UNIÓN EUROPEA DE MÉDICOS ESPECIALISTAS (UEMS)
EUROPEAN UNION OF MEDICAL SPECIALISTS (UEMS)

Section of Occupational Medicine

The Future of Occupational Medicine in Europe

UEMS-Section of Occupational Medicine
Barcelona, 13-14 September 2002

Proceedings of the UEMS Workshop

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1. Introduction

The Section of the Union of European Medical Specialties on Occupational Medicine is the official body of this speciality in the European Community (http://www.uems.net/). It has been established for some 8 years. It seemed timely to draw together the experience of specialists from across the EC to see whether a common vision for the future of Occupational Medicine in Europe could be articulated. If it could be, then it would form a common basis or platform for developments in the existing EC and in any enlarged form.

To deliver this vision, a workshop was held in Barcelona in September 2002. Its objectives were: **1)** to understand our common views and the different perspectives in leading professional organisations, **2)** to review the processes of specialist training across Europe and discuss harmonisation and equivalence of the varied training programmes, **3)** to produce a common vision for the speciality in Europe, and **4)** to produce an action plan to take forward the professional and social agendas of the speciality.

The workshop was attended by both UEMS Section members and official national body delegates from a majority of EC states and thus may be taken as an authoritative statement of principles and issues. There were 53 participants from 19 different countries (see appendix 1). In the present document the workshop's output is reported. It includes a summary of each of the eight workshops that were organised and a list of the main topics and conclusions for each.

2. Summary of Workshops

2.1. Training of Occupational Physicians

This was the first topic as it is of basic importance and relevance to the speciality. Both training at the undergraduate and postgraduate levels were discussed.

Undergraduate training

There were a range of perceptions, perhaps amounting at times to disagreement, about whether undergraduate medical training should properly be seen as part of the "common" training of occupational physicians (OPs). That is, whether or not the training of OP is to be seen as wholly a postgraduate process.

These perceptions stem from a range of premises and interpretations of belief, law, etc. as discussed below. A most interesting primary belief relates to whether or not basic undergraduate medical education (typically 6-7 years in most EC countries) is sufficient preparation of itself for specialist occupational medical practice. Only a minority of attendees at this workshop considered that it was. This relates to a more profound, basic issue of debate about what the purpose of undergraduate medical training actually is: basic, pluripotent or specialised. This subject is discussed in more detail elsewherei[1].

Postgraduate training

An alternative belief system, and that supported by the majority of workshop attendees was that the learning process for occupational medicine needed to be or was entirely a postgraduate stage. However, there were differences of view on two issues. These were the so-called "common trunk" pathway and the need for it, whether standing alone or leading up to subsequent further, specific, specialist training.

"Common-trunk" training is general, in-service (medicine) training, typically carried out in the first three years or so after grad-

1. Cashman C, Slovak A. Delphi Survey on Occupational Medicine. ICOH meeting "Towards a multidimensional approach in Occupational Medicine service: scientific evidence, social consensus, human values." Modena, 13-16 October 2004.

uation. That relevant to occupational medicine is general internal medical training. It was argued by some participants that this was sufficient training to practice occupational medicine as a specialist, although some acquisition of advisory, research, influencing and managerial skills (e.g. health promotion, sociology) might be usefully superadded.

A more popular view, and actually that formally endorsed by the Section is that there should be a specialist training period of four years following qualification and/or common trunk training which focussed on OPs competencies as defined at EC level by the European Association of Schools of Occupational Medicine (EASOM)[2,3].

It became clear in the discussion on these subjects that some of the divergences of view related to differences in historical national practices but, equally clearly, that some reflected different interpretations on entitlement under the E.U. directive on workers health and safety rights and the consequent establishment or modification of occupational health and safety (OHS) services.

There were also differences of view about the value of theoretical training, as opposed to practical in-service training. In some countries theoretical training may "take-out" the trainee from actual work practice for 1-2 years, whereas in other countries the theoretical training has been integrated with in-service training by such means as distance-learning courses and personal (own-time) study.

