Occupational Medicine

Keys to success in a Byzantine labyrinth

IAN REID ENTWISTLE

My entry into occupational medicine was greatly helped by joining the Merseyside group of the Society of Industrial Medical Officers, before it became the Society of Occupational Medical Officers. Meetings were held at the premises of one of its members each month—in my case a passenger liner—and were well attended. I became joint secretary and arranged these meetings, which became a rather exclusive luncheon club. Doctors concerned in occupational medicine in the area thus knew each other well, and I was charmed by the way they all helped and advised me. The society filled the gap that the Faculty of Occupational Medicine at the Royal College of Physicians of England now occupies since its foundation in 1978. I was privileged to become a founder member of this faculty shortly after occupational medicine became an accredited specialty at the Royal College of Physicians of London, and this recognition extended to the European Economic Community.

Perhaps because I had helped to organise a joint provincial meeting with our colleagues in Eire, with whom we on Merseyside have always had close ties, I was invited to become a founder member of the Faculty of Occupational Medicine at the Royal College of Physicians of Ireland, the first faculty of occupational medicine in the world. The memory of their relaxed philosophy of life and their magnificent, warm hospitality will always remain with me.

Better health screening

Cunard was reorganised in the early 1970s, a full time director of medical services was appointed at Southampton, and a modern medical department set up that was orientated towards full pre-employment and periodic screening of both shore staff and seafaring staff. This allowed us to practise modern occupational medicine—the Merseyside medical staff and I continued to work in Liverpool and the Dr Finlay life establishment from which I had operated in the Cunard building was replaced by a completely re-equipped ship. The higher standards of health screening was unpopular at first but resulted in a much fitter seafaring population, fewer overseas hospitalisations, and thus fewer repatriations from abroad.

The passenger ships had now left the Mersey for ever, and my work was thus confined to screening the officers and men resident in the north of England, Scotland, and Northern Ireland and annual sea service on board. A great deal of our energies were concentrated on the stricter standards of health screening was unpopular at first but resulted in a much fitter seafaring population, fewer overseas hospitalisations, and thus fewer repatriations from abroad.

Since the Royal Seafarers container base was completed there

is frequent contact with both transatlantic and Far Eastern container ship traffic and with the personnel that man them. This includes the health care of the large staff on shore who manage them. The accommodation and facilities that these new ships provide for a smaller complement of officers and men contrasts sharply with that on the old traditional cargo vessels and even the passenger ships, including the *Queen Mary* and *Queen Elizabeth* that I knew so well. There are still itinerant seafarers from the shipping pool who are signed on voyage by voyage, but more are contract men whose career is with the one company.

With the retraction of shipping in general and on Merseyside in particular I welcomed work with other dissociated groups of companies in the area where we were establishing medical services. I accumulated a varied portfolio of consultancies in companies operating shipping, brewing, food processing, flour milling, light engineering, electrical components, petroleum products, computers, and road haulage. Each industry provided a new and different challenge in occupational medicine, from which an overall improvement in health and safety could usually be effected. Sometimes the problems were unique in a particular industry, whereas others were shared in common with other industries.

The conclusion that the high incidence of bronchitis and asthma in flour millers resulted from the combination of their damp, draughty conditions and a sensitivity to the flour weevil, or soya flour itself, in susceptible individuals was arrived at after an intriguing study done in cooperation with an occupational hygiene laboratory and illustrates a problem that I imagine is unique to this type of industry.

In another organisation the discovery of large areas of exposed mercury in a laboratory with higher than normal room temperatures provided me with a clue to the behaviour pattern of the toxic chemist who worked there. When the diagnosis of mercury poisoning was later confirmed the unfortunate patient totally refused to accept it, even though he exhibited all the symptoms of *Alice in Wonderland's* Mad Hatter, presumably for the same aetiological reasons.

The policy of screening executives has many supporters and many opponents. Investigating a symptomatic anaemia, picked up at such a screening, in a 40 year old managing director led to the early detection and successful surgical treatment of a silent carcinoma of the colon and convinced me for all time of the value of screening.

