PRACTICE OBSERVED

Occupational Medicine

Civil Service

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After nearly two decades in general practice and with the exuberant teaching of Donald Hunter impressed firmly on my subconscious it was, perhaps, no surprise that I should want to see at first hand the problems of people at work. My partners were, as always, generous and understanding—"merely a mid-life crisis" or "an unlikely civil servant" were phrases meant to comfort my wife. My children were, and still are, bewildered. On joining the Civil Service I noticed a change. "What exactly do you do, Dad?" By the time I have launched into a tortuous explanation of my role they have disappeared.

The Civil Service Medical Advisory Service provides advice on occupational health to all Civil Service departments except industrial and research and development establishments of the Ministry of Defence that were formerly the responsibility of the Ministry of Supply. We also provide a similar service to a number of other government bodies—for example, the Agricultural Research Council, Forestry Commission, and Crown Agents.

The unit came into being in 1944 as the Treasury Medical Service and was later grafted on to the existing Post Office Medical Service. When the post office became independent recently each medical service developed according to the different needs of the population it serves. But to many people, including doctors and civil servants, we are still the Treasury Medical Service.

There are 14 doctors under the medical adviser. Headquarters are in London, and we have divisional offices in Edinburgh, Manchester, and Cardiff. There is a small occupational health nursing service, and we can call on the special skills of departmental welfare officers to help with social problems or to liaise with family practitioners and hospital staff regarding rehabilitation.

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at work. Safety officers monitor the environment in their own departments, but when more detailed investigations are required—such as an occupational hygiene survey—special skills are sought from within the Civil Service or from commercial or academic bodies.

Population at risk

The popular image of a Civil Service is that of a sedentary office worker in a low risk job, cocooned in the mystères of policy making, administration, or clerical work. Although there are many staff so employed the range of occupations in the Civil Service is varied and thus of much interest to the occupational physician. The Civil Service is the largest employer of scientists in the United Kingdom. Consequently, the health and safety of the laboratory worker are prominent in our work. But in the Civil Service there are people in many specialised occupations, such as divers, air traffic controllers, forestry workers, printers, veterinarians, geologists, engineers, and policemen—the list is long and a variety of queries may arise. Moreover, civil servants come in all shapes and sizes and standards of health may range from the Olympic athlete to the severely physically handicapped person who requires special aids and supervision to work full time.

Nature of work

Some of my friends think that my work must be largely administrative. But mostly it is leg work with a large clinical content. Although the main policy and administrative centres are in London, the Civil Service is scattered throughout the country. I confess to wondering occasionally whether some of the most interesting problems in the least accessible sites. A particularly attractive feature of occupational medicine is that

on difficulties at work, domestic problems, or progress of treatment can help us both in our attempts to rehabilitate the patient at work.

When inquiring about a patient's health we like to obtain his informed consent, pointing out that we are seeking information from his doctor which, while remaining confidential between us, may be used as a basis for advice to management on his fitness for work. Patient confidentiality is an important and sensitive issue, and when seeking a report from general practitioners we are not careful to put our foot on the proverbial burning bush. The information we receive is kept in confidential medical records that are available only to staff of the medical advisory service and are separate from other personnel records. Whereas the management of the patient is the primary concern, it is a condition that inadvertently might be a hazard to himself or colleagues at work, an informed comment, expressed in general terms, is all that is usually required to help them.

Overseas civil service

Many civil servants work overseas, and this expatriate group, together with their families, present particular problems for both the occupational physician and the general practitioner. The standard of fitness for service overseas needs to be higher than at home. We expend much effort in careful selection, health screening, immunisation programmes, and health education of such people, who are exposed not only to different health hazards from their colleagues at home but also to the additional stresses of separation from their family and domestic upheaval. Despite all these efforts, they still fall ill, often where health services are less developed than at home and thus it may be necessary to evacuate the patient to the United Kingdom for assessment and treatment. Surprisingly, the most difficult medical problems faced by people working abroad are not the tropical illness of malaria, amoebiasis, and parasitic infections, common though they are, but the more familiar ones of ischaemic heart disease, breast cancer, and exposure to alcohol. When medical evacuation occurs families may feel the absence of their family doctor; their National Health Service records have often been irrevocably lost; and they may feel isolated and their home is usually left during their absence overseas, so preventing return to familiar surroundings. An important part of our work is to try to fill this gap in medical care, when necessary to arrange investigation and treatment, and to give support until the patient has returned to the care of his general practitioner.

Postgraduate training

Apart from following our own in-service postgraduate training in, for example, epidemiology, occupational medicine, and tropical medicine, we also have a teaching commitment. Many occupational physicians have been general practitioners. This is invaluable, because these areas of medical care are complementary and close cooperation between family practice and occupational health services may be mutually advantageous and improve the quality of patient care. Despite the large number of general practitioners who have a part-time commitment to occupational health, the subject scarcely figures in the programmes of most postgraduate centres. In an attempt to bridge this gap our service contributes in a small way to postgraduate education by giving short courses on occupational health of common interest to both general practitioners and occupational physicians.

