health care was made mandatory in Europe (33, 34). Moreover, Italian medical doctors starting medical school before January 1980 (when a dental degree separate from the medical degree was established in the country) were allowed to practice dentistry in Italy (35). Lastly, as mentioned above, until August 1991 doctors could freely continue to practice as OMCs without any further post-graduate specialization by Art. 55 of D.Lgs. 277/1991 (32). Different however from what occurred to consultants in public health medicine and legal/forensic medicine, those doctors practicing dentistry and primary care were not subject to retroactive application of a new more restrictive law. Only doctors qualified or registered after the new laws went into effect encountered professional restrictions, whereas the others were allowed to continue working under their previously acquired rights, without specific further training in addition to the medical degree, both within Italy and in any other member state of the EU. In similar fashion, the same rights should also be applied to Italian doctors wishing to practice as OMC in other EU member states, if they qualified as MCs by art. 55 of D.Lgs. 277/1991, or if they entered postgraduate specialist training in public health medicine

or legal/forensic medicine before 2008 (i.e. before the introduction of D.Lgs. 81/2008), or alternatively after 2008, provided they qualified as a MC by undertaking the above specific Master course in occupational medicine.

On these grounds an appeal to the European Court is a realistic consideration. In the context of a highly inter-connected Europe any aspect at a country level has in fact inevitable relevance abroad. In this fashion, the resolution of an Italian legal and corporate controversy, as described above, could be extremely useful to address similar situations in other European settings.

Riassunto

La Formazione del Medico Competente: Vizi Normativi in Italia e Prospettive Europee

Background. L'esercizio delle funzioni di medico competente in Europa presuppone una formazione medica specialistica post-laurea. La normativa italiana prevede un percorso di formazione specialistica post-laurea della durata minima di quattro anni in accordo con le direttive europee, al fine di ottenere un diploma di specializzazione che è poi riconosciuto nell'intera Unione.

Discussione. Nel 2002 una legge Italiana ha stabilito che anche i medici specialisti in igiene e medicina legale fossero abilitati all'esercizio delle funzioni di medico competente in Italia. Tuttavia, una successiva legge promulgata nel 2008 (D.Lgs. 81/2008) ha cambiato il quadro, stabilendo che solamente i medici con formazione specialistica post-laurea in medicina del lavoro erano legittimati al libero esercizio delle funzioni di medico competente. Le altre due categorie di medici (gli specialisti in igiene e medicina legale) sono ora tenuti ad un'ulteriore formazione post-laurea - un master universitario di secondo livello - per ottenere l'abilitazione all'esercizio delle funzioni di medico competente.

Conclusioni. I medici che hanno iniziato la scuola di specializzazione post-laurea in igiene e medicina legale prima del 2008 (cioè prima del D.Lgs. 81/2008), con l'opzione di poter esercitare anche come medici competenti al completamento del loro percorso formativo specialistico, sono rimasti vittime di un'applicazione retroattiva e, pertanto, ampiamente dubbia sul piano del diritto e comunque senza precedenti. Il decreto legislativo (D.Lgs. 81/2008) di cui si parla ha privato quei medici di diritti acquisiti. Inoltre, anche dopo aver otte-

nuto l'abilitazione all'esercizio delle funzioni di medico competente attraverso il succitato percorso integrativo di formazione master, gli specialisti in igiene e medicina legale non vedono la loro qualifica riconosciuta negli altri paesi membri dell'unione europea. Anche in questo caso è chiara la violazione dei diritti lavorativi e questa controversia dovrebbe essere portata all'attenzione della corte europea.

Declarations section

List of abbreviations:

EU= European Union

D.Lgs. 81/2008= Legislative Decree N. 81/2008

LHU=Local Health Unit

OMC= Occupational Medicine Consultant

MC= *Medico Competente*

OHC=Occupational Health Consultant

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