

Activities of Private Clinic- or Hospital-Based Occupational Physicians in Japan

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Abstract: The present study was initiated to examine the activities of private clinic- or hospital-based occupational physicians (OPs) and to identify difficulties the OPs encountered in their occupational health service (OHS). A questionnaire was sent by mail to 557 OPs in Kyoto prefecture, Japan. Effective answers were obtained from 86 OPs who were private practitioners or physicians in hospitals and served as OPs on a part-time basis. Considering 3 h as a unit, a majority (92%) served <1 to 2 units/month. The leading fields of OHS provided by the OPs were general health examination and its follow-up, prevention of overwork, and mental health care, as well as support of workers on sick leave to return to work. OPs wished to allocate more time for maintenance and management of work and the work environment, mental health care, work area rounding, and attendance at the safety and health committee meetings. Difficulties were encountered most often in the management of mental ill health and overwork, and support of employees' return to work. Many OPs also reported difficulties with industrial hygiene-related issues such as risk assessment, and maintenance and management of work and the work environment. The present survey identified difficulties that were frequently encountered by private clinic- and hospital-based OPs in their practice of OHS; these include issues on mental health, overwork and industrial hygiene. The needs to offering OPs specific opportunities to gain information and skills in these areas are stressed.

Key words: Difficulties in occupational health service, Enterprise size, Japan, Occupational health service, Occupational physician, Time allocation

Introduction

Occupational physicians (OPs) in Japan are responsible not only for the maintenance of the health of workers

through regular health examinations, health guidance and consultation, but also for the maintenance and management of work conditions and the work environments. The responsibility of OPs also include contributing to the prevention of overwork and mental health problems¹. The latter is especially important because cases of mental ill health possibly due to overwork are increasing and currently represent a pressing problem in Japan²⁻⁴.

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Table 1. Comparison of three certification systems for OP in Japan

	JMA ^a -certified OP	JSOH ^b -qualified OP	UOEH ^c training course
Certification	Basic occupational health lectures (50 h)	Completion of basic OH training ^d 3-yr practice training under supervision of senior certified OP ^d Presentation or publication on OH research	Lecture on occupational medicine at university Training by practice in OH (1 wk) in 5th grade at university Comprehensive training of OH (10 h) after graduation
Re-certification	Renewal course lectures (20 h within 5 yr)	Active in OH field more than 3 yr Attendance in scientific congress more than 3 times in 5 yr	No re-certification
Owners of the certification	General practice-based OPs	Parts of full-time OPs and OPs in OHS organizations	Only UOEH graduates
Typical type of OHS	As part-time OPs	As specialist OPs	As specialist OPs

^aJMA: Japan Medical Association; information cited from Ref. 5. ^bJSOH: Japan Society for Occupational Health; information cited from Ref. 3. ^cUOEH: University of Occupational and Environmental Health, Japan; information cited from Ref. 4. ^dExamination should be passed at the end of the course.

Both the Japan Society for Occupational Health (JSOH)⁵ and the University of Occupational and Environmental Health (UOEH)⁶ provide courses to train up specialist occupational physicians, but the numbers of graduates of these courses are still limited. Thus, a majority of occupational physicians (OPs) in Japan are trained by the Japan Medical Association (JMA) through its training course⁷; according to JMA statistics, such certifications were given to 73,302 doctors in 2008 and earlier⁸ (Table 1).

Of the JMA-certified OPs, 43% were private practitioners and 55% were based in hospitals⁸, and most served on a part-time basis (to be called part-time OPs in this article). As their large number suggests, the JMA-certified part-time OPs are indeed core forces in occupational health services (OHS), especially in small- and medium-scale enterprises. The number of currently active JSOH- or UOEH-qualified OPs is estimated to be about 1,700⁹; these OPs mostly serve in large-scale enterprises or occupational health organizations, or have their own independent offices on a full-time basis (to be called specialist OPs); OPs who serve in large-scale enterprises or occupational health organizations are not always JSOH- or UOEH-qualified but they are very much specialized through practice.

