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Occupational Medical Examinations during the COVID-19 Epidemic

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Introduction

1. Occupational medical examinations (OME) may affect social distance safety, create fomite- and (possibly) airborne transmission COVID-19 (C19) risks between the examiner and the patient.
2. The question arises whether OME's should be performed during the C19 pandemic and/or under the state of disaster; and if so, under which conditions?

Employer duty

1. Statutorily, the duty to have a system of OME's and the corresponding actions in place, vests with the employer.
2. Disaster Management Regulations define a 'new normal' legal framework as it applies to the existing statutory requirements.
3. At the basis of this legal framework is an application by the SA Government of technical medical/epidemiological advice given by the national panel of C19 experts.
4. As Governments, worldwide, have to mix values other than health (amongst other economic, political), the pandemic management 'directives' have raised queries as to the statutory standards.

Communication and consultation

1. When evaluating whether an employer's occupational health duties are executed to the reasonably practicable standard, the employer's appointed Occupational Medical practitioner's (OMP) knowledge and expertise are imputed to the employer. An OMP's conduct is measured against the general level of skill and diligence expected from a medical practitioner with a specialist qualification and expertise in occupational medicine[1].
2. There should, therefore, be important communication and consultation between OMP and employer and decisions on deferment or prioritisation of OME should emanate from this consultative process.

[1] P Benjamin in 'The legal, policy and ethical framework of occupational health practice in the South African mining industry', SIMRAC Handbook on Occupational Health Practice in the South African Mining Industry

Safety critical and C19 OME's

1. Some C19 health-assessments are an employer duty (e.g. vulnerability- assessment, -monitoring, return to work after C19) which may be essential during the epidemic.
2. Fitness for work OME's for safety critical professions (e.g. in Mining, Transport, Construction) may be essential for the continuity of operations.

Policy on reasonable deferment and prioritisation of OME

1. It is reasonable to defer all OME except those that are safety critical until it is deemed safe to resume them.
2. OME's should be in place for urgent, mandatory and safety critical work exposures only.
3. A risk assessment defining appropriate C19 risk controls for both patient/employees and medical personnel should reach an acceptable risk level.
4. With the planned C19 containment in place, certain examinations and tests can be done safely.
5. Evidently, important variables in this risk assessment include the (epidemiological) status of the epidemic in the employee cohort and the (legal) status of the declared Disaster. The evolution of the pandemic in SA is, currently, favourable and deferment conditions may be reduced.
6. A catch-up plan towards legal compliance should be defined and monitored.

Specific examinations and tests

1. Spirometry
    1. Spirometry poses a high risk of aerosolization.
    2. The SA Thoracic Society has advised that all spirometry should be stopped unless there is an urgent clinical need.
    3. Spirometry can be postponed, except in urgent and important cases (e.g. diagnosis of occupational asthma and reporting to COIDA); there are physicians who have put the required C19 extraordinary engineering controls in place.
    4. A spirometry catch up plan should be defined.

2. Audiometry
    1. If the decision is made to do the full clinical OME, then adding audiometry is not increasing the risk.
    2. Audiometry can be executed with proper social distancing and adequate fomite control within acceptable residual C19 risk levels for the patient/employee and for medical personnel.
    3. Except for pre-placement and baseline examinations, Audiometry is seldom urgent and can be delayed if the risk is perceived unacceptably high.
    4. It may also be a good 'new normal' practice to review the need for Audiometry:
        1. Review the OREP and latest occupational hygiene reports and confirm that the specific employee or cohort is indeed still exposed to an 8 h rating level equal to exceeding 85 dBA.
        2. Review the frequency for periodic audiometric screening as defined in SANS 10083; i.e. annually for 3 years and thereafter 2-yearly, provided the respective contributions to the PLH at any of the specified frequencies in table 1 are not equalled or exceeded.
    5. An Audiometry catch up plan should be defined.

3. Vision screening
    1. Safe vision screening can be done using clinical techniques and Snellen rather than with vision testing machinery.
    2. The techniques are described in the vision screening section of the SASOM Driving Medical Guideline.

4. Clinical examination and testing (e.g. HGT, ECG) breaches the 1.0 m social distance (but is unlikely to be > 15 min and thus not necessarily creating a 'close-high-risk' C19 contact exposure); controls should include:
    a. The C19 risk assessment for the occupational health practice.
    b. Bunching prevention at arrival, within waiting areas, at facilities, testing stations etc.
    c. Social distancing in passages, examination rooms.
    d. Ventilation and air quality control in all rooms.
    e. Screening of the patient/employee (by a health professional) prior to examination.
    f. Fomite control for the clinic, facilities, and also pre- and post-examination.
    g. Surgical mask wearing by the patient/employee.
    h. Vulnerability assessment (and risk avoidance) of the OMP performing the examination/ ditto for nursing personnel assisting.
    i. Health PPE worn by the OMP (see DOH Guidelines) and any nursing personnel required to breach the social distancing.
    j. Appointment of responsible persons as required in the National Health Act, Disaster Management Act and Protection of Personal Information Acts, as these apply to C19.

5. It is for the OMP to continuously re-assess the C19 risk of OME's and conclude on residual risk acceptance/rejection.