It was concluded that there were conflicts to be resolved in setting a training programme about whether OPs are practical clinicians or more "public health administrators", or both. In relation to this discussion, competence in risk assessment and management, and health promotion were considered to be particularly important issues.

In summary, development areas were identified as follows:

- Competence to operate health promotion.
- Competence on advising on OHS and hygiene.
- Competence in policy development.
- Competence in information provision (communication).
- Competence in multidisciplinary practice.

2. Macdonald E, Baransky B, Wilford J. Occupational Medicine in Europe: scope and competencies. Health, Environment and Safety in Enterprises Series n. 3. Bilthoven: WHO European Centre for Environment and Health, 2000.
3. Occupational Medicine. Chapter 6, Charter on Training of medical especialists in the EU requirements for the Specialty Occupational Medicine. Available in: www.uems.be

2.2. Assessment of Competencies of Occupational Physicians.

It was clear to the group that performance must be monitored, both technical and behavioural aspects. Of these facets, the latter is more difficult to assess since it would include communication skills, leadership, team participation and customer satisfaction.

To simplify the discussion, this was limited to postgraduate and, even more specifically, post specialist assessment. It was noted that core competencies for postgraduate training have been fully developed and published[2,3] and therefore little need was identified for further discussion, except to note the dynamic nature of the speciality and thus the need to regularly review and update these competencies.

In relation to the assessment of established specialist practitioners, it was noted that the UEMS generally recommends 250 hours of continuous medical education (CME) spread over five years[4], though there was a differentiation to be made between CME and Continuing Professional Development (CPD). This requires further careful thought in terms of definition and practical structuring. As an example, Switzerland specifies an annual CME/CPD mix of 90 hours comprising 40 hours reading and 50 course hours. Compliance to these requirements is randomly audited biannually.

A separate issue, and a vexing and difficult one, is the checking and training of trainers (and indeed examiners). It was recognised that there were a variety of quality assessment (QA), audit or monitoring systems in academic practice although seemingly little transnational standardisation, despite being considered quite similar across countries. It was noted as examples that standardised assessment was widespread in the USA, whereas in the UK this issue had only recently begun to be addressed by the specification of minimum update training requirements.

It was anticipated that, overall, in the assessment of competency the likelihood was of an increase in standardised assessment instruments, e.g. multi-choice tests, observed clinical situation examinations, etc.

However, some colleagues considered that testing and written requirements were both bothersome and unnecessary.

4. UEMS. Charter of Continuing Medical Education of medical especialists in the European Union. Available at: http://www.uems.net/uploadedfiles/174.pdf.

Also, some practices, such as simply recording reading lists, are no longer considered sufficiently rigorous. This is for example the situation in the UK.

Other problems are economic. Thus, for example, in Norway CME is opposed on economic grounds. Since there is no established mechanism for recognising/rewarding those who comply with CME requirements as opposed to those who don't (and thus don't incur the costs of doing it). Employers/customers have considerable difficulty in accepting the additional costs involved, even if they are happy enough to have the benefits.

Finally, peer review, peer appraisal and auditing were discussed. These can be effective methods of assessment and appear to be being increasingly used. It was noted that internal crossover auditing had been successfully used in a number of enterprises in some EC countries. However, there are some reservations about the rigour of such arrangements as they may fall into mutual and critical complacency. As an alternative, an external OPs specific audit process has been developed in Germany in the last few years, and is gaining increased usage and acceptance. The place of such audit in the CME/CPD/revalidation/recertification equation is unclear.

In summary, consensual views coming out of this workshop were that:

- CME and CPD are necessary.
- There is a need to survey different national CME/CPD programmes and publish the comparative findings.
- Performance monitoring of both technical and behavioural skills needs to be part of the process.
- The place of audit generally and as part of CME/CPD needs to be discussed further and established.
- Economic costs of these activities have to be addressed as a political/structured issue in medical practice.
- These are grounds for standardisation at EU level.
- Training in the skills to operate these processes is needed and would be easier if practice was standardised.

2.3. Delphi discussion – What does it mean for societies?

A Delphi study had been carried out previously (see appendix 2) and its results were discussed in the workshop.