A nation-wide survey conducted by the Ministry of Health, Labour and Welfare, Japan¹⁰ revealed that 75.8% of enterprises with ≥ 50 workers had OPs (either with a full-time or part-time contract). As expected, the percentage was higher (99.8%) for enterprises with $\geq 1,000$ workers and lower (63.7%) for enterprises with 50 to 99

workers. The percentage for even smaller enterprises (so-called micro-enterprises) is not known as there was no legal stipulation that the micro-enterprises have OPs.

Reports on the activities and job satisfaction of OPs have been published by several research groups¹¹⁻¹⁹ as well as by a number of regional occupational health promotion centers²⁰⁻²³. Nevertheless, there are no currently available reports on the difficulties experienced by private clinic- or hospital-based part-time OPs in their daily OHS or that evaluate the time spent by OPs in various OHS activities.

The purpose of the present study was to characterize the OHS performed by active OPs in Kyoto Prefecture, Japan. The survey focused on the current and desired length of time spent by OPs in major OHS activities. The survey targets were further extended to identify difficulties the OPs had encountered during their OHS. A separate survey was conducted on the activities of specialist OPs in Japan in comparison with those of specialist OPs in the Netherlands¹⁹; the results of the latter survey on specialist OPs were compared with the present findings on part-time OPs.

Materials and Methods

For the questionnaire survey, the registry of OPs in the Kyoto Occupational Health Promotion Center was employed. The list was originally prepared by the Kyoto Medical Association, Kyoto, Japan, and was subsequently updated by the Center taking advantage of additional available information for effectiveness of communication

Table 2. Number of plants classified by number of workers

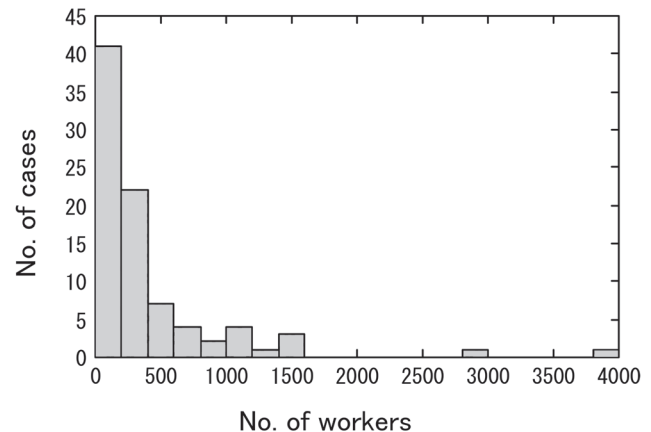
	No. of workers	No. of plants (%)
1	<50	39 (19.6)
2	50–99	77 (38.7)
3	100–299	58 (29.1)
4	300–499	15 (7.5)
5	500–999	5 (2.5)
6	≥1,000	5 (2.5)
Total		199 (100.0)

with the OPs. In 2008, the list contained the names and postal addresses of 557 OPs.

The questionnaires (for details, see Appendix) was sent by mail to the 557 OPs in the registry early in November, 2008. A reminder letter was sent in the middle of the month, and the completed questionnaires were collected at the end of the month. Responses were received from 175 OPs (response rate: 31%); of these, 76 physicians stated that they were no longer active as OPs. Thus, the usable answers (excluding those from 13 cases of industrial health organization-based specialist OPs) were obtained from 86 OPs (49% of the 175 respondents, or 15% of the original 557 mail addressees), who were either private clinic-based or hospital-based (64 and 22 OPs, respectively). A preliminary analysis revealed that there was essentially no difference between the former and the latter OPs with regard to their functions of occupational health physicians. Thus, the present analyses were conducted based on the 86 effective answers. An additional analysis was made of the 76 physicians who had ceased providing OP service to investigate the reason for the termination of the OP service.

With regard to the enterprises served, a single enterprise may, depending on its scale, have more than one business office or production plant, e.g., a head office and several production plants. In the present study, both offices and plants are referred to as 'plants'.

A normal distribution of the data was assumed, and the arithmetic mean (AM) and arithmetic standard deviation (ASD) of the data were calculated. However, because a normal distribution of the data was not always confirmed, Mann-Whitney test was employed to detect possible difference. The Chi-squares test was also applied when appropriate. For evaluation of statistical significance, $p < 0.05$ was employed as the cut-off point.

