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Health Protection through Occupational Health Care – Fiction or Reality?

Foreword

The question as to the relevance of occupational medicine for industrial health protection has been answered in the affirmative by the legislature by means of statutory regulations, in particular by the "Arbeitssicherheitsgesetz" or ASIG (work safety law).
These legal regulations describe the required conditions in which active health protection through occupational health care is no longer fiction, but reality. It therefore seems reasonable to compare the required conditions with existing conditions as determined by empirical evidence. The object of this paper is to begin this comparison on the basis of results of the research project "Regulierung von Statuspassagen im Erwerbsleben durch Experten - Das Beispiel der Betriebsärzte" (The regulation of Status Passages in Working Life by Experts – The Example of Company Doctors). This project was carried out within the framework of the Sonderforschungsbereich at the University of Bremen, sponsored by the Deutsche Forschungsgemeinschaft (DFG) under the title of "Statuspassagen und Risikolagen im Lebensverlauf. Institutionelle Steuerung und individuelle Handlungsstrategien" (Status Passages and Risk Situations within a Lifetime. Instituional Control and Individual Strategies for Action).[2]

In this project we examined how the occupational conduct of company doctors is shaped and what conditions influence their actions and judgements in general, and particular in terms of occupational status passages.

In this essay, initial descriptive results will be compiled; an evaluation of the research material is only at a preliminary stage.

We have differentiated according to the following conditions of influence:

1) **Demands:** Contractual relationship with the company and legal statutory regulations (Work Safety Law, accident insurance stipulations, work-related medical examinations).

2) **Context factors:** These include branch of industry and size of company, health-related facilities and cooperative relations with company doctors within the company, corporate culture with regard to employees with disabilities (i.e. campany welfare policy).

3) **Professional equipment**, **(occupational inventory):** This includes qualifications, ie. knowledge and experience in occupational medicine with

[1] Peter Boy kindly assisted us with the statistical evaluation.

[2] In this project an analysis was made of the significance of company doctors in the regulation and control of work-regulated status passages. The term status passage denotes here the transition from one period of life into another; for example, starting school, marriage, starting work, changing jobs, retirement. Within the occupational context status passages refer inter alia to recruitment, dismissal, transfers within the same company, occupational or medical rehabilitation.

concommitant skills and abilities, but also institutional form and degree of professionalisation. Institutional form is shown both by the legal status of the company doctors within the company (independence/non-partiality, demarcation of their area of responsibilities and by the provision of staff and technical equipment for the occupational health facilities.
The term professionalisation here pertains to the criteria by which a company doctor orientates his/her actions. These are not solely attitudes or opinions, which do not necessarily have consequences for actual professional conduct, but the daily practices and procedures which develop into an established occupational routine.
The degree of professionalisation can thus be measured at least by the extent to which company doctors – all of whom, after all, have to fulfil the same statutory requirements – share a common professional bearing/demeanour (or occupational inventory) which enables them to fulfil these requirements.

It was already found at an analysis of the pertinent laws at an early stage in the research project that contradictory demands are made of company doctors. Firstly, contradictory expectations exist from a legal point of view in the conflict between prevention and their role as expert assessors (both tasks which the company doctor is perceived as having to carry out), and then there are the concrete situations in which the doctor has faced with the contradictory expectations of the different groups within the social structure of the company.
The requirement, for instance, to make prognostic evaluations of the staff performance capacity for the purposes of personnel decisions conflicts with the need to evaluate, for the purposes of prevention, work situations and job pressures in relation to the state of health of the employees.
The expectations of the individual employees can also lead to conflict. These frequently interpret the conduct and duties of company doctors according to their experience with general practitioners outside the company context. Is is our hypothesis that whether such conflicts lead to an overburdening of company doctors or whether they can be compensated in the day-to-day procedures, is determined by professional equipment resources and factors within the company context.

Methodologically, the following steps were undertaken: We conducted a written questionnaire survey of 3.000 company doctors randomly selected out of the 9.602 doctors within the former Federal Republic of Germany who where legally entitled to conduct preventive medical examinations. We obtained details for this from the lists provided by the state federative accidents insurances (Landesverbände der Unfallversicherungen). The return of 1.034 questionnaires represented an expected quota of 33 %, which when compared on an international scale may be regarded as comparatively good. The lists from the accident insurances were the only possible access to the research field, as more comprehensive lists of all medical practitioners acting as company doctors in the old Federal Republic, showing for instance age, gender, qualifications and type of employment, do not exist.