Back injuries in jobs requiring heavy lifting, peptic ulceration in drivers of heavy goods vehicle headlamps, in operators of visual display units, and overuse injuries in workers on all types of repetitive production line work are conditions encountered in a variety of industries. Such illnesses emphasise the importance of ergonomics—designing a machine to fit man's physical ability—training, and the role of the medical department in health education if they are to be prevented or the incidence reduced.

A further example of a medical problem that spans different industries is in the brewing industry and the shipping industry, where alcohol is available and there are traditional attitudes

involving sickness absence certified by those they brand as corrupt general practitioners in the area.

When faced with these managerial attitudes it is best for the doctor to keep his head down and not even whisper that he had in mind innovative screening procedures. More often than not, and with a few exceptions, the manager is financially successful. This will result in promotion elsewhere.

It is fortunate that in shipping maintaining a medical department is recognised as cost saving, although this may rarely be seen in other industries. The medical department in a shipping company is a small but important one. The occupational medical officer, whether full time or part time, will come face to face with trade unions and admire them on the one hand for negotiating the basic conditions and rights of their members and at other times step back to watch their unbelievable lenienting like activities. Having a good working relationship with unions is important and results from practising humanity and fairness to personnel at all levels. Trust should be built up so that the unions will know that attempts made by cunning management to dismiss their members by the cowardly use of the medical department will be of no avail. Employees who are branded as malingerers may in fact be suffering from unrevealed personal or family sickness. Sickness absence may disguise other social causes. Thus the medical department is there to protect and if possible help them, and this may be done better by the nurse than the doctor. If the medical team is to be respected and trusted throughout this minefield of vicissitudes medical and commercial confidentiality must be respected.

Throughout my work in occupational medicine I have continued in full time single handed practice in the National Health Service owing largely to my very good fortune in having loyal and high calibre staff in the practice and in the companies I work in, and owing to the excellent colleagues who have "held the fort" for me during necessary absences on business. Others may judge whether I have done justice to both halves of my working life, but I believe that the combination of general practice with occupational medicine has been entirely complementary, because each supports and improves the other.

My appointments in occupational medicine have allowed me to maintain a very manageable number of patients on my NHS list and develop the type of doctor/patient relationship that I enjoy. Remaining in practice has permitted me to continue to treat sick people, which is what I believe I was trained for, and not become a medical administrator. Part time consultancy work in several firms has allowed me an independence—albeit a lack of security—and the freedom and tenacity to speak and act in each industry in a way that I would not have dared had I been a full time salaried doctor in a single company.

There have been some gradual changes in general practice during this period. Practice is easier with ancillary staff, night deputising services, and the other benefits accorded to general practitioners. The financial return is also much greater. Some interest has been lost because of the disincentive to carry out minor surgery, closure of the local general practitioner maternity unit, and conversion of the cottage hospital into a geriatric unit in my area. Like all practices, the average age on my list has increased. Changes in the law and attitudes to abortion, contraception, and drug addiction have taken place, but overall my general practice has not altered a great deal.

The occupational consultancy appointments have produced a broad spectrum of medical and commercial interest, bringing me into contact with persons, situations, and places that I would never have met or been able to visit had I remained in general practice only (but it has been a tight rope of missionary work). The increased income has allowed me to pursue the style of general practice that I have wanted. The rewards and, for that matter, the frustrations, are many. Financially, the combination has produced a high standard of living, allowed me to become a member of the Royal Society, and, among other things, indulge my taste in exotic motor cars and travel. In less tangible and more important terms it has produced a life experience through medicine that I could never have purchased. I can recommend it.

Thinking About the Unthinkable

Retirement

F E S HATFIELD

I was born in 1910, the only child of parents who divorced soon after my birth, leaving me to be brought up in a one parent family with a working mother. I qualified in medicine in 1936, and in 1940 married a doctor wife. On 1 January 1944 we took over a single-handed practice whose principal had died. The house was an ideal family house, and we fell in love with it. We already had two children and had decided that we wanted a "proper family"—if possible, one in which every child had both a brother and a sister. We were fortunate in achieving this with five children. Population pressures were less in evidence then. To this day I feel that I missed the social skills which children learn mainly through their sibling relationships.