The group considered there were two ways of addressing this title. The first on which the group concentrated was about what occupational physicians do, or aspire to do, and what impact this has on the societies in which they work: also what the expectations of those societies are or are becoming. The other way of looking at it was about what changes will be required of our professional societies to meet the coming challenges. Clearly, the first approach leads organically to the second, and so professional societies will have to reflect on the issues thrown up.

It was noted, as a preliminary and basic observation, that expectations placed upon us were strongly influenced by the economic health of societies, and it was further noted that this was reflected in practice currently according to the stage in the economic cycle of different EC states.

Members of the workshop came from 11 EC members, or aspirant states, and their input to the following bullet points derives from this wide range of national societal expectations:

- Directives as drivers: in those states where there was a low expectation of OH (occupational health) services, both from workers and society generally, the beneficial impetus of EC directives as a stimulus for action was often pivotal.
- Learning from (shared) experience: even where there were low expectations, there were a substantial minority of employers who were very positive about the potential of OH to optimise the performance of human capital as being the "most valuable assets". Such situations where available to be used as "path finding" examples for others to follow.
- What people want as opposed to what they need: there were unresolved and substantial differences between what individual work people sought from OH services, as opposed to the more strategic views of stakeholders such as trade union organisations, employers, etc.
- All too difficult: the necessary public dialogue needed to inform/influence ostensible stakeholders seemed often to be suppressed not infrequently by self-censorship. This seems to require new tactics to "break out" of these constraints and engage in meaningful dialogue.
- Optimism: nevertheless most EC societies were seeing a big growth curve for OH services at present.
- Opportunities thus came from a number of sources (not always wholly welcome) like "work/life" legislation,

aspirations to "OH for all", litigation, etc.

- Threats came from dismantling of existing and quite sophisticated/ complex/rich OH provision in some EC countries, lack of physicians, increasing numbers of small, medium-sized enterprises (SMEs), increasing fragmentation of employment continuity (outsourcing, contractorisation, etc.).

2.4. Delphi discussion – Reflection on values and practice

Of necessity, this section has a philosophical, rather idealistic tone which creates the risk that it can be dismissed as somewhat unrealistic. However, it can and should be acknowledged that there is a strong aspirational driver to the practice of occupational health, which is reflected in its often quite heavy politicisation in different EC societies. The aspirational drivers for the practice of occupational health, derive from a set of ethical perceptions which we hold professionally about how our societies should properly behave towards their worker members. They also derive from interest: interest in the provision of care, interest in the condition of the workplace and the nature of the activities carried out there, and interest in the technical aspects of the examination of the workplace and workers.

It is noted that professionally the Occupational Health and Safety specialities have a split of client groups, with a potential for conflicts of interest which have to be bridged by careful observance of the niceties of good professional practice. These client groups comprise workers and employers, as well as the wider society in which they live. This range of clienteles is somewhat greater than the traditional medical model, and thus OPs have to build their values uniquely in a way which meets all these needs.

These values can be summarised as follows:

- A duty of service to our clients.
- A duty of confidentiality to individuals balanced against a duty of fairness to those for whom they work.
- A duty of transparency and consistency.
- A duty to follow best practice, maintain knowledge and acquire appropriate new knowledge.
- A duty within the wider practice of medicine not to do harm.

2.5. Vision – Training and assessment

To a certain extent the discussion in this workshop and that on competencies (section 2.6) had to address some of the issues explored in 2.1 (training) and 2.2 (competencies). It is of interest to note the summary views derived from part of the exercise:

- The differences of approach and the service demands in different countries (e.g. sickness absence – core activity in some countries, prohibited in others).
- The variations in proximity and relationships with public health as a speciality.

As a consequence it was considered that the teaching of occupational medicine needed to be very close to reality: it has to be of relevance to real current day practice and that it be done as close as possible to that practice. Thus a problem-based approach might well be developed with most training being "on the job" and theoretical aspects being attended to mainly by processes such as distance learning rather than more traditional didactic methods. It was also necessary to recognise that whilst the common border with public health was a long and intimate one, the practical activities of the specialities were rather different. Thus occupational medicine was a clinical individual-based discipline with strong managerial and structural frameworks, whereas public health was most directly focussed on management, structure and policy.

