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# OCCUPATIONAL MEDICINE IN CHILE: CERTIFYING OCCUPATIONAL PHYSICIANS TOWARDS RECOGNITION, STRENGTHENING AND DEVELOPMENT OF THE MEDICAL SPECIALTY

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**Introduction** Occupational medicine is not formally recognised as a medical specialty in Chile and there are no clinical training programs in Chilean universities. Despite this situation, health authorities have developed occupational health protocols that give occupational physicians relevant roles and the Congress asked to strengthen occupational medicine to implement the National Safety and Health Policy. In absence of formal certification of specialists, the Chilean Society of Occupational Medicine has certified occupational physicians since 2014. This study aims to describe Chilean occupational physicians who are members of this association.

**Methods** 75 applications were received (2014–2016). 54 physicians (72%) fulfilled the criteria to be certified as occupational physicians (59.3% male) and the rest remained as collaborating members. An electronic survey was sent during January 2017 to collect information from members (85% response rate).

**Results** 78% of 46 physicians that answered the survey were 40 years or older and 74% had worked at least 10 years in occupational medicine. 87% got their medical degree in Chile and the rest in other Latin-American countries. 35% (n=16) have a medical specialty (public health (n=5), occupational medicine (n=3), rehabilitation medicine (n=2)). Occupational medicine specialists were trained abroad. One physician (2%) has a doctoral degree; 32 (70%) a master degree; 37 (80%) a diploma certificate; 23 (50%) completed other training programs. 72% completed 2 or more postgraduate programs; most referred were public health (29%) and health management (20%). 59% declared more than one job, most usual were: management of occupational insurance (54%), private companies (30%), public institutions (28%) and independent activity (24%). 74% work in Santiago and 20% in extreme north/south. 4% work in shifts. 50% also work in other than occupational medicine; 2/3 have a management position; 39% teach; 15% do scientific research. 78% are 'highly satisfied/satisfied' with their current positions.

**Discussion** Occupational physicians in Chile are highly trained professionals with diverse academic background. Job positions are limited as the specialty does not formally exist. Standardisation of academic training is mandatory prior to recognition of the specialty and creation of specialty programs.

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# PRINCIPLES OF FITNESS FOR DUTY EVALUATIONS

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Certifications for fitness for duty and return to work programs are an integral part of every medical practitioner's duties. Fitness for duty decisions have a direct impact on

employee availability and productivity in the workplace. Increasing trends of sickness absenteeism, presenteeism and declining organisational wellness indices have become a common trend as a result of subjective and unsound fitness for duty and return to work evaluations. The increasing use of dysfunctional and out-dated principles of light duty, indefinite sick leave and unqualified medical retirement among others that are desynchronized with occupational risk exposure profiles and person job specifications requires urgent redress.

Fitness for duty decisions must take into account work processes, inherent job demands and attendant occupational risk profiles. These must be based on functional terms clarifying the restrictions and limitations in the face of workplace occupational exposures and job demands. The new approach of 'fit' notes versus sick leave notes has brought a new dimension in the return to work principles. The use of person job specifications, hazard identification and risk assessment methods and task analysis leads to an improvement of informed decision making for medical practitioners. Fitness for duty evaluations play a pivotal role in ensuring appropriate job placements and injury prevention. It is vital that medical practitioners apply the fundamental principles in assessing return to work and fitness for duty.

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# SMOKING ADJUSTED INCIDENCE OF BLADDER CANCER USING PROXY SMOKING FROM LUNG CANCER IN NORDIC MALES

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**Objectives** The objective of this study was to observe the occupational variation in risk of bladder cancer that is not attributable to smoking.

**Methods** In the Nordic Occupational Cancer study (NOCCA), 11 458 cases of bladder cancer and 2 08 297 cases of lung cancer cases were observed among men in Denmark, Finland, Iceland, Norway and Sweden during 1961–2005. The expected numbers of bladder cancer in occupational category were corrected with smoking prevalence estimated on the basis of lung cancer risk in the category. Crude and smoking-adjusted standardised incidence ratios (SIR) with 95% confidence intervals (CI) were calculated for each occupation.

**Results** The smoking-adjusted SIR for most of the occupations was closer to 1.00 than the unadjusted SIR. It signifies the role of smoking as a risk factor of both bladder and lung cancers. Highest statistically significant smoking-adjusted SIRs were observed among chimney sweeps (SIR 1.33, 95% CI: 1.08 to 1.61), waiters (1.18, 1.04–1.34) hairdressers (1.16, 1.04–1.28), cooks and stewards (1.13, 1.01–1.27) and printers (1.10, 1.03–1.06).

**Conclusion** Smoking is a strong risk factor bladder cancer but there are other factors in some specific occupations in