Editorial

Competence, Communication . . . and Corollary?

The competitiveness of the national economy and the efficiency of industry is intimately bound up with the training of the workforce. Concern over the need to raise the level of competence of people at work has been expressed for some years, driven particularly by the growing familiarity with our European partners. The Department of Employment through the Training Agency and the National Council for Vocational Qualifications, has initiated a process bringing together employers, educators and trainers in an attempt to define standards of performance (competences). The trend has now touched occupational health and safety, raising a number of questions which will have to be addressed in the future.

A Press Release from the Health and Safety Executive published on 3 December 1990 announced the setting up of the Lead Body for Occupational Health and Safety (OHS LB). The role of this body is to identify the knowledge and abilities necessary to be competent in the various jobs and occupations undertaken by 'occupational health and safety practitioners'.

Are occupational physicians, ‘occupational health and safety practitioners’ within the meaning of HSE’s terminology? Lest there be any doubt, the term is defined in the 'notes for editors', a helpful footnote to the document. The paragraph gives an unequivocal definition of the term which includes occupational physicians and indeed nurses, both of whom are accountable to other bodies for their professional standards.

It would appear, prima facie, that the Lead Body is about to lay down the knowledge and abilities necessary for occupational physicians to become accredited as 'competent'. Yet the Faculty of Occupational Medicine is the body charged with professional standards, with their aim to develop and maintain the 'highest professional standards of competence and ethical integrity'. Competence for physicians is also a matter for the General Medical Council, who may of course enforce sanctions in any case of incompetence. The arrival of yet another body will serve to confuse matters even further and do little to improve the public image of health and safety.

Competence-based education and training is however an idea whose time has arrived (with apologies to Victor Hugo!). Its appeal lies in attempts to delineate in explicit terms what competencies an individual should have at the conclusion of their training. Perhaps its popularity is based on its compactness and sharp definition of educational philosophy. But upon a closer look, it appears to be linked to society's concern over the twin issues of competence and accountability. The discipline has now to be accountable for the knowledge, skills and attitudes of its practitioners; and thus to ensure that there is a close fit between those characteristics and industry's requirements, which is maintained throughout one’s professional life.

It is self-evident that certain areas and levels of knowledge are common to all doctors. But in specialist practice, unique skills, knowledge and attitudes are employed. Thus one would not expect the part-time occupational physician/general practitioner to have the same knowledge and skills as a specialist occupational physician; nor indeed the same level of knowledge and skills in areas common to both types of practice. It is the nature of the work and indeed the work setting that will determine what competencies are required in practice.

Several medical specialties in common with other professions have identified competencies required for practice by their members. Indeed there are tried and tested techniques for the identification of competencies. It is to be hoped that whatever the response of the specialty, a structured systematic approach to their identification will be employed. The alternative is perhaps to leave the task to a committee as far removed from the 'shop floor' and real world practice as they possibly can be. It has happened in the past and should not now be allowed to occur again.

Employers may be facilitated in seeking to identify competent health and safety staff. But competencies, once identified, need to be acquired and maintained. The competency map becomes a device for planning continuing education programmes, an area of activity in which we, hitherto,
appear to have been driven by serendipity rather than a planned structured approach. Inevitably, we must then ask: who is to organise, fund and implement such programmes?

There is no doubt that competency-based education and training has a role in the medical specialties as in other professions. It offers us an opportunity to build realistic continuing education programmes and indeed an undergraduate curriculum based on a practice-related model. Leaving aside the manner in which the Lead Body has ostensibly been thrust on occupational physicians, the opportunity to rethink our approach to education and training should not be lightly dismissed.

Occupational medicine practice is moulded as much by social policy, legislation and even political compromise as by advances in medical science. The maintenance of those competencies once identified in a fast-changing world will become a professional responsibility in clear, sharp focus like never before and so we would wish to sound at least one caveat: can specialist recertification be far behind.

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REFERENCES