**Fig. 1.** Number of workers served by one occupational physician.

Results

Demographic and other characteristics of the 86 active OPs

Of the 86 OPs who completed the questionnaires, 77 and 9 (90 and 10%) were men and women, respectively. Sixty four physicians were private practitioners and 22 others were physicians in hospitals. The proportion of physicians in their 30's, 40's, and 50's and those who were 60 yr of age and over were 3%, 15%, 26% and 56%, respectively, a majority being over 50 yr of age. The length of clinical practice experience was 33.4 ± 9.7 yr (AM \pm ASD; median=34 yr), and most of the respondents specialized in general practice or internal medicine.

Services as OPs

The 86 respondents had experiences as OPs of 13.4 ± 8.3 yr (median=11 yr). They served in plants 6.2 ± 8.1 h/month (median=3 h); the monthly service hours showed a remarkable skewness.

In total, the 86 OPs served in 199 plants. Of these plants, the majority (174 plants or 87%) had less than 300 workers (Table 2). One OP served in 1 to 10 plants with an average of 2.3 (± 1.7 as AM \pm ASD; median=2 plants).

Considering 3 h as a unit of service, a majority (92%) served <1 to 2 units/month; of these, most served less than 1 unit/month. When asked the number of workers treated by an individual OP, 8 of the 86 OPs gave no answer. An analysis of the remaining 78 cases showed that each OP served between 5 and 4,000 workers (AM \pm ASD, 426 ± 610 ; median, 210). As shown in Fig. 1, there was a remarkable skewness in the distribution. Classification by type of business of enterprises showed that 37 OPs (43%)

Table 3. Time allocation by fields of service: current versus desired allocation

Field of services	Time allocation (h)			
	Current	Desired	Desired/Current (%)	Difference ^a
1 Plan and advice for OSH policy	1.0	1.4	(136)	0.4
2 Attendance at the meeting of HS committee	1.4	1.9	(135)	0.5
3 Rounds of the work area	1.2	1.6	(136)	0.4
4 Risk assessment	0.6	1.0	(171)	0.4
5 Maintenance and management of work	0.6	0.9	(150)	0.3
6 Maintenance and management of work environment	0.6	0.9	(152)	0.3
7 General health examination	2.2	2	(91)	-0.2
8 Follow-up of examination	1.9	2.6	(134)	0.7
9 Specific health examination	1.1	1.0	(88)	-0.1
10 Health and hygiene education	1.2	1.2	(99)	0.0
11 Health promotion activity	1.3	1.4	(110)	0.1
12 Mental health care	1.5	2.0	(137)	0.5
13 Prevention of health hazards due to overwork	1.7	1.9	(116)	0.3
14 Development of comfortable workplaces	1.1	1.1	(100)	0.0
15 Guidance of workers on sick leave	1.2	1.1	(92)	-0.1
16 Diagnosis for return to work and follow-up	1.2	1.3	(110)	0.1
17 Pre-employment health examination	0.9	0.9	(93)	-0.1
18 Health examination at the start of employment	1.0	0.9	(85)	-0.2
19 Others	1.8	5.0	(273)	3.2

^aDifference = Desired time (h) – Current time (h).

served in manufacturing industries, while 22 OPs (26%) served in clinical or health and welfare-related enterprises.

Time allocation for activities; comparison between the current and desired allocations

The leading fields of service in which currently OPs spent their times were 7. General health examination (2.2 h/month; Table 3), 8. Follow-up of health examination (1.9 h/month), 13. Prevention of heavy work-induced health hazard (1.7 h/month), and 12. Mental health care (1.5 h/month). OPs wished to allocate more time for 8. Examination follow-up (2.6 h/month), 12. Mental health care (2.0 h/month), 13. Prevention of overwork (1.9 h/month) and 2. Attendance at the safety and health committee meetings in the plant (1.9 h/month). The discrepancy between the current and the desired allocation was greatest for 4. Risk assessment (171% as the desired/current ratio), 5. and 6. Maintenance and management of work, and the work environment (150 and 152%, respectively). In contrast, time allocation for health examinations appeared to be sufficient (i.e., Fields 7, 9 and 18 in the Difference column in Table 3).

