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# Occupational medicine

Paris, it is said, means different things to different people, and so it is with occupational medicine. Over the years the Society of Occupational Medicine has sought to raise the standing of the specialty and these efforts culminated in 1978 in the formation of the Faculty of Occupational Medicine within the Royal College of Physicians of London. But there is still far to go. Too often, even now, applicants for posts see themselves simply doing "medicals" for pre-employment or for "break-down" pensions. Hunter's excellent textbook, correctly titled *Diseases of Occupations*, has inadvertently left many doctors believing that occupational medicine comprises an exotic set of diseases ranging from arc eye to weaver's bottom.

If, then, occupational physicians do not spend their time on dull routine medical examinations or looking for odd trade diseases what do they do? Perhaps the best description is that occupational medicine is concerned with two matters: the effects of work on health and the effects of health on the capacity to work.[1] Both of these judgments require good clinical ability together with an intimate knowledge of the workplace and its organisations.

Let us consider firstly the effects of work on health. The toxicity of a material may easily be looked up in a textbook, but it is more important, and more complex, to understand the toxic hazard of the process in which that material is used. The occupational physician needs to know how the material might enter the body, what practicable measures might be used in prevention (including the setting of environmental standards), and how to