Occupational health doctors in France – an endangered species

Wearied by never-ending reforms, swamped by a soaring workload and ever-expanding duties, undermined by lack of recognition of their speciality by society, the state and the wider medical community, occupational doctors, especially younger medics, may start looking for a change of career.

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Renault's occupational health service provides smokers who work at its HGV manufacturing plant with chewing gum kits.
Image: © Belga

"Some colleagues I've talked to say, *The reform is a worry; if it doesn't suit, we'll change professions*. I sometimes think I could do with a change of career, but I'm not yet ready to just drop occupational health", vouchsafed one occupational doctor in a professional publication[1]. France's occupational doctors have latterly been taking to blogs, reports issued to the press, and attention-grabbingly titled books to voice the disquiet besetting their profession (see: More information p. 22).

According to official figures at 1 January this year, France had 5 694 occupational doctors comprised of 4 011 women and 1 683 men[2]. At 54.8 years, occupational doctors have the highest average age of all of medical specialities. The average age of occupational doctors in the Centre and Poitou Charentes regions even tops 57 years. As things stand, nearly 75% of occupational doctors are aged fifty and over.

And the projections are sobering. A Ministry of Health study predicts that the numbers could shrink by 62% between 2006 and 2030[3] with mass outflows to retirement in coming years not being offset by new inflows as fewer medical students find their calling in the profession.

These figures show the scale of the demographic challenge for the secure future occupational health surveillance of workers in general. It is partly in a bid to address this looming shortage that the Ministry of Labour has for almost two decades been working on a major reform of the occupational health system. Why is it still not yet done? In France, occupational health services remain a highly political issue and an arena of contention which broadly pits two diametrically opposing approaches – a health service that serves workers and one that serves the economy – against one another.

It all started in Vichy...

To understand these tensions, we must go back to legislation passed by the collaborationist Vichy government in 1942, when medical services were first imposed on business[4] with the intent of identifying French workers fit to perform the infamous "compulsory work service", i.e., being shipped off in their hundreds of thousands to Germany to replace the German workers sent to fight on the Eastern front.

After the Liberation, the newly-appointed Minister of Labour, Communist MP and former metalworker Ambroise Croizat, sought to make the occupational health services tainted by Vichyism palatable to workers. In 1946, he steered through parliament a new law on occupational health services based on Republican principles like universality ("occupational health services are for all employees"[5]). This Act spells out the remit of the occupational doctor: "The occupational doctor has a purely preventive role. It is to avoid any deterioration in workers' health by reason of their work, in particular by superintending their hygiene at work, the risks of contagion and their health".

In short, a system meant purely to serve workers, but in which the idea of medical selection of labour persisted, especially through the provision for checking workers' fitness. The imperative post-War need for reconstruction, a prerequisite for which was the preservation of "industrial harmony", and a new government minus the Communists, worked against the law being implemented in line with its initial ideals.

Almost seventy years on, the 1946 Act remains the cornerstone of the Republican, "French-style" approach to occupational health services. "The French system is based on the principles of the Constitution of the Republic which make protection of workers' health a basic function of the state, and tasks occupational doctors with carrying out that public policy remit", argues Alain Carré, one of the organizers of "Santé et médecine du travail" a coalition formed to oppose the marketization of occupational health services.

In some professionals' view, the grindingly slow reforms started in the 1990s to meet the requirements of the EU's 1989 Framework Directive on health and safety at work are throwing this model into question.

Multidisciplinarity: hopes and mix-ups

Under pressure from the European Union[6], France made changes in 2000 to give a more multidisciplinary steer to its occupational health system, rebranding occupational health services as "health and safety at work" services. The idea is to deliver real primary risk prevention by buttressing occupational doctors with other professionals like specialised occupational health nurses, occupational health assistants and specialists in other fields (ergonomists, toxicologists, metrologists, psychologists, etc.) known by the acronym "IPRP" (intervenants en prévention des risques professionnels – occupational risk prevention operators). "Multidisciplinarity", which is the main focus of occupational health service reforms in France, has been beset by numerous difficulties in practice. Dissatisfied with how it was being implemented, the government sought to bolster it by passing new legislation in 2011.