Difficulties encountered by OPs

Difficulties were experienced most often in 12. Man-

agement of mental ill health (36 OPs; Table 4), and 15. Guidance of workers on sick leaves (11 OPs). The former was followed by 13. Prevention of health hazard due to overwork (30 OPs) and 16. Diagnosis of return to work (15 OPs). Many OPs had difficulty in dealing with industrial hygiene-related issues such as 4. Risk assessment (14 OPs), and 5. and 6. Maintenance and management of work and work environment (11 cases each). Because most OPs major in general practice, the respondents were generally self-confident regarding physical health management (typically providing general health examinations) except for a few specific health examination issues. To solve the problems related to lack of experience with mental health issues, proposals were made such as providing opportunity for exchange of information on these issues with experts such as psychiatrists for common sharing of experiences and for construction of a network.

Reasons for terminating OP activities

As stated above, 76 physicians responded that they were no longer active as OPs. When asked (by multiple choice) for their reasons for ending such service, the most common answer was shortage of time (40 cases, 53%), followed by lack of suitable enterprises (28 cases, 37%); in this context, lack of suitability may imply inconve-

Table 4. Fields of difficulties experienced by occupational physicians

Field of services		Fields of difficulties	
		Cases	(%) ^a
1	Plan and advice for OSH policy	3	(3)
2	Attendance at the meeting of HS committee	3	(3)
3	Rounds of the work area	3	(3)
4	Risk assessment	14	(16)
5	Maintenance and management of work	11	(13)
6	Maintenance and management of work environment	11	(13)
7	General health examination	0	(0)
8	Follow-up of examination	4	(5)
9	Specific health examination	12	(14)
10	Health and hygiene education	4	(5)
11	Health promotion activity	2	(2)
12	Mental health care	36	(42)
13	Prevention of health hazards due to overwork	30	(35)
14	Development of comfortable workplaces	6	(7)
15	Guidance of workers on sick leave	11	(13)
16	Diagnosis for return to work and follow-up	15	(17)
17	Pre-employment health examination	1	(1)
18	Health examination at the start of employment	3	(3)
19	Others	4	(5)
Total		173	

^a Percentage for 86 occupational physicians.

nience of commuting to the base clinical facilities or poor economic efficiency. Insufficiency of knowledge and experiences were mentioned in 6 cases.

Discussion

The present study disclosed three major points concerning the involvement of OPs in Kyoto Prefecture, Japan; 1. a majority of OPs serve less than 3 h/month, 2. the leading service provided by OPs are support of workers' return to workplaces, mental health/overwork issues, and practice of general health examinations, and 3. the mental health and overwork issues, as well as industrial hygiene issues create the major difficulties in OPs' daily OHS activities.

The analyses reported in the present survey were primarily based on responses from 86 currently active OPs. The fact that 76 physicians (43% of 175 respondents) were inactive at the time of the present survey suggests that many physicians are not active as OPs despite the fact that they possess JMA certification. Low participation rates (38.6–46.7%) of physicians in OHS despite acquisition of certification as OPs have also been reported for other prefectures^{20–23}. Terada *et al.*¹⁷ observed that only 94 (23%) physicians were active out of 405 private clinic- or hospital-based physicians who had registered as OPs in

a labour standard inspection office in central Tokyo. The number of OPs registered by the Kyoto Medical Association as certified OPs represent 1,448 members of the Association⁸. It is quite conceivable that the OHS participation rate of the 1,448 certified physicians may not be high.

Among the 86 respondents, the proportion of men (90%) was approximately equal to the proportion of men among all physicians, i.e., 81.1% for men vs. 18.9% for women²⁵. Similar analyses involving other prefectures in Japan, 87 to 94% of OPs, were reported to be men^{20–24}. These results suggest that OHS is provided by the two genders with no specific bias. Many OPs (46–47%) serve in only one enterprise^{20–24}.

With regard to age distributions, a large fraction of the present survey participants were >60 yr of ages; on average, the OPs participating in the present survey are older than those in most other prefectures, where the modes in age distribution fell within the 40's²⁰ or 50's^{21, 22}. In one prefecture, however, the largest fraction of the OPs surveyed were in their 60's²³, similar to the present case.