As well as between-nation differences in emphasis, some difficulties came from problems of definition and the incomplete understanding of our clients, particularly the general public, about the objectives of the speciality. To be specific, OPs have a good understanding of competencies and aims but societal stakeholders in many countries do not.

Thus, the aim must be to derive from the core competencies already published2, a common core of training and assessment needs which can gain acceptance across UEMS and hence, within our stakeholder societies.

In conclusion, the group's vision for training and assessment is that:

- OH competencies at present vary to some extent due to different societal demands and cultural expectations across the E.U.
- Competencies across occupational health need to be broad but a common core is necessary and achievable.

- Training will need to be modified to a mixture of methodologies deploying the benefits of modern technology. Future practitioners will need to be trained using evidence-based medicine, learning through problem-based resolution and addressing clinical, risk and event-related learning situations.

2.6. Vision – Competencies, Scope and Societal Need

In essence, this workshop group was given an unlimited remit to envision the position of the speciality in 5-10 years. This proved very challenging.

Areas of discussion were as follows:

a) To obtain a better match/balance between our own vision of what our speciality attempts to deliver and that which our general publics (society at large) expect from our speciality.

b) To deliver the core competencies as a product by speciality training institutions.

c) To develop the future profile of the OP, particularly the key skill of responding to and influencing stakeholders.

d) To invest in developing new skills by focussing on new entrants to the speciality, whilst maintaining and enhancing the skills of existing specialists.

e) To develop a hierarchy of competencies: some are key; others less so, or subject to some variation according to national traditions (see also 2.5 above).

f) To develop competence to deliver "bottom up"/"grass roots" OH initiatives.

g) To develop enhanced communication skills to better influence and interact with both stakeholders and colleagues in allied disciplines.

Out of these discussions it was possible to identify some key areas for action which might comprise a specific, action plan for the next 5-10 years:

- The consolidation of core competency criteria.[2,5,6]
- The identification of areas of improvement/skill development in influencing, communication, audit, visible assessment, financial/economic justification, leadership, regular review and update to maximise relevance.

2.7. Action Plan – Strengthening the profession

This workshop strand served to consolidate many of the themes discussed earlier in this text and it is thus

of benefit and importance to set down here the "top" or "key" themes which emerged:

- Expansion of the concept of Occupational Medicine into broader and more relevant societal delivery needs. Thus to develop the concepts of work ability and work-relatedness/multi-functionality in illness.
- Differentiating clearly the boundary between OH and primary care whilst working diligently to enhance communication effectiveness at that boundary.
- Closer working relationships with specific important groups of medical colleagues, e.g. outreach into primary care clinics to try and detect occupational disease earlier and more accurately. Similarly with other specialities, especially public health, rheumatology and psychiatry.
- In relation to working relationships the development of a co-ordinating facilitator role for OH.
- Better networking within the speciality (especially lone practitioners) to share and develop a common vision as well as technical competencies.
- Enhance the visibility and attractiveness of the speciality to medical students and new doctors.

2.8. Action Plan – Influencing the European Agenda

The ultimate objective of the workshop was the production of an action plan for the UEMS Section to take to influence the European debate.

Two questions were addressed to focus the debate:

1) What is our vision of what we can offer and what is the message we would like to give?

2) Within five to ten years, who should we contact?

2.8.1. Our vision/message

This took up a large part of the workshop strand and the outcomes resonate with the foregoing sections:

Health promotion / promoting work ability.

This is a big issue according to responses to the Delphi survey1. We do not pay sufficient attention to wellness programmes and especially not to leader-

5. Westerholm P, Baranski B. Guidelines on quality management in multidisciplinary Occupational Medicine Services. Health, Environment and Safety in Enterprises Series n.1. Bilthoven: WHO European Centre for Environment and Health, 1999.
6. Rantanen J. Challenges for occupational health from work in the information sociedad. Am J Ind Med 1999;Suppl 1:1-6.

ship, which we leave to others. Yet occupational physicians occupy a pivotal position in respect of influencing the work/life balance even if, in some EC countries there were currently legislative obstructions to the discharge of such influencing roles. The "enabling" of promotion/workability by the pressure to remove such obstructions could become a UEMS Section objective.