"We believe the whole thing stems from a misconception. The government saw multidisciplinarity mainly as a way of addressing the shortage of occupational doctors. But we think the opposite – that multidisciplinary working cannot be seen as a response to the shortage of occupational doctors. Our organization has always favoured the multidisciplinary approach but as a means of improving prevention purely for the benefit of employees. In services with an acute shortage of doctors, the introduction of multidisciplinarity has been disastrous", says Mireille Chevalier, Acting General Secretary of occupational health professionals' union Syndicat national des professionnels de la santé au travail (SNPST).

1. Jégou Fl. (2010) Le désarroi d'un médecin du travail face à la réforme, Les Cahiers S.M.T., 24, May 2010. www.a-smt.org
2. La démographie des médecins. Répertoire partagé des professionnels de santé, Direction de la recherche, des études, de l'évaluation et des statistiques (Drees), ministère des Affaires sociales et de la Santé. www.drees.sante.gouv.fr
3. Attal-Toubert K., Vanderschelden M. (2009) La démographie médicale à l'horizon 2030 : de nouvelles projections nationales et régionales, Études et Résultats, Drees, 679.
4. Initially, only on firms with more than 50 employees.
5. In fact, the 1946 Act makes occupational health services compulsory only in private sector firms. They were not extended to public service employees until 1982. See Buzzi S., Devinck J-C. and Rosental P-A. (2006) La santé au travail. 1880-2006, La Découverte.
6. The European Commission started infringement proceedings against France for failure to transpose Article 7 – protective and preventive services – of the 1989 Framework Directive on health and safety at work into national law.

Sociologist Pascal Marichalar, who wrote his doctoral thesis on occupational health services in France[7], argues that multidisciplinarity is a revisited technocratic approach to workplace health issues that reflects the employer's agenda. "The way in which multidisciplinarity has been implemented is often little more than the technicization of prevention and a shift from a medical practice-based approach and relationship to the employee, with the idea that getting workers to talk about their work is the quickest way into the reality of work, to a technical approach disconnected from workers themselves where the sole focus is on the work environment", he told *HesaMag*.

The gradual introduction of multidisciplinary working also raises questions about the independence of IPRPs. Alain Carré believes that IPRPs are ambiguously situated: "Looking at the European legislation, their job is to support the employer. I have found that industrial psychologists in particular were unsure whether they should be siding with the employer or the workers. Also, unlike occupational doctors, they are not classed as employees with protection from dismissal which leaves them more exposed to pressure from employers".

Working on his thesis, Pascal Marichalar came to realize what limited discretion these new operators in prevention had: "to get to see an occupational doctor, I just contacted them directly, and they readily gave interviews in work time. Every time I contacted an IPRP, they asked me to wait because they had to get management approval. I had to submit the questions I was going to ask to a senior manager. In some services, I noted that the IPRPs' offices were directly facing the managers' offices, so there was a de facto check on what they were up to".

Parity for show

As well as widening the range of players involved in occupational health through multidisciplinarity, the 2011 Act also seeks to bring parity to the boards of directors of intercompany occupational health services[8], which have long been the sole preserve of employers. They must now have equal numbers of employer and trade union directors. Many observers, however, see this as parity for show because the chairman of the board, who is always chosen from among the employers, has a casting vote in the event of a tie.

"The trade unions were deposited in a management system and can't get to the point of having quality demands. Where health and safety at work are concerned, it perpetuates a system of trade unions in a negotiation mindset with health on one side and jobs on the other side of the scales", observes Mireille Chevalier. "Occupational health should never be up for negotiation", protests SNPST representative and current General Secretary Jean-Michel Sterdyniak.