For 35 years the family and the practice were the centre of our lives. Retirement was unthinkable. I maintained that I was not "the retiring sort" but would go on as long as I could. It seemed to me that life without medicine would be life without a purpose. I was so convinced of this that I made the great mistake of opting out of the National Health Service superannuation scheme. Fortunately, my wife stayed in. We agreed that on statutory grounds mine was likely to outlive me.

The practice grew with the increase in population and much new building. In 1946 another doctor couple joined us as partners, and about 15 years later a third couple, making us a unique partnership of three men and their wives. The practice continued to expand, so this pattern has changed. It is a happy partnership with different personalities who provide a spectrum that should suit any patient.

Now my children are all married and have their own homes. They have scattered—one family in the USA, one in Australia, and three in England. They have produced 12 grandchildren. Children grow very quickly. Inevitably, with such a scattered family we are finding it more and more difficult to maintain a meaningful relationship with them. In all fairness to our partners we could not take long holidays. To go to Australia for three weeks, or even the USA, seemed a very uncommittal enterprise. We began to realise that the unthinkable should be thinkable, and that we should start making plans for retirement.

Learning about retirement

My "hobby" during the past 15 years has been family therapy. The insights that I got from this once the new type of investigation added a new dimension to my concepts of illness. Up till that time I, in common with many doctors, had thought of stress as vaguely having to do with illness. I had heard of "life event scales" but had never taken them seriously. Now I became aware of the important role of emotional forces in the family and how a change in the balance of these forces could lead to illness.

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In my work with families I had sometimes had to help them with problems resulting from retirement. In fact, the very first couple that I sat down with were having a crisis in their lives because of the husband's impending retirement. He was an administrative officer in a local authority that had recently been reorganised. He was filling in time until his next birthday and was bored and miserable. His wife said, "I don't know how I'm going to manage when he is at home all day. When he is at work I can please myself; I can take the bus down to the local shops and window shop, if he was at home he would offer to take me in the car. If I said 'no', I would rather go on my own 'he would be all but in my pocket.' My patients had taught me quite a lot about retirement.

We all know that retirement has been of growing concern to the medical profession as doctors have become more aware of the medical hazards of retirement. I had seen quite a few deaths in the year after retirement. I had seen people develop major illness—such as rheumatoid arthritis or hypertension or even cancer—as they reached retirement. How does one avoid these things?

Withdrawal from practice

I was apprehensive. Could I weather the emotional crisis? How does one retire and still remain healthy? I discussed this with my wife, and we agreed on a plan of gradual withdrawal, almost like a weaning process or the withdrawal of a drug. She retired from the practice and drew her pension but continued with her family planning work. A new young man took her place. I reduced my share of the statutory one third, which would still qualify me for all the allowances, and opted out of night duty and weekend duty. My wife did one surgery a week for me so as to keep her skills going and to keep in touch with the practice. Having got used to part-time work, I set myself a final date for total retirement—namely, my 72nd birthday, when all seniority allowances would stop. I set myself a programme to withdraw one by one by my principal medical activities outside the practice—two groups of social workers and a clinic for marital therapy at Harps. Each event meant a party and painful farewells, and I emphasise the word painful as that, I think, is the key to healthy retirement. Just as it is the key to "healthy bereavement"—to face the pain and not to shy it.

On 1 April last I retired completely, and my wife and I took off for Australia. We stayed with my daughter, her GP husband, and four grandchildren. We became immersed in the nursery, and I was fascinated with a study of four small children, aged 5 to 4 months. I cycled with the eldest everyday to his school. The next two came with me to the local park. We thoroughly enjoyed the wide open spaces of the country, the borders of New South Wales and Victoria. Although it was winter, the sun was always hot and on mid winter days we were able to sit on the veranda at midday with the air temperature only 50 F but with warm sun. I decided that the only difference in my retirement life and adult life was the time factor. Young children have no sense of time. "Tomorrow" has very little meaning, "next week"

towards alcohol consumption, and people who are predisposed to alcoholism are attracted and can indulge without management knowing.