Our second methodological procedure consisted of thematic qualitative interviews with 49 doctors from all over the former West Germany.

Results:

1) General:

In the case of the written questionnaires a discrepancy became evident in the self-image of medical practitioners working in occupational medicine. 532 doctors (ie over 50 %) returned the questionnaire with the comment that they had nothing whatever to do with companies. Furthermore, these doctors stated that they were not actually occupational medicine practitioners and only infrequently carried out a few medical examinations (for example in the case of noise exposition). This becomes interesting when one considers that these doctors are also counted as medical practitioners engaged in occupational medicine providing occupational health care for the working population. This stands in contradiction to the way the doctors see themselves.

The questionnaires were actually only completed by 502 doctors who perceived themselves as company doctors. It is important to know that company doctors are not allowed to work in curative manner. The following evaluation is based on the data gleaned from this group of respondents.

2. **Contextual Factors**

28 % of the doctors worked for only one company, 14 % covered two companies, 9 % three companies, 18 % covered four to ten enterprises and 37 % more than ten companies. 22 % did not respond to this question.

Tables 1 and 2 indicate the size and branch of industry of the companies attended to individually or of the first three companies predominantly attended to by one doctor.

Table 1: Number of employees in companies covered (N = 502)

Number of Employees	only or first company %	second company %	third company %
1 - 50	12	8	6
51 -100	6	9	8
101 - 500	22	22	15
501 - 1000	16	9	6
1001 - 5000	19	3	1
more than 5000	9	-	-
no answer	16	48	63

Percentages have been taken to the next highest number or rounded off.

Table 2: Branch of enterprise covered (N = 502)

Branch/ Sector	only or first company %	second company %	third company %
Metal	32	16	9
Chemical	8	5	3
Trade	3	2	2
Transport	1	1	1
Service	14	11	9
Food	3	2	2
Public Service	18	8	6
Other	9	6	4
No Answer	14	50	65

The success of the work of a company doctor can depend considerably on the health-related social infrastructure of a company and on special programmes or facilities.

Tables 3 and 4 provide information about how frequently company doctors find such facilities available in the largest or only company and in the smallest company they attend to.

Table 3: Health orientated social infrastructure in the largest (only) and smallest company serviced (N = 502)

Services Provided	largest or (sole) company %	smallest company %
Works Council/Shop steward	76	33
	79	34
Representative of Employees with disabilities	58	14
Safety officer	76	38
First Aid officer	70	35
Work safety committee	63	20
drugs/alcohol (addiction) officer	18	1
Company nurse	30	4

Table 4: Health related programmes in the largest (sole) and smallest company coverd. (N = 502)

Programme	largest (sole) company %	smallest company %
Nutritional programme	23	4
Anti-smoking programmes	14	3
Sport and keep-fit programmes	13	2
Addiction (Alcohol) programmes	30	5
special programme	11	2
Health groups/ Ergonomics groups	3	-
sheltered workplaces	27	7
Jobs for employees with severely handicapped jobs	47	15
Jobs for pregnant women	22	5
special instructions for dangerous work materials	46	19

4. Professional equipment (occupational inventory)

Qualification:

23 % of the doctors who responded (N = 502) stated that they were "Occupational Health Practitioners" (Arzt für Arbeitsmedizin, the highest degree). 27 % named as their highest qualification the supplementary qualification “Betriebsmedizin” and 38 % had the basic minimum qualification required in this field (“Kleine Fachkunde”). We have no data for the remainder. 87 % of doctors with the “Kleine Fachkunde” were self-employed. 42 % of Occupational Health Practitioners were regular company employees, 38 % were employed in occupational health centres, while 178 or 36 % of the 502 respondents classified themselves as retired practitioners. Other doctors had been working in the field of occupational medicine for various length of time: 5 % for less than two years, 16 % two to five years, 26 % six to ten years, and 30 % for eleven to twenty years.

Contractual Status

21 % of the company doctors had a permanent position in a company. 13 % were employed in an centre servicing more than one company. 68 % were self-employed, 77 % of these as general practitioners. Some doctors were cross-category, as more than one of the three contractual situations applied to them.