OPs reported spending many hours for 12. Mental health care, 13. Management of heavy work issues, 14.+15. Support of return to work, as well as 7.+8. General examinations and follow-up. All of these are the fields in which the demands for OP service have increased following recent

amendments in regulation^{1, 26}). It is interesting to note that while OPs in other prefectures, like the OPs in the present survey, reported spending many hours for health examination, follow-up and health counseling^{20–23} (Table 3), OPs in other prefectures reported spending less time on management of mental health issues and over-work cases than OPs in the present analysis. Management of mental health cases, however, has been among the important issues of medical consultation^{20, 21}). It has been reported that the cases with mental health problems in workplace have been increasing in recent years^{2–4, 27}).

A comparison of the activity of private clinic- or hospital-based part-time OPs in the present study with those of specialist OPs reported by Moriguchi *et al.*¹⁹) is of particular interest. Moriguchi *et al.*¹⁹) studied 72 specialist OPs (61 men and 11 women) who were associated with the National Federation of Industrial Health Organizations, Japan. Whereas the service time (in h/month) of specialist OPs was 20 h/month (as a mode, and 26.1 h as AM) whereas the service time of the part-time OPs in the present study was 2 h/month (as a mode) and 6.2 h (as AM); thus, the service time was substantially shorter for the part-time OPs than for the specialist OPs.

Calculation of the monthly service duration per plant (in terms of units representing 3 h/month/plant) revealed that, for specialist OPs, the monthly service duration per plant was <1 unit in 271 plants (56.3% in 481 plants) and 1–2 units in 147 plants (30.6%). For part-time OPs, it was <1 unit in 132 of 190 plants (69.5%) and 1–2 units in 42 of the plants (22.1%). These data suggest that specialist OPs served longer in each plant than part-time OPs.

With regard to the current versus desired time allocation, the results obtained in the present survey of part-time OPs generally agree with previous findings on specialist OPs¹⁹). Specialist OPs expressed the desire to have more time for 1. Plan and advice for OSH policy, 4. Risk assessment, 5. Maintenance and management of work environment, 13. Prevention of health hazards due to overwork, and 15. Guidance of workers regarding their return to workplaces. The differences in desired time allocation between part-time OPs and specialist OPs suggest that specialist OPs tend to pay more attention to preventive service than part-time OPs. Part-time OPs, however, also understood the importance of 4. Risk assessment, 5.+6. Industrial hygiene issues, 8. Health examination follow-up, and 12. Mental health issues, even though the part-time OPs for most part possessed only limited experiences in these fields (except for follow-up of health examination) and tended to experience difficulties in management (Table 4).

With regard to service hours provided by OPs in small-scale enterprises, part-time OPs spent about 9 h/month in OHS while specialist OPs spent 22 h/month. However, the time spent per plant was more or less similar, i.e., 3.1–3.6 and 2.1 h/plant²¹). Hino *et al.*¹⁴) reported that the time spent in OHS by specialist OPs (including the time for preparatory work and transportation) was approximately 3.5 h/plant. In a survey of three wards in central Tokyo, Terada¹⁶) observed that active OPs spent 11.5 ± 2.1 h/month (AM \pm ASD) for OHS, and that 50 of the 94 OPs routinely made worksite rounding. In contrast, routine worksite rounding (i.e., once a month or more) was performed only by 11.0% of OPs who served assumedly on a part-time basis¹⁵); the low rounding rate might be related to the shorter service hours of this group.

Plomp and Ballast²⁷) stressed the importance of gaining the trust of the workers in conducting good OHS, and identified independence, agency and expertise as three essential conditions for development of such trust. Frequent contact with workers will contribute in winning the trust. Kudo *et al.*¹⁸) noted that health consultation improves the attention of workers to health check-up results and daily health management. From administrative viewpoints²⁸), employers in large-scale enterprises expect OPs to participate actively in dealing with mental health problems, proper allocation of manpower in worksites, and prevention of overwork¹³), whereas the major areas of expectation in smaller enterprises were capability in conducting health examinations, participation in improvement of the work environment and the health education of workers¹¹).