The 2011 Act also requires all intercompany services to draw up a "multi-year service plan" that sets the service priorities and is meant to be the link between government health and safety at work policy and the daily work of occupational health services. Jean-Michel Domergue has put a lot into drafting this document for his intercompany service based in Créteil (south of Paris). "We started from scratch and painstakingly worked up a plan that has ended up not much short of 200 pages", he enthuses. The document assigns each (full-time) occupational doctor a maximum 2 800 employees and sets out the multidisciplinary team's consensus view on how consultations should be organized and even ways of improving the traceability of work-related exposures.

While writing the document was an opportunity for Dr Domergue and his colleagues to re-examine their practice, discuss the profession, in a word, look with fresh eyes at the meaning of their calling, most turn out to be just tick-box exercises. "Most often, the plans have been written by the manager or chairman of the board of directors," admits Dr Domergue.

Commercial pressure

Commercial pressure is the biggest threat of all to good occupational health service practice. "We are pulled by conflicting requirements: doctors are asked to do increasingly more things, especially in terms of exposure traceability, at the same time as dealing with

"In services with an acute shortage of doctors, the introduction of multidisciplinarity has been disastrous."
Mireille Chevalier

7. A version for the lay reader was recently published: Marichalar P. (2014) Médecin du travail, médecin du patron? L'indépendance médicale en question, Presses de la Fondation nationale des sciences politiques, 184 p.
8. The very great majority of employers discharge their health and safety at work obligations by joining an intercompany occupational health service (SSTI). These services are responsible for health surveillance of 94% of the non-agricultural private sector working population. A limited number of private companies, usually very large groups, have their own health service, known as "in-house services".

A late but committed calling

For twenty-odd years, Dr Nicole Vigneron was a GP in private practice. Fifteen years ago she decided to stop being a general practitioner and retrain as an occupational doctor. "An occupational doctor friend said, 'Why not go into occupational health? I think it would suit you'. The problem was, I had a very negative perception of it. But she managed to talk me round".

Nicole Vigneron sat the special medical residency exam in occupational health – the so-called "European competition" – which allows a qualified doctor to recycle into that speciality after two years' training.

"I absolutely loved occupational health from the word 'go' because it added so much to what I had done in general practice. I found it very complementary in that it made me recall diagnoses that I hadn't made", she says enthusiastically.

It was hard going to start with, however. She was taken on as a fixed-term contract worker in the state civil service. It was not long before she observed major health problems with civil servants in one department. Her attempts to bring the situation to her employer's notice were not well-received. "I was quickly given to understand that it was none of my business. When you tell an employer about the health risks going on in his business – whether public or private – they take it as an accusation and tend not to listen", says Dr Vigneron.

Relations with her public sector employer went rapidly downhill and she was let go. "They padlocked my door. I never imagined it could get that extreme", she recalls, still visibly scarred by the ordeal. "Half the employees signed a petition to keep me, so that was nice at least".

After her dismissal, she was immediately taken on by a Paris-based intercompany service for its medical centre on the Champs Elysees – a high-end district where she attended to employees of ready-to-wear clothing, cleaning and hairdressing businesses and a big finance industry concern.

The fact of working and being able to discuss with colleagues strengthened her commitment to defending to the hilt her view of her chosen profession.

"Independence – you have to claim it, then keep it", she says, referring to an initial face-off with the management of a company affiliated to her health and safety at work service. "In my annual report, I flagged up a number of problems, including impossible work schedules, health problems developing due to extreme employee fatigue, cases of high blood pressure in a workforce with an average age of 25. The employer said I couldn't justify this because I hadn't seen enough people. You only have to announce something that the firm doesn't like for it to hide behind the rules, saying, 'that's not on – you don't make enough visits, you spend too much time with the employees when you do'", says the occupational doctor.

"The health and safety at work service is still an employer's service. They say: 'Doctor, the fact is that you aren't getting enough done. You just need to get a lot more done. Simply put, they want us to shoot through it, and I won't do that. I want to take some time with each employee because even if I don't see them all, it gives me a better understanding of the business so I can help it identify and then reduce the risks".