Facilities

In terms of institutional form, not only the contractual status but also the provision of medical and technical facilities and staff by the companies are relevant. Table 5 illustrates that technical equipment and staff provision are generally by no means optimal. Thus, only 55 % of company doctors with the "Kleine Fachkunde” have their own doctors or medical room in the largest of companies serviced by them. Merely one third of doctors can carry out work-related medical examinations within the company with relevant measuring instruments such as audiometric equipment.

Table 5: Technical and staff provisions for Occupational Health Care within the largest or sole company serviced

Provisions	All categories % N = 502	Doctor of Occupational Health % N = 115	Occupational Medicine % N = 134	Kleine Fach-kunde % N = 192
Medical room	68	93	92	55
Laboratory	34	59	43	21
measuring apparatus (eg Audiometric equip.)	49	71	71	34
Other measuring instruments, eg noise level measurements	36	59	50	22
Baths/Spas, Massage	17	29	17	13
Other	12	32	15	2
Additional doctors	17	40	12	8
First Aid officer	21	37	25	13
Nurse, Medical aide	38	62	47	26
Medical-technical Assistant	17	41	15	9
Secretary	27	53	29	16
No Medical Personnel	23	18	26	29

Degree of Professionalisation

The requirements of the professional role are not only determined by contractual agreements with the company, but also by the legal stipulations, in particular paragraph 3 of the Work Safety Law. The empirical question arises to what extent do company doctors recognize, evaluate and fulfil these requirements.

In the questionnaire, company doctors were asked about the degree to which they fulfilled the requirements of the Work Safety Law. Whether or not the technical planning and staffing requirements of the Work Safety Law (as itemised in table 6) were fulfilled ca be ascertained and differentiated according to whether they were carried out to an "optimum" or "minimum" degree. "Optimally" can be interpreted here as "very often" or "frequently", whereas "minimally" can be understood as "sometimes", "rarely" and "never".

Table 6: Handling of the requirements of the Work Safety Law whilst carrying out company doctor duties (N = 502)

Requirements	very often	frequently	sometimes	rarely	never
Consultation during planning, execution and maintenance of industrial plant	3	13	19	24	21
Consultation in planning, execution and maintenance of social and sanitary services and equipment	6	20	24	16	17
Support in the acquisition of technical work means and the introduction of measures and methods of production, measures and of work materials	2	12	24	22	20
Support in the selection and testing of personal safety equipment	13	31	16	9	12
Support and deliberation in questions of work pace and rhythm, work hours and breaks	2	9	22	22	25
Support and advice in questions of shaping the place of work, the job, the conduct of the work and the work environment	5	25	23	15	14
Advice and support in the organisation of First Aid within the firm	27	27	12	5	12
Advice and support in questions job/work change as well as integrated and reintegration and reintegration of the handicapped	20	28	14	8	13
Advising, informing and training of employees in questions and requirements of work safety	14	29	19	11	9

This table reveals such a broadly spread spectrum of variations that this fact alone raises the question whether the company doctors analysed constitute a unitary profession or not. About one-third of the respondents carry out a regular professional practice that approximates the legal definitions of that professional category. In later evaluations we intend to clarify what enables this one-third to comply with legal requirements.

Results of the thematic qualitative interviews regarding occupational orientation

With such a broad range of occupational practice it can either be assumed that a homogeneous occupational self-image has not yet crystallized or that an already existing homogeneous occupational self-image within the profession collides with vastly differing context of action rather than variations in the occupational self-image that explain the great differences in conduct.

The following initial results of the thematic qualitative interviews concentrated on themes mentioned by almost all interviewees.

The professional factors were looked into the problem-centred interviews on the basis of statements about the criteria according to which doctors orientate their activity, and their function and decisions. The qualitatively compiled material was structured according to citeria of the sociology of professions. By compariing each individually relevant activity and normative orientation of the interviewees it was possible to determine supra-individual action structures, which mediate between the professional reference system and the demands of the company. This social action takes place within the framework of experiential situations, in which typical social situations crystallise which in turn constitute action routines in the sense of professional strategies. Professional conduct is not arbitrary but effected by means of interaction and communication forms and in relation to given institutional structures on the one hand and subjective orientations, reflections and intentions on the other. These elements which constitute the day-to-day activities of company doctors will now be filtered out of the interview material to determine patterns of interpretation and frames of reference of social situations. The most significant dimensions related to the sociology of professions, with which the action orientations of the company doctors were analysed and the interviews evaluated, can roughly be represented as follows in Chart 1.