The OHS model is various subject to social conditions such as availability of human resources including OPs. In France for example, specialist OPs played an almost exclusive role until recently when ‘occupational hazard prevention operatives’ joined the task²⁹). In the Netherlands, specialist OPs receive 4 yr education and training³⁰), and the quality of OHS providers is examined by a committee in which representatives of employers and employees jointly participate³¹). In the Republic of Korea, group occupational health service (OHS provided by a team of a physician, two occupational health nurses and two industrial hygienists) has been introduced^{32, 33}). For Japan, under conditions of a shortage of specialist OPs, efficient participation of part-time OPs would be a practical measure. In this respect, meeting the current demand for specialized information and skill especially in the areas of mental health, overwork and industrial hygiene is important. The possible participation of occupational health nurses in routine worksite rounding to support activities of

OPs³⁴) has also been discussed. With regard to industrial hygiene, cooperation with OHS-providing organizations is a practical solution because OHS-providing organizations have an industrial hygiene section³⁵).

The present analysis has several limitations. First, 12.5% of the enterprises served by the present 86 OPs had more than 300 workers (Table 2), whereas the enterprises with more than 300 workers accounted for 8.3% in Kyoto Prefecture³⁶) and 9.6% in Kyoto City³⁷). Thus, although a majority of the enterprises studied were of small-scale, the enterprise size of the present survey was somewhat skewed toward to larger ones. With regard to the types of enterprises, manufacturing and health-related enterprises were two primary types of enterprises that employed the OPs surveyed in the present study. Both in Kyoto Prefecture³⁶) and in Kyoto City³⁷), the manufacturing and health-related enterprises took the 3rd and the 6th positions in the number of enterprises, indicating that the present study is biased in the distribution of types of industries studied.

The third limitation of the present study is that, while both musculoskeletal disorder and mental ill health were complained of by workers in the United Kingdom³⁸) and in Finland³⁹), musculoskeletal disorder issues were not specifically addressed in the present analyses. In addition, Doucet *et al.*⁴⁰) stressed the positive role of OPs in enabling the return of workers to workplaces after episodes of stroke. Although the return of workers to workplaces was discussed in general, specific needs such as post-stroke care⁴⁰) were not addressed.

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Appendix. Sample of the questionnaire

1. Please answer your gender and age.
 A) Gender 1 Male 2 Female
 B) Age 1 29 years-old or below 2 30–39 years-old
 3 40–49 years-old 4 50–59 years-old
 5 60 years-old or above Years
2. How long are you active as a clinical doctor? Years
3. What is your speciality? (e.g. general practice, surgery etc.)
 *If yes, please answer Q.6. Yes No
4. Are you active as an occupational physician at this moment?
 *If no, please kindly answer Q.5 and send back the questionnaire with the enclosed return envelope. Thank you very much for your cooperation.
5. May we ask why you do not serve as OP?
 (1) No plants (or offices) to serve. (4) Time shortage
 (2) Poor matching in work conditions (other than fee issue) (6) Others
 (3) Poor fee (5) Insufficient knowledge or experience in occupational health
 If yes to (5), please give the suggestion of lecture subject.
6. What is your routine work? Please select.
 (1) Doctor in a hospital (2) Private practitioner
 (3) In company OP (4) OP in occupational health organization
 (5) Doctor in research institution (6) Practitioner as OP or occupational health consultant
 (7) Others: please specify in the box
7. How long have you worked as an occupational physician? Years
8. How many hours do you work as an occupational physician a month?
 Hours/month
9. How many companies do you work for as an occupational physician regularly?
 No. of companies

1	Company with less than 50 employees
2	Company with from 50 to 99 employees
3	Company with from 100 to 299 employees
4	Company with from 300 to 499 employees
5	Company with from 500 to 999 employees
6	Company with more than 1000 employees
10. On the assumption that 1 unit equals 3 hours, how many companies do you work for as an occupational physician in each unit category in a month?
 No. of companies

1	Company with less than 1 unit/month
2	Company with from 1 to 2 unit/month
3	Company with from 3 to 4 unit/month
4	Company with from 5 to 8 unit/month
5	Company with from 9 to 15 unit/month
6	Company with more than 16 unit/month

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11. Please answer total number of employees in the companies which you work as occupational physician. employees in total
12. Please answer the types of industries for which you work as an occupational physician (please circle all cases).