The role of our academic institutions.

In many EC states, it was felt the speciality academic institutions were seen to be "invisible" at grass-roots level. Our vision should therefore be to maintain and strengthen grass-roots professional and "public" links. This was seen as being of primary importance if one is thinking of maintaining good competencies.

What sort of doctors are we?

If we consider OH links with the workplace, our general perception is that we may be seen to have stronger links to the human resources (HR) function than to production management or workers. On the other hand, the Delphi survey suggests that we mostly see primary care as marginal to our role, although not necessarily to our links. These are areas to think about further and work on.

OHS programmes.

There was general agreement that all workers should have access to these, a simple objective, as yet unmet, which would have great benefit globally. As governments and businesses see themselves largely operating in economic rather than altruistic mode currently, the promotion of health at work has to be presented in those terms. This emphasis does have a danger which is that it would align us with public health as a "policy" discipline, rather than a "care" function and so, to avoid being too abstract, we need to emphasise the practical delivery of health promotion and work ability.

2.8.2. Our Contacts – within 5-10 years

Our position needs to be that OH is a good "company" because it has a good product to sell. If we are satisfied about this then, at the appropriate EC level, we can identify our cus-

tomers and sell the product. This implies that we would wish to talk to:

- Employer bodies.
- Human Resources bodies.
- Trade union bodies.
- Official EU bodies (H and S at work, etc)

It also implies that we would have working relationships with these bodies, but these would have to be underpinned by linkages or alliances with other players from whom, and for whom, we would provide mutual support ("singing from the same songsheet"):

- Bilbao – European Agency for Health and Safety at Work.
- ICOH/ILO.
- European Network for Workplace Health Promotion.
- Dublin – European Foundation for the Improvement of Living and Working Conditions.

2.8.3. Methodology actions

So, if we are to speak with one voice the above forms a framework plan. Next steps are:

- To review and peruse the London Declaration of Ministers of Health (1999) – i.e. to challenge it constructively.
- Produce a very careful short position paper to give ourselves a platform for making the contacts and exerting the influence we intend.

3. Conclusion

The purpose of the Barcelona workshop was to see whether at the EC level, our speciality of occupational medicine could identify common values and a common platform for future action.

Structurally, because of our role and because of our often institutional semi-marginalisation, this could have been difficult and indeed some specific barriers did become apparent.

However, the commonality of most of the vision and the unanimity of purpose were much the stronger themes, perhaps to some extent, surprisingly so. There was agreement that it is vital to improve training, QA and responsiveness to stakeholders. Occupational health physicians' leading role in maintaining healthy organisations and healthy workplaces, should be further developed. This does indeed give us a common view and a common platform, and one where any barriers become challenges to overcome

Appendix 1

Participants at the worshop "THE FUTURE OF OCCUPATIONAL MEDICINE IN EUROPE" (Barcelona, September 2002)