Chart 1: Orientations of company doctor activity

Dimensions	Expression
Attitude to job/choice of career	Joborientation _____ vocation
Relationship to legal requirements	strong _____ weak
Problem orientation	
Social reference	health ____ hazard ____ illness
Image of company	population _____ individual cases
Professional focus	social drawn up _____ economically and technically determined
Understanding of duties	
Demeanour orientations	prevention _____ cure
	expert ____ mediator ____ assistent
	advice _____ examinations, assesment

The account given by company doctors shows in the interviews show that in the company doctors daily work routine the varying dimensions overlap and interpenetrate.

Attitude to the Occupation/Motives for Choice of Career

The reconstruction of the reasons for deciding to become a company doctor reveal active as well as passive factors of different relations to vocation and professional self-image.

Two extremes may be found in the interview material

a) One explanation given by a considerable number of company doctors for their choice of career was their failed attempts at a regular career in a clinic or a practice in other medical fields.[3]

b) In the second category of respondents, the decisions are clearly related to an understanding of Occupational Medicine as an independent branch of medicine, with its own pertinent area of responsibilities. This group combined their comprehension of the field with practical requirements and social commitment.

Problem Orientation

Apart from legal or contractual requirements, company doctors can deduce their activities and decisions from the concrete circumstances concerning work load and working conditions, the work demands and the health-related situation of the company.

The work of a company doctor reveals differing problem complexes. On the one hand, simple methods of analysis (such as the determination of blood lead content) can be required; on the other, problems concerning social structures/constellations, values and objective require a more complex and difficult approach (like, for example, the design of jobs with a view to maintaining good health). In the first case, a knowledge of the field occupational health is enough to deal with disease and the impairment or reduced working capacity in simple terms. More complex connections with public and individual health requires more far-reaching interpretations of the company doctor. The types of problem orientation range from that of a mechanistic interpretation of illness or a conception of risk which identifies the likelihood of becoming ill alone as a term of characteristic (eg hypertonia as an exclusion criterion for certain jobs), to a comprehension that also integrates subjective disorders and psycho-social conditions in the recognition of a problem. The concept of illness is used differentially here. With one section of company doctors, it includes psychosomatic disorders from the classical clinical point of view and labels such problems as "illness". Difficulties arise with another group of company doctors who have a narrower understanding of illness and have to operate with social problem definitions and strategies to a greater extent.

One noticeable outcome of the interviews evaluation must be emphasised here, and that is in how the notion of illness held by individual medical practitioners determines their identify as company doctors. The opportunity to identify illness within their own contexts of action - independent of whether its source is traced back to the individual or the working conditions - seems to be the conditio sine qua non that justifies and

[3] Thus the pressure of competition and rivalry as well as the economic constraints deterred one company doctor from establishing his own practice a dermatologist ("I don't have the soul of a businessman"). For another, the opportunity to train as specialist became more and more remote due to the particular constraints of the hierarchical structures within the hospital, which finally lead to the pursuit of a different career.

guarantees their professional status within the social structure of the company.

The effectiveness of "illness" orientations of differing types produces contrasts to and breaches with the "operational logic" of rational, smooth functioning, which are at least in part responsible for the conflict experience of the interviewed company doctors.

Social reference

The discernible tension in the problem orientations of company doctors between simple reference to physical parameters by which normative assumptions about illness and health can be made, and more complex references to structures, developments and evaluations, has a corresponding equivalent in the social context. Social references are pronounced in the relations with personnel as a whole or on an individual level.

It is noticeable in the interview material that the company doctors generally had difficulties in differentiating between their own social relationship and those of a doctor practising therapeutic medicine. Time and again they refer to "patients", which they later correct to "probationer", "employee" or "staff member". The orientation to individual cases corresponds to the aforementioned clinico-therapeutic understanding of illness and facilitiates situation-specific professional conduct. Even though company doctors in the interviews refered to specific groups or staff sections, they very rarely develop epidemiologically plausible criteria for preventive action.

Company Image

In the interviews images of the companies can be found which range from that of the company as a socially "inhomogeneous structure" to the "big apparatschick", in which the company doctor is but "a small cog in the machinery". The consequence is an action orientation to company welfare policies which in certain cases is able to break through the prevailing technically and economically orientated company strategy. Some succeed in developing an understanding of company interests and power structures in which they can accommodate their occupational health work.