I am always amazed and appalled at the dull and monotonous nature of the work that so many people do throughout their lives, much of it physically harmful owing to its repetitive nature, and a great deal of it depressing and mentally enervating owing to the lack of stimulation and creativity. Perhaps much of the industrial unrest that we have witnessed in the past two decades has resulted from this monotony of the work of the industrial worker compared with life styles seen on television programmes in the evenings, or experienced briefly during the annual package holidays. My several attempts over the years to alter this by either rotating jobs or forming small groups of workers to produce a complete, and I hope satisfying, object have failed entirely. The concept has always been completely rejected by both unions and management, to my amazement.

Adventuring into the Byzantine labyrinths of occupational medicine is an unusual and unique experience for a medical practitioner and it provides experiences—not all of them pleasant—that have no parallel in general or hospital practice. Security of tenure—that is, the life time appointment—does not exist in either full time or part time work. If, however, a large proportion of one's income is generated by occupational medicine, as mine is, it is vitally important to extract a contract from the employer of at least a year's duration, committing both the doctor and the company to each other, with a statement of intention when the contract expires. Such documents are difficult enough to obtain for seasonal work and almost impossible for item of service consultancy. Even so, I will have nothing to do with "gentleman's agreements": hard experience has taught me that those who use this expression rarely qualify.

Selling good health

It is usually necessary to "sell" the concept of medicine in industry continuously, to justify plans and expenditure, and often to argue the clinical necessity of a programme with a person who is not medically qualified. None the less, if a company is to remain profitable and in business the medical officer must have a conscious regard for its fortunes and financial position. I have found it most useful to have a small shareholding in each of the companies that I serve to maintain an overview of their structure and current position.

Keeping accurate records and good communication with patients, hospitals, general practitioners, and employers are crucial to the success of a company physician. Management is used to business methods and to optimistic expressed positively, quickly and concisely in typed reports. Vague verbal statements and quickly scribbled medical shorthand are not appreciated. The success of an occupational medical service depends on the attitude of the most senior management. If they believe in it and the chief medical officer has direct and continuous access to them success is virtually guaranteed. If this does not apply then a career as a birth control specialist with the Bantu will be much more rewarding. There is no comparable situation in general practice to the boardroom assessments and executions that precede the passing of the tumbler, often taking with it to unknown destinations the supporters of medicine in that company.

Morale falls, discipline is dyspeptic, and individuals emerge at the helm who are notable for their self-seeking ruthlessness and a deep hatred of doctors and all that they represent (nurtured doubt since the time of the Industrial Revolution, and, among other things, medicine in their company is at best a philanthropic, paternalistic, welfare function or a fashionable union stop designed to protect management from the effects of the Health and Safety Act. It is a means to an end, and the end is often for a wanton disregard of the health care of their workers, seeing the medical unit as a totally unproductive charge on the industry that competes with a free National Health Service outside its gates, and its only purpose to challenge the validity of

no meaning at all. Emotional storms come and go. Children are easily distractible. A child will seek for five minutes at the most, an adult will seek for five minutes the common phenomenon of "cut offs" in families which family therapists say is detrimental to family growth and well being.

Now we are home and have to face life without that drug medicine. Do we stay in our big family house with no family to fill it, or do we move to something smaller? We should find it difficult to find a house more conveniently situated than this one. We can sell all our possessions between £10 and £20 and am without 300 yards of the front door. We can step across the road on to a footpath across fields; five minutes' walk brings us to a tube station. But a smaller house down the road with all the same amenities has cost more than the market, so now we are trying to cope with all the hassle of buying and selling a house. This problem we share with most retiring couples. If we stay in our large house with its old surgery premises we have to make it pay for itself by letting it to a modern medical centre. Some years ago, Can we sell in today's depressed housing market? Should we stay in the same village or move away? A great GP friend of mine has moved away and made a new life in a new village where he is no longer labelled as "the doctor."