Having learned lessons from her time in the public sector, Nicole Vigneron challenged the company's decision to change their occupational doctor. She demanded that the company's works council (EC) should take a decision as the regulations provide. Despite support from one union rep who had herself suffered from problems related to her working hours, the works council took the employer's side. Dr Vigneron referred the matter to her intercompany service's supervisory committee – a body of employer and employee representatives drawn from member companies and occupational doctors elected by their peers, and chaired by the chairman of the intercompany service's board of directors. The first vote upheld the company's decision. "That first meeting was not held as per the rules. So I decided to challenge the decision" says Dr Vigneron. A second vote went in her favour, but she keeps the company only "on paper" since the head of the intercompany service stood by his decision to hand it to one of her fellow doctors.

> "Independence – you have to claim it, then keep it."

The dogged resolve shown by Dr Vigneron is very rare. Most occupational doctors would rather "lose" a firm than embark on a protracted battle that will set them at odds with their employer. "Looking back, I understand them, because it is immensely wearing and tiring to stand up for your rights. You would not credit the pressures I have come under, summonses to meetings and remarks like: 'Doctor, it's just you in this situation'".

Never particularly militant, Nicole Vigneron joined a union in order to stand at the workplace elections. She is now a staff representative and member of the works council for her service. She is also the doctors' nominee on the board of directors and the supervisory committee. "I was elected by my peers. So that counts as some recognition of what I did", she emphasizes. "I'm trying to urge the others to stand up a bit, to stop being afraid."

*In workplaces with more than 300 employees, the occupational doctor writes a company-specific annual activity report which is submitted to the works council and health and safety committee.

"Employers can easily run tactical rings around trade unionists."
Alain Carré

Propaganda poster for the compulsory work service (STO). The July 1942 Act introducing works medical services in France would be used to implement the STO.
Image: © Belga

a growing number of people. We have to select just a number of employees to follow-up. Companies that have paid a fee feel aggrieved if not all medical consultations are held. And as my service continues to sell medical consultations ...", complains Serge Opatowski, an occupational doctor in a Paris intercompany service.

"Intercompany services make an informal division of work between the medical part of the business which employers recognize they have no right to interfere with, and the service organization and administration part, in particular occupational doctors' work schedules which they feel they have the right to set themselves. But setting these work paces has an impact on the content of work, especially workplace visits[9] which are the poor relation of occupational health services", argues Pascal Marichalar.

In a minority of one

The Labour Code may afford occupational doctors some protection against dismissal or re-assignment, but in reality it is exceptionally hard for a doctor to withstand pressure from a disgruntled employer (see Box *A late but committed calling*) – particular so when support from employees and union reps is not forthcoming. The employee-occupational doctor relationship is underpinned by probably more complex mechanisms than those that determine that with the employer.

Various of the seven occupational doctors interviewed for this investigation pointed to a lack of training or occupational health culture and a more general lack of strategic vision among employee reps on CHSCTs[10]. "There is a high degree of naivety among the trade unionists. Employers can easily run tactical rings around workers reps with the old pals act", observes Alain Carré. Doctors have also reported getting no support from worker reps on CHSCTs after initiating a notification procedure[11] following serious deteriorations in workers' health. Without guaranteed support from workers' reps, many occupational doctors give up the solitary fight.

The unions have always harboured suspicions about occupational doctors, often seeing them as closer to the employer. Jean-Michel Domergue explains this in sociological terms: "Not many occupational doctors come from working class communities, so they naturally feel closer to management than workers".

Alain Carré also sees a sense of class identification, but believes the problem in building a relationship of trust with workers lies with the fitness notice[12]. Like most occupational doctors' associations, he wants it scrapped as a hangover of the medical selection of workers practiced in the early days of company health services[13]. Figures from a study done in the Vaucluse département[14] showed that issuing a notice of unfitness results in almost every case in the worker losing his job, which is clearly not calculated to endear a worker to his occupational doctor. ●

More information

Ehster J.-M., **Funds H.** et **Zimermann N.** (2010) Menaces sur la santé au travail. Des médecins parlent, éd. Pascal Galodé, 183 p.

Fernandez G. (2009) Soigner le travail. Itinéraires d'un médecin du travail, Erès, 254 p.