Professional Focus

The remarks made by the interviews with regard to their relation to problems, persons, or the company as a whole, and especially how these are structured by their concept of illness, point to a basic dilemma in the conduct actions of company doctors. This dilemma arises out of the conflicting characteristics of curative and preventive measures. Many company doctors have internalised their curative orientation with regard to diagnosis, therapy and prognosis in the course of their experience in clinics and ambulatory or outpatient practice. These professional routines allow company doctors a safe standardised opportunity to act in problematical situations without having to ascertain the scope of the problems and action, or having to justify the objectives of their action. Company doctors emphasise

the routine character of their work ("many years of clinical experience") and their "freedom from directives" according to the Work Safety Law.

While these classical individual medical routines directed at individual medical treatment are accepted by all company actors, company doctors nonetheless complain about being drawn into conflict-laden constellations of company interests when they introduce preventive concepts for the improvement of working conditions ("I tried that unsuccessfully time and time again, and then stood there out on a limb", "you only get your fingers burnt".) These conflicting demands and expectations are a feature of the everyday experiences of the company doctors.

In plain terms one might say that the difficulty of company doctors in proceeding professionally is essentially that there, that their acquired knowledge and abilities - namely to diagnose illnesses and to apply the appropriate therapy - cannot be directly applied if they are to follow the basic tenet of prevention. On the other hand they lose their traditional, independent, therapy-orientated bearing/medical status if they develop concepts and procedures for prevention from conditions that cause illness. This paradoxical task leads to irritations and role ambiguity which reveal themselves in various sections of the interview material. Thus, a contrast is constructed between occupational medicine and "Grand Medicine" which is concerned with “life and death”. Complaints are voiced that company doctors are not regarded as "reputable medical specialists" and not accepted as "proper doctors” by employees as they are not allowed to provide medical treatment. The frequently expressed feelings and opinions about general practitioners may likewise be interpreted in this light.

One observation regarding natural interactions not anticipated in this project raises a question still to be answered, and that is to what extent signs of inadequate professionalisation gathered from the action orientations influences the actual activity of company doctors.

A constantly recurring factor in the observations is the disjunction between the socialisation in the profession of medical practitioners on the one hand, and the socialisation within the profession of company doctor in the execution of his/her day-to-day practice on the other. On the basis of the empirical material data gathered one can thus speak of borrowed professionalism of the company doctors, that is, borrowed from those members of the medical profession working in curative medicine.

Regulation of Status Passages

The medical examination of recruits represents one of the most visible and at the same time consequential regulatory mechanisms controlling status passages within working life. 68 % (N = 502) of the interviewees stated in the questionnaire that they undertook medical check-ups for recruitment purposes.

The frequency of direct and indirect participation in measures for the regulation of the working life/occupational progress within the company is shown by table 7. Thus, vocational as well as medical rehabilitation measures are rather seldom events in the

perception of company doctors. Rarer still, are reports on suspected occupational diseases.

Table 7: Maßnahmen zur Regulierung von innerbetrieblichen Berufsverläufen im größten bzw. einzig betreuten Betrieb (N = 502)

Measures taken	very often %	frequently %	sometimes %	rarely %	never %
occupational rehabilitations within the last 12 months	2	10	22	22	20
medical rehabilitation within the past 12 months	4	18	22	14	15
report of an occupational disease by a company doctor within the past 12 months	-	2	14	34	37
general work-related medical check-ups in accordance to ASiG §					
group specific examinations	18	24	14	11	19
	9	19	18	15	24

The diagnostic activity by the doctor plays a considerable role. After all, 42 % of respondents state that they frequently or very often carry out general work-related medicical examinations in accordance with § 3 of the Work Safety Law in the largest or only enterprise serviced by them. If one considers the relevance of these examinations, then the central significance of diagnostic work within the sphere of activity of company doctors becomes even more manifest.

Professional Role

The problems arising out of the demands made on the professional role of company doctors are exemplified by the advisory dunctions required of them by law. Their advisory activities are dealt with extensively in the interviews. Frequently this activity is spoken of in terms which express regret for limitations imposed by themselves and others on their own scope of action and competence ("we merely advise" "we don't have the power, we only have an advisory capacity", "we are the jesters of industry, can say a lot, but we don't have any real power"). For another group of interviewees however, their advisory function also offered them a certain degree of freedom with opportunities to act positively, as they were freed of the pressure of responsibility ("as one only starts the ball rolling, one does not have to catch or try to stop it").