- Giorgio Assennato, *Italy*
- Mònica Ballester, *Spain*
- Marcel-André Boillat, *Switzerland*
- Isabel Caixeiro, *Portugal*
- Alain Cantineau, *France*
- Ole Carstensen, *Denmark*
- Antoon de Schryver, *Belgium*
- Vlasta Deckovic-Vukres, *Croatia*
- Niels Ebbehoj, *Denmark*
- Solveig Fiedler, *Austria*
- Oern Terje Foss, *Norway*
- Annette Gaessler, *Germany*
- Franco Giuliano, *Italy*
- Ahlborg Gunnar, *Sweden*
- Bill Gunnyeon, *United Kingdom*
- Catherine Harrison, *United Kingdom*
- John Harrison, *United Kingdom*
- Kevin Holland-Ellitot, *United Kingdom*
- Kaj Husman, *Finland*
- Reinhard Jagger, *Austria*
- Johnny Johnsson, *Sweden*
- Turid Klette, *Norway*
- Helmut Krueger, *Switzerland*
- Ewan B. Macdonald, *United Kingdom*
- Tom Macmahon, *Ireland*
- John Malone, *Ireland*
- Begoña Martinez Jarreta, *Spain*
- Raphael Masschelein, *Belgium*
- Bente Moen, *Norway*
- Jadranka Mustabegovic, *Croatia*
- Eleni Oikonomoy, *Greece*
- Claus Piekarski, *Germany*
- Pere Plana, *Spain*
- Stanislav Pusnik, *Slovenia*
- Luc Quaeghebeu, *Belgium*
- Jorma Rantanen, *Finland*
- Manuela Santos, *Portugal*
- Alister Scott, *United Kingdom*
- Consol Serra, *Spain*
- David Sherson, *Denmark*
- Alenka Skerjanc, *Slovenia*
- Knut Skyberg, *Norway*
- Andy Slovak, *United Kingdom*
- Bastiaan Sorgrager, *The Netherlands*
- Metka Terzan, *Slovenia*
- Jane Frolund Thomsen, *Denmark*
- Michel Vanhoorne, *Belgium*
- Axel Wannag, *Norway*
- Andre NH Well, *The Netherlands*
- Jane Wilford, *United Kingdom*
- Hanke Wojciech, *Poland*
- John Wollaston, *United Kingdom*
- David Wright, *United Kingdom*

Appendix 2

DELPHI STUDY

UEMS – Delphi Survey of European Occupational Medicine Practitioners and their Organisations.

One of the actions from our last UEMS meeting was to conduct a Delphi exercise to assess our different viewpoints of our speciality, our different interests and our aspirations.

The purpose of this was so that UEMS could have a sound understanding of its member's values, beliefs and aims and so could better represent their views in the European Forum.

We now send you a copy of our questionnaire, which we have designed for this purpose. We would be grateful for quick responses until January 20th 2002 to:

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This survey is limited to 40 key questions, 10 questions in each field. This is to make replying easy and quick and to ensure that only core issues are addressed.

THE FIELDS ARE:

1. What our speciality aims to do? (scope)
2. What is important? (objectives/priorities)
3. Where have got to in achieving our aims and objectives/priorities? (positioning)
4. Where do we want to be/where should we want to be? (aspirations)

The questions are related to the positions established in the WHO document "Occupational Medicine in Europe: Scope and Competencies". (2000).

Please arrange to have the questionnaire completed by a person or group who fully represents the views of your national professional opinion.

Please read the guidance on completing the questionnaire before you do so to ensure that it is done in a standard way.

Ewan B. Macdonald
President OM Section UEMS.

Andy J.M. Slovak
Treasurer OM Section UEMS

Country: . . . . . .

Person completing: . . . . . .

. . . . . .

UEMS Delphi Survey

Q1 – 10:

Scope of Occupational Medicine in your Country

In our country we are involved in the following activities:

		YES	NO
Q1.	Assessment of fitness to work	☐	☐
Q2.	Health promotion/promoting work ability	☐	☐
Q3.	Diagnosing occupational ill – health and injury	☐	☐
Q4.	Advice on the prevention of occupational disease	☐	☐
Q5.	First aid/emergency management	☐	☐
Q6.	Primary care/treatment (general health)	☐	☐
Q7.	Quality Systems	☐	☐
Q8.	Surveillance of work – related conditions	☐	☐
Q9.	Exposure assessment/measurement	☐	☐
Q10.	Sickness absence surveillance/control	☐	☐

UEMS Delphi Survey

Q11 – 20:

What is important to you?

How important is each of the activities that you do?

Rank each activity listed in Q1 – 10 by giving it a score in the box (1 is the most important, 10 is least important – each number can only be used once).

		Priority/Rank (1 - 10)
Q11.	Assessment of fitness to work	☐
Q12.	Health promotion/promoting work ability	☐
Q13.	Diagnosing occupational ill – health and injury	☐
Q14.	Advice on the prevention of occupational disease	☐
Q15.	First aid/emergency management	☐
Q16.	Primary care/treatment (general health)	☐
Q17.	Quality Systems	☐
Q18.	Surveillance of work – related conditions	☐
Q19.	Exposure assessment/measurement	☐
Q20.	Sickness absence surveillance/control	☐

UEMS Delphi Survey

Q21 – 30:

Where have you got to in achieving your aims and objectives in your country?