Ramaut D. (2006) Journal d'un médecin du travail, Le cherche midi, 176 p.

For the past twenty years, a group of occupational doctors in Bourg-en-Bresse (eastern France) has published an annual report of anecdotal evidence from doctors about the difficulties encountered in daily practice. These alarmingly-titled documents ("Le désastre", "Apocalypse Now", etc.) are available on: http://collectif-medecins-bourg-en-bresse.over-blog.com

Carnet d'un médecin du travail is a sporadically-updated blog of personal thoughts from an occupational doctor http://medecindutravail.canalblog.com. See also Box *Blogging to cope.*

9. Since 1979, occupational doctors have had a statutory requirement to spend a third of their working time on workplace visits (for job analysis, observing work done for risk assessment, etc.). It is a requirement very rarely fulfilled for want of time.
10. Health and Safety Committees (CHSCT) are the main bodies responsible for protecting workers' health and safety in firms with 50 or more workers.
11. The July 2011 health and safety at work reform introduced a new provision requiring an occupational doctor who establishes that a risk to workers' health is present to make a written and substantiated proposal for measures to preserve it. The employer must take the proposals into consideration and if he rejects them, must give a written statement of the reasons for which no action can be taken on them.
12. After a medical examination, the occupational doctor issues a notice of the employee's fitness or unfitness for his work.
13. Carré A. (2013) Inaptitude, un piège à désamorcer : en finir avec «l'aptitude», Les Cahiers S.M.T., 27, October 2013. www.a-smt.org
14. The study by doctors working in intercompany services showed that 90% of employees declared unfit were eventually dismissed. Only 23% found employment again. Coll. (2008) Devenir des salariés licenciés suite à une inaptitude au poste de 2002 à 2004 en Vaucluse, 53 p.

Blogging to cope

Since 2005, an occupational doctor posting under the handle Sentinelle (sentinel) has been blogging, often humorously and always empathically, about the problems of workers she meets on her medical visits. She tells us about Tania, a 50-year-old building caretaker fired after a work accident (in fact, an assault by one of the building occupants) and Patrick, a maintenance worker at breaking point after yet another humiliation. Or the working conditions of manual workers in the ready meals industry and those – basically little more enviable – of managers on the brink. "Consultations are increasingly becoming somewhere to talk about the violence of the work world in confidence", she wrote in May 2013.

Above all, Sentinelle tells it like it is. Scrolling through the "Archives" section of the blog gives a clear picture of the idealistic young practitioner.

"The dictionary definition of a sentinel is a soldier or guard whose job is to stand and keep watch for the enemy, prevent surprises, and stop those seeking entry without permission and without identifying themselves. The sentinel must remain at his post whatever happens unless relieved by his officer", she wrote in September 2005, explaining her choice of pseudonym.

Her initial enthusiasm soon gave way to questions and increasingly severe doubts. She queries where the profession is heading, its contradictions and before long, on the point of her own practice.

"Occupational doctors are still forever begging for the unique risk assessment documents that haven't been written or stuffed away in cupboards and not updated; they are forever being told that they are not doing their job of making periodic visits when no-one in a number of firms asks them to help improve workplace prevention. Their job is to tick boxes like the new fitness sheet", she wrote in her last blog, which dates back to October 2013.

"I started this blog with a vision of a shop where you put a number of things in the window to showcase the profession. Today, I see more dead ends than ways forward. It gets you down. It's unpleasant to think there's nothing you can do", she said on the phone last July.

Asked about what led her into occupational health, Sentinelle, as in her blog, tells it straight: "I really wanted to be an A&E doctor. I had to give it up because the job didn't fit with children and a family life". Working in occupational health guarantees set hours, a 35-hour week and job security. "When I started out, I imagined a routine, same old-same old job. I found something else entirely – a fascinating and enthusing job. There aren't many places where you talk about work. You don't talk about it with friends or your partner – after a while, they get fed up with it – with your GP, who sees around 45 patients a day, you might as well forget it", she says.