1	Agriculture, forestry and fishery	10	Real estate agent
2	Mining	11	Eating and drinking facilities, Hotels and other lodging facilities
3	Construction	12	Medical, health and welfare services
4	Manufacturing	13	Education and learning support
5	Electricity, gas and water supply	14	Services
6	Information and communication	15	Public business
7	Transportation	16	Others (please specify)
8	Wholesale or retail trade		
9	Finance and insurance		

13. Please answer the current and ideal working hours for different types of activities as a whole in the companies as an occupational physician.

Activity	Current (Hours/month)	Ideal (Hours/month)
1	Plan and advice for occupational safety and health policy	
2	Attendance at the meeting of health and safety committee	
3	Rounds of the work area	
4	Risk assessment	
5	Maintenance and management of work	
6	Maintenance and management of work environment	
7	General health examination	
8	Following of health examination	
9	Specific health examination related to special work risk factors	
10	Health and hygiene	
11	Health promotion activity	
12	Mental health care	
13	Prevention of health hazards due to overwork	
14	Production and maintenance of comfortable workplaces	
15	Guidance of workers when sickness absence is present	
16	Diagnosis for return to work, and follow-up	
17	Pre-employment health examination	
18	Health examination at the start of employment	
19	Others (please specify)	

14. Please answer your qualifications for occupational medicine.
 (1) Certified Occupational Physician of Japan Medical Association
 (2) Certified Occupational Physician of Japan Society for Occupational Health
 (3) Certified Occupational Health mentor of Japan Society for Occupational Health
 (4) Certified Occupational Health Consultant
 (5) Others ()

2

Please answer Q15 to 21 subject of type of your OP certification
 15. JMA certified OP: Do you think the training for qualification is sufficient for the task as an OP?
 (1) Sufficient (2) Mostly sufficient (3) Partly sufficient (4) Insufficient
 Please give any lecture subject for improvement

16. JMA certified OP: Do you think the training for certification renewal is sufficient for the task as an OP?
 (1) Sufficient (2) Mostly sufficient (3) Partly sufficient (4) Insufficient
 Please give any lecture subject for improvement

17. JSOH certified OP: Do you think the training for qualification is sufficient for the task as an OP?
 (1) Sufficient (2) Mostly sufficient (3) Partly sufficient (4) Insufficient
 Please give any lecture subject for improvement

18. JSOH certified OP: Do you think the training for certification renewal is sufficient for the task as an OP?
 (1) Sufficient (2) Mostly sufficient (3) Partly sufficient (4) Insufficient
 Please give any lecture subject for improvement

19. JSOH - certified mentor in Occupational Health
 Do you think the training for mentorship renewal is sufficient for the task as an OP?
 (1) Sufficient (2) Mostly sufficient (3) Partly sufficient (4) Insufficient
 Please give any lecture subject for improvement

20. Certified Occupational Health Consultant: Do you think the training for qualification is sufficient for the task as an OP?
 (1) Sufficient (2) Mostly sufficient (3) Partly sufficient (4) Insufficient
 Please give any lecture subject for improvement

21. Certified Occupational Health Consultant: Do you think the training for certification renewal is sufficient for the task as an OP?
 (1) Sufficient (2) Mostly sufficient (3) Partly sufficient (4) Insufficient
 Please give any lecture subject for improvement

22. Please identify field you encounter any difficulty in your occupational health service (circle the number)

Field	Field
1 Plan and advice for occupational safety and health policy	11 Health promotion activity
2 Attendance at the meeting of health and safety	12 Mental health care
3 Rounds of the work area	13 Prevention of health hazards due to overwork
4 Risk assessment	14 Production and maintenance of comfortable workplaces
5 Maintenance and management of work	15 Guidance of workers when sickness absence is present
6 Maintenance and management of work	16 Diagnosis for return to work, and follow-up
7 General health examination	17 Pre-employment health examination
8 Following of health examination	18 Health examination at the start of employment
9 Specific health examination related to special work risk factors	19 Others (please specify)
10 Health and hygiene	

Please give any suggestion to solve the problem

23. Occupational Health Promotion Centers offer training for OPs on the following subjects:

Please evaluate the training on

- A) Health management
- 1. Very important
- 2. Important
- 3. No comment
- 4. Less important
- 5. Not important
- B) Work environment management
- C) Work management
- D) Mental health issue
- E) Overwork management
- F) Legal regulations on occupational safety and health

24. Please give any comments to Occupational Health Promotion Centers

Thank you for your cooperation.