Multidisciplinarity in Occupational Health Services in France

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Plan

1. Research question and methodology (data collecting and treatment)
2. The « multidisciplinarization » of occupational health services
3. Conflicts of jurisdictions
4. The role of audiences
4. Conclusion : professional and political stakes
1.1. Research question

Occupational health services are becoming « multidisciplinary » :

- How are the borders between professional territories defined ? What professional and political stakes are raised by the division of labour process?
1.2. Methodology: Data collecting

- Fieldwork in 2010-2011 in several occupational health services and in local institutions
- Around 100 semi-directive interviews at various levels of the organizations
- Observation of meetings and professional gatherings (congress, training sessions)
1.3. Methodology: Data treatment

Thematic analysis of interviews and field notes, with two focuses on:

• The various representations of the field of prevention of occupational diseases and risks (who does what? For what final purpose?)

• The evolution towards a new division of labour and its political and professional stakes
2. The « multidisciplinarization » of occupational health

Occupational medicine services are above all medical services. But:
- a « shortage » in medical labour
- and the legal context
Lead to a reform towards « multidisciplinarization »
2. The « multidisciplinarization » of occupational health

- The lack of occupational doctors is such that the reform appears necessary (¾ occupational doctors are aged 50 or above).

The french State, through « numerus clausus », reduces the number of doctors to make them more incline to accept « rationalizing » reforms of the health system (M-O Déplaude, 2007)

In several cases, the decline of the demographic power of doctors and the introduction of other professional groups with whom they have to collaborate go hand in hand.
2. The « multidisciplinarization » of occupational health

- 1989: European framework directive
  - Companies are compelled to use a multidisciplinary approach to improve the health and safety of their workers

- 2001: Companies are legally obliged to assess their own professional hazards and write them down in a document (DUERP)
  - They need help to do so: a new market opens up

- 2002: French « social modernization » law
  - French interpretation of the European directive: from occupational medicine to occupational health; mental health is now specifically targeted as well.
  - A multidisciplinary organization becomes compulsory in occupational health services
  - Takes up the idea of employers' associations: to offer a service that would be more « global »

- 2011: Occupational health services reform
  - The mission to avoid any degradation of the workers' health due to their work now relies on the occupational health services and not on the occupational doctors anymore.
Mission: to prevent the workers' health from being affected by their work

**Occupational doctors**

With the assistance of:
- Secretaries
- Medical experts mobilized ad hoc on certain cases

Means of action:
- Periodic medical examinations, individual follow up of the workers; assessment of their ability to work
- Doctor's interventions in the workplace, collective follow up of working conditions
Mission to prevent the workers' health from being affected by their work

**Occupational health services**

(managed by: directors, human resources, training, quality standards)

- Medical team:
  - Occupational doctors,
  - secretaries, nurses,
  - occupationnal health assistants

Technical team:
- Ergonomists, psychologists, HSE engineer, toxicologists, statisticians, etc.

- Means of action:
  - Individual follow up of workers / assessment of ability to work
  - Interventions in the workplace (paying or included in the subscription / doctor or other experts)

= **Widened field of intervention**
  (beyond the original mission)
2. The « multidisciplinarization » of occupational health services

Division of labour follows two different logics:

- The « multidisciplinarization » of occupational health as prescribed in the law
  - « IPRP » (Occupational hazards prevention staff)
- The compensation of the shortage of doctors by a newly trained staff:
  - Nurses, « Occupational health assistant »

Two types of actors are newly introduced in the « multidisciplinary » occupational health services

Each professional group covers a jurisdiction that they need to maintain or to extend; the « system of professions » (Abbott 1988) relies on an interprofessional competition.

Several « audiences » (public opinion, media, etc.) influence the terms of the struggle between the professions.

Professions and their audiences evolve interactively, like « linked ecologies » (Abbott 2003).
3. Jurisdictional conflicts

Competition on the individual follow up of workers

Ex: the support of individual cases of addictions or mental suffering in the workplace:

– Some doctors prescribe a follow up by a nurse, under their responsibility

– Others mobilize an occupational psychologist, who is part of the « technical team ».

– How do they frame this follow up? Vocabulary (« interview » as opposed to « consultation »); number and length of the interviews; reports; attempts to integrate the psychologists to the medical team etc.)
3. Jurisdictional conflicts

Ressources and constraints of each professional group condition the way they see themselves in relation to the others:

- Ex : Occupational medicine is an unprestigious segment of the medical profession with a large majority of women
  
  - It influences the relationships with the nurses: refusal of collaboration, delegation of the « dirty work » to improve the prestige of their activity
  
  - Reversal of « stigmas »: multidisciplinarity as an opportunity to become « project manager » ? (the hierarchical relations with other groups become problematic)
3. Jurisdictional conflicts

- The competition in the field of « interventions in the workplace »

Employers are compelled by law to:

- Get « ability to work » certificates for their workers
- Assess their company's risks

Is labour going to be divided accordingly?

- To doctors: individual follow up (because they are the only ones who can deliver certificates)
- To « technical » staff: a function of support in the management of occupational risks
4. The role of audiences

In occupationnal health services, the power struggles between professionnal groups depend on several «audiences»:

1. The State (laws, public policies in the field of occupational health)
   - Groups expect laws to precise «who does what» and reinforce their legitimacy on a territory
   - For example: nurses expect their occupational health training to become compulsory and a statutory recognition of their degree
4. The role of audiences

2. The management of services: an organizational function

Middle management tries to objectivize the borders between the territories

- Normative function of training sessions: «How to collaborate in a multidisciplinary team?»
- Surveys on the various groups
- Human resources choices influence the border conflict. For example: should we hire clinical psychologists or work psychologists?
3. Companies and their workers

Example: Employers fear that the intervention of a psychologist is going to affect their public image

- A lot of doctors, facing « psychosocial risk » situations, turn to ergonomists for help because they don't trigger such fear
- Doctors turn to psychologists for individual follow up, invisible to the employers' eyes (when organization allows the psychologists to perform individual interviews)
4. The role of audiences

Professional, corporate and bureaucratic ecologies are linked:

– The State's control on occupational health services is reduced
  • The « technical team » is often employed by a related organization and thus escapes the statutory control of Occupational Medical Inspection

– The employers' control is improved:
  • The technical team doesn't have the same protected status as the doctors; young and with little experience, they enjoy less support of institutionalized professions:
    – confidentiality, code of ethics, professional associations etc.
5. Conclusion : professional and political stakes

The controversies concern professional borders but also the limits of the missions that fall on the organization as a whole.

Before the reform, the services' missions were limited to the ones that fell on occupational doctors, and were defined by law (but there was room for interpretation).

They now exceed these statutory missions.

The « demedicalization » of occupational medicine operates in the benefit of a service offer to companies.
5. Conclusion: Professional and political stakes

Multidisciplinarity appears as a management device that justifies the rationalization of each group's activity.

« Demedicalization » of occupational medicine is also a « deprofessionalization » of the field, in which the corporate et bureaucratic logics (Freidson, 2001) overpower the professional logic and threatens the autonomy it would ensure to the various occupational groups dealing with prevention in the workplace.