The separation that has occurred between occupational medicine and general practice is artificial and inappropriate. The dispersal of the Civil Service from London gives us an opportunity to develop links with family doctors who are interested in the working environment of their patients. It remains to be seen whether general practitioners can also participate in other areas of occupational medicine.

not only has the patient to be examined but also his place of work. As in home visiting in family practice this sometimes gives a simple answer to what had seemed a complex problem. And, like family practice, there may be unexpected findings—cells living happily in laboratory dishes in the middle of Whitehall or a stock of cyanides and boarding pikes in a Ministry of Defence store, apparently for contemporary use.

The environmental problems that arise may affect any of the Civil Service departments or be peculiar to the work of one unit. Formaldehyde sensitivity arising from unsatisfactory cavity wall insulation or concern over the carcinogenic risks of a photocopier toner may affect any department. Other problems are more specific to a particular occupational group. For instance, the surveillance of marine inspectors who have been exposed to high concentrations of crocidolite in their careers or the supervision of veterinarians and milk samplers in the brucellosis eradication scheme. Although we generally supervise over-industrial work, some areas in the Civil Service are manufacturing units such as the Royal Mint, the Ordnance Survey, much of the work of Her Majesty's Stationery Office, and the reprographic services of the national museums.

The clinical content of our work varies. If there is the possibility of a work related illness a formal clinical assessment must be made. Personnel managers sometimes need guidance on an individual's fitness to work in a particular job, perhaps after a prolonged illness or before taking on a particularly demanding task. Indifferent health may occasionally contribute to the decline in a person's efficiency and we may be asked to estimate the likelihood of recovery.

There are also routine medical examinations, much beloved by individuals and trade unions, who have a touching but unjustified faith in their value as predictors of disease. Most are for statutory purposes for divers or heavy goods vehicle licence holders, for instance. Other examinations are based on less sure ground, such as for people going on a tour of duty overseas or for those reaching the most senior grades in the Civil Service. Every five years the United Kingdom is host to heads of state or senior ministers of the European Economic Community and the Commonwealth, when our unit provides the primary medical and nursing cover for emergencies that might occur among the large staff of such conferences. These meetings may be held in fine country houses, the medical staff invariably being placed firmly below stairs. We once were incarcerated in a wine cellar for two days—alas, sadly empty of the contents for which it was designed.

Interface with general practitioners

There is a lot of paper work, consisting mainly of referrals from personnel officers about staff who are thought to have health problems. For example, officers with lengthy spells of sickness absence and on whom advice is needed on a likely date of return to work and guidance on rehabilitation; or someone whose health has broken down and recovery seems unlikely, when the possibility of premature retirement must be considered and precise information on the patient's health is required to give a prognosis.

Because the Civil Service has 600 000 employees it is clearly impossible for us to examine all the problems that are referred. Instead we rely on the services of general practitioners. Frequently, with consent, we seek information from the patient's family doctor who can usually give an informed and balanced comment on the circumstances. When such a report might strain the all important doctor-patient relationship an independent assessment is sought from our local medical officer. Local medical officers are experienced family doctors who have an interest in occupational medicine and some knowledge of employment in the nearby Civil Service establishments. With the information collected from these sources we can usually advise the employing department. A valuable relationship is often established with the general practitioner. Exchanging informa-

Practice Research

Whooping cough: what proportion of cases is notified in an epidemic?

DOUGLAS JENKINSON

The assessment of changes in the morbidity and mortality from whooping cough over recent decades and the evaluation of the risks versus the benefits of immunisation depend on accurate data on incidence. The principal source of these data is statutory notifications of the disease, but these data may not accurately reflect the true incidence. One possible source of inaccuracy is a change in the notification practice of doctors when the incidence of the disease is high or at a time of public and professional debate about it.¹⁻³ This study attempted to measure the notification rate of whooping cough in a large health authority at a time of high incidence and of raised public and professional concern about the disease.

Methods

A letter with a stamped preaddressed envelope was sent to every general practitioner on the family practitioner committee list (correct at mid-September 1982) who practised in the Nottingham Health Authority, timed to arrive in the first few days of October 1982. Each doctor was asked to estimate the number of patients living in the health authority boundary in whom he or she had made the diagnosis of whooping cough during the month of September 1982 and to write the number on the letter and return it anonymously. Doctors were asked not to change their normal notification practice as a result of the inquiry. Data were obtained from every case of whooping cough notified between 1 August and 12 November 1982 to the health departments of the four borough and city councils whose boundaries form the limits of the Nottingham Health Authority.

Results

Of 292 general practitioners who were asked for information, 244 replied (83.6%). Three doctors gave a number range; the average number was used. Two doctors qualified their estimate with "possibly" or "probably" and these were discounted. The total estimated number of whooping cough diagnoses made during September 1982 was 518 (table 1). The population of the Nottingham Health Authority at the 1981 census was 566 800.

Cases of whooping cough notified in the Nottingham Health Authority were arranged chronologically according to the date of

TABLE 1—Number of cases of whooping cough diagnosed by doctors in the Nottingham Health Authority during September 1982

No. of cases reported	0	1	2	3	4	5	6	7	8	10	12	24
No. of doctors reporting	109	23	32	30	15	4	13	3	6	8	1	