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I have been a principal in general practice for 25 years. For the first 21 of those years I worked in a busy mining practice where domiciliary midwifery was incoherently (but happily) replaced by confinements in a modern general practitioner unit. Four years ago, at the ripe age of 44, I decided to spend my declining years in a rural practice and am now on the west coast of Scotland with 450 souls and bodies, under my personal care. For the first time in many years I am practising real medicine again. I know all my patients and their problems, and they know their doctor. I do not need a computer to keep in touch with them or their treatment. But I do have time, that very precious commodity; time to listen to, to examine, and to talk to every patient whether the problem be trivial or catastrophic. Most of all, I have time to study—time to keep myself abreast of developments in medicine.

When I qualified, I did not believe that I knew everything about general practice. I believed that qualification laid on me theonus of constantly keeping up to date with modern theory and practice in all branches of my craft. This I have endeavoured to do over 25 years (both with and without the old carrot of certified attendances at undergraduate courses). Similarly, I obtained my Diploma in Obstetrics and Gynaecology, I regarded it as a diploma to go on learning.

To return to the "obstetric problem." If the criterion for inclusion on part II of the list is 10 deliveries then I shall be cut

think most GPs have some difficulty in keeping social relationships and professional relationships apart. Staying in the same village means somehow converting at least some professional relationships into social ones.

To sum up—retirement is a major challenge requiring a large restructuring of one's life. Any major change is painful but also offers opportunities. Old doors are closed, new doors are open. In these days of easy travel the world is open and package tours take all the hassle out of travelling. There is more time to get to know one's grandchildren, to pursue one's hobbies. It is a challenge for both husband and wife. The wife's problem can be expressed as "I married you for better, for worse, but not for lunch." The husband's problem is his loss of role identity. One day he is Mr Bos, next day he is just Mr Smith. So both have to face a certain loss of identity.

Finally, one has to come to terms with death and not be afraid of it. I personally do not believe in any sort of life after death. My immortality is in my children and grandchildren. I hope that I have given them a better start in life than my parents gave me. I hope that they will give their children a better start than I gave them. That is my measure of human progress. The final challenge of life is to grow old gracefully and face death courageously.

Practice Politics

An open letter to the General Medical Services Committee

Dear doctors,

I fear that you are about to take an irrevocable step of great concern to a small but endangered species of doctor. I refer to the proposal being discussed in the "new obstetric list" debate—namely, that the criteria for retention on part II of that list shall include a minimum of 10 deliveries a year. I am one such rural practitioner. My average annual number of deliveries in the general practitioner unit is four, and I should therefore fall at the wayside of "progress." Let me tell you why I believe this should not be allowed to happen to myself and others in a similar predicament.

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To return to the "obstetric problem." If the criterion for inclusion on part II of the list is 10 deliveries then I shall be cut

off, with no right to press my case or argue my record. "He who only delivers four babies a year cannot be competent." But I deal with only two or three patients with myocardial infarcts every year—who is going to challenge my competence to manage them? I see only one new patient with diabetes and two new patients with hypertension each year. Am I competent to deal with them efficiently and to try to prevent the dangerous sequelae consequent upon ineffective management? I can do far more damage to a patient and his family if I am not competent in these conditions than I can by supervising four cases a year of what is after all a natural process.

This letter should obviously encourage a charge of conceit. This is not intended. I am in fact very humble about my craft and am aware that I still have much to learn and that I am bound to have made mistakes over 25 years (though none I think irretrievable). But I do take pride in the fact that I have taken pains and time to keep my talents bright.

So what will happen if you take away my right to practise obstetrics? My patients will travel for their obstetric care to a larger practice 10 to 15 miles away or all will be referred to my nearest consultant unit—150 miles away in Glasgow? They will, I think, grumble, but will probably accept it as being a "sign of the times" even though it will be contrary to the wishes of many mothers.

And myself, what of me? ("You take my life when you do take the means whereby I live.") I shall probably become bitter and twisted. I shall continue to practise rest of medicine among this marvellous community, and I shall not suffer financially. But you will have taken a little joy, a little excitement, out of my professional life. Some of the spark will have gone.

I remain (at present) your obedient servant,

GEORGE R HORTON
Mull of Kintyre,
Argyll