Please compare your aspirations (see Q31 – 40) to how far you believe they have actually been achieved till now. Show how you rank current performance on the scale provided.

	Rating Scale ***Comprehensive / Well developed / Acceptable / Under developed / Non existent***	
Q21.	Assessment of fitness to work	☐☐☐☐☐
Q22.	Health promotion/promoting work ability	☐☐☐☐☐
Q23.	Diagnosing occupational ill – health and injury	☐☐☐☐☐
Q24.	Advice on the prevention of occupational disease	☐☐☐☐☐
Q25.	First aid/emergency management	☐☐☐☐☐
Q26.	Primary care/treatment (general health)	☐☐☐☐☐
Q27.	Quality Systems	☐☐☐☐☐
Q28.	Surveillance of work – related conditions	☐☐☐☐☐
Q29.	Exposure assessment/measurement	☐☐☐☐☐
Q30.	Sickness absence surveillance/control	☐☐☐☐☐

UEMS Delphi Survey

Q31 – 40:
What are our aspirations?

Essentially what we are trying to see with these questions is how far we share the same vision for the future. This is very important for our future advancement as a specialty in the European arena. It combines aspects of the measurements that we have made in the previous sections (Q1 – 10, Q11 – 20, Q21 – 30).

However it is important to recognise the difference between what is important to us as specialists in a particular medical area as opposed to what we judge politically to be important in establishing and advancing the specialty. It is more the political view we are looking for in this section.

In your country say what you believe that occupational medicine will best be advanced by concentrating on. Rank each activity, listed below according to your belief by giving it a score in the box (1 is the most important 10 is the least important – each number can only be used once).

		Priority/Rank (1 - 10)
Q31.	Assessment of fitness to work	☐
Q32.	Health promotion/promoting work ability	☐
Q33.	Diagnosing occupational ill – health and injury	☐
Q34.	Advice on the prevention of occupational disease	☐
Q35.	First aid/emergency management	☐
Q36.	Primary care/treatment (general health)	☐
Q37.	Quality Systems	☐
Q38.	Surveillance of work – related conditions	☐
Q39.	Exposure assessment/measurement	☐
Q40.	Sickness absence surveillance/control	☐

Guidance – completing the UEMS Delphi Questionnaire.

1. The questionnaire is intended to capture our joint European perceptions of the practice of occupational medicine.

2. To do this it is necessary to examine the following headings.

- Scope.
- Objectives/priorities.
- Position now.
- Aspirations.

3. The same 10 key issues are used in looking at each heading. However the response required is different in each case.

4. Q1 – 10: Scope

This is a simple choice between whether or not you believe a particular activity to be part of occupational medical practice in your country. For example, you may consider assessment of fitness to work to be part of OM practice but not primary care so:

Q1.

Assessment of fitness to work:

Yes ☐ No ☐

Preg. 6.

Primary care/treatment (general health):

Yes ☐ No ☐

5. Q11 – 20:

Here we are ranking priorities. If you believe, for example that "fitness for work" is the most important activity then this should be numbered 1 and the least important should be numbered 10. The others would fall in between.

e.g.

Priority/Rank (1 – 10)

Q11

Assessment of fitness to work: ☐

Q16

Primary Care: ☐

Q20

Sickness absence surveillance/control ☐

6. Q21 – 30: Position now

This is intended to show where you have got to on each subject in your country compared to where you believe you aspire to get. Describe your current general level of achievement by picking one of the boxes for each subject.

For Example:

Comprehensive/Well developed/Acceptable/Under developed/Non existent

Q21

Assessment of fitness to work: ☐☐☐☐☐

Q23

Health promotion/ promoting work ability: ☐☐☐☐☐

Q27

Diagnosing occupational ill – health and injury: ☐☐☐☐☐

7. Q31 – 40: Aspirations

This is scored in exactly the same way as Q11 – 20.