All the respondents reported that it was difficult at first to get used to company structures. One first had to learn who was responsible for what, and "how do I actually talk to such a foreman". One group of the interviewees stressed the necessity of "proceeding diplomatically", using a great deal of persuasion and being careful not to be exploited. In particular, the relationship to the employee, often labelled as "patient", is frequently dominated by an aspect of control. The likelihood of "being taken for a sucker" by the employee is countered by some by examining them at close intervals, as well as "stringent control". Only a small group of company

doctors found that the attraction of the job lay in "sitting between the chairs". These doctors responded positively to the chance of playing different roles in the course of their day-to-day work, "moving back and forth from one side to the other", acting as "mediator between the varying interests" without however falling into the trap of "committing oneself to one side or the other".

The interview passages to this aspect of the work of company doctors prove that with regard to codes and standards of conduct, the actual situations in the daily interactive relationships is of greater efficacy. Depending on the problem at hand, the company doctor can cross the boundary between different roles (that of expert, mediator or helper), so that the professional role generally is at the disposal of the company doctor but must also be adjusted according to each situation.

Focal Points of Professional Conduct

According to the empirical findings the decisions of company doctors relating to the regulation of status passages within the company represent one focal point of their activity. However, an interesting discrepancy arises between the results of the written questionnaires and statements made in the interviews.

The narrative interview passages about the professional day-to-day work, nevertheless indicated fewer actual and concrete decisions about status passages than assumed by us and found in the written questionnaire. Even if it is not be expected that company doctors extend their regulative functions when concerned with status passages, the relatively little discussion and reflections on these facts must be emphasised as needing closer interpretation.

Furthermore the evaluation of the scope of a company doctor's own action, his or her own competence and the resources available also need to be taken into consideration. In this respect, some of the interviewees, in an effort to exonerate or justify themselves, referred to the emphasis in the Work Safety Law on their function as advisors.

The possibilities open to company doctors were depicted by some of those questioned as bound to a decision-making process which involved the whole company, with different participants – including experts - in which "everything is sorted out", and the company sees to it that "things are taken care of". This positioning of their own professional conduct, which is valid for larger and medium-sized companies, reinforces their orientation to occupational medicine primarily concerned with examination and evaluation.

Even though some of the interviewees were of the opinion that "occupational medicine should not consist purely of examinations", other interviews show that the very activities of examining and evaluating create a feeling of security and identify for them in their professional role. One company doctor, for instance, stated that she "did not feel particularly at home" at company work safety committee meetings, for example, and that she would "much rather carry out examinations", as that is what she had learnt. Another company doctor finds positive aspects of his work in the treatment of acute cases of sickness, whilst another does not want to go without at

least a rudimentary diagnosis.

To summarise, it can be said that a certain type of company doctor falls back on classical professional types of activity (diagnoses, therapy and prognosis) to help shape their professional role, even though they are well aware, that indeed "no therapy is allowed to be undertaken" and that "for all intents and purposes we are examining healthy individuals".

Conclusion

Company doctors, as was shown in our nationwide (West-Germany) investigations, are at a far more elementary stage of development than most of the other branches of the medical profession. A uniformity in the execution of their professional duties conforming to the statory requirements of the Work Safety Law has not taken shape as yet. Neither has a professional self-image as preventive and advisory group of doctors crystallised to the same extent that, say, specialists in internal medicine perceive when distinguishing their work from that of surgeons. Company doctors, to a large extent, still relate themselves to curative medicine, which however they do not practice. Only a minority of those interviewed seem to be able to draw their strength from a fully developed, institutionally consolidated profession (Habitus), which is primarily connected with the specific preventive requirements of company doctors.

Nevertheless, one cannot say that no company doctor corresponds the image portrayed in the ASIG. Professional practice leads to tremendous diversity. Approximately one third - a by no means insignificant number - seems to act in accordance with the image that the ASIG has of occupational health practice.

Our next task will be to further analyse the data we have gathered further and try to establish what enables this one third of our study population to correspond to this image - whether it be company contexts and welfare policies, or professional bearing/Habitus (occupational inventory - institutional form of the company doctor's position within the company). The less the reasons for this capacity lie in their qualifications and training, and the more they lie in the institutional form, the day-to-day routines of professional practice and in the company contexts and welfare policies, the clearer our final conclusion will be. That is that the attempt to make occupational health care a more significant part of health protection must to all intents and purposes fail if it is primarily approached via the qualified "theoretical" training of company doctors rather than supervised institutional changes in the day-to-day running of companies.