"My office is a place where you can untangle work stories. I try to see how working conditions can make them suffer. I get them talking, try to see where the rub is. The person opposite me might fumble for words, break down in tears, sometimes", she reflects. "But I'm not there to act as a psychologist. I have to make decisions so as to fulfil our mission of preserving health", she cautions.

To ensure that she does a proper job, Sentinelle, who works 4/5^{ths} time for her children, decided to do no more than 1 500 visits a year, whereas intercompany services often push their occupational doctors to see at least 3 000 workers each year. "The Code of Medical Ethics says that occupational doctors cannot work to dictates of profitability. If some day they force quotas on me, I will pack it all in. Happily, medical independence is fairly well respected in France".

After nearly ten years in the profession, Sentinelle is wondering what direction to give her career. She often feels powerless, such as when the employer she is seeing is himself deeply upset at having to implement decisions taken thousands of miles away. Such situations, which she describes as "blind alleys", have increased with the globalization of the economy. Asked about her personal future and that of her profession, she dodges the bullet: "The important thing is why we stay". Despite the difficulties, Sentinelle is not ready to abandon her guard post.

"My office is a place where you can untangle work stories."

Occupational health nurses – stopgap or architects of prevention?

The occupational health services reform of the early 2000s opened up the field of occupational health to other professionals than occupational doctors alone. One group – nurse specialists in occupational health – were destined, in a shortage of occupational doctors, to play an important role in the field of prevention at the workplace.

The post of works nurse is a long-established one in French workplaces, but only in big companies, having been a statutory requirement only in industrial firms with more than 200 workers and service businesses with more than 500 employees.

With French occupational health services turning more towards primary prevention entrusted to the multidisciplinary team (see main article), intercompany services now have to take on nurses trained in occupational health. Training has since 1995 been provided in ten French universities, but has only been a legal requirement since 2012 for nurses wanting to work for an occupational health service.

In Lille, Véronique Bacle heads the nursing centre in a social service that provides its members with occupational health nurses and social workers. The service now has 45 occupational health nurses.

"To start with, we met with a lot of resistance from occupational doctors. Gradually, cooperation developed and some fears were allayed. Occupational health was the only speciality where collaboration with nurses was not the natural order of things. Occupational doctors were used to working with their secretaries. They had to relearn to work with another profession in near-identical areas of work", says Ms Bacle. She stresses the positive contribution of properly trained occupational health nurses to relations with employees because "they are more in touch with work-face experiences and have less of a medical approach than doctors".

That said, Véronique Bacle admits the validity of some concerns, in particular the inclination of some heads of intercompany services to make up the lack of occupational doctors by recruiting nurses. A concern further heightened by the fact that since July 2012, occupational health services have been legally allowed to task nurses with duties related to the follow-up of employees' health through the "nursing interview". The nurse quizzes the employee about his health and occupational hazards following a protocol drawn up with the occupational doctor. If the interview turns up no problems, the nurse issues a "nurse follow-up certificate"* which the employer can use to prove that he has fulfilled his obligations as regards employee health surveillance.

"The heads of intercompany services may see it as a stopgap for the shortage of occupational doctors, thinking that it will satisfy their members who are continuing to pay their fees when their employees may not have been seen by an occupational doctor for four years. Some think, 'we'll keep firms happy by offering them nursing interviews'. And suddenly, you're getting back-to-back nursing interviews that may not even last half an hour", laments Véronique Bacle.

> "Nurses more in touch with work-face experiences."

Independence is another issue of concern. Occupational health nurses lack the protection against dismissal enjoyed by occupational doctors.

Véronique Bacle plays down this risk for nurses in intercompany services, however: "Organizationally, their line superior may be the director of the occupational health service; they are part of a team and share a number of ethical concerns with the occupational doctor". "Where they are directly employed by the company, things are much more complicated. Then, they may come under tremendous pressure with regard to medical confidentiality and reporting of work accidents. That is why we are demanding protected status", she claims on behalf of the SNPST occupational health professionals' union of which she is an active member.

* Not to be confused with the fitness-unfitness notice which remains the sole prerogative of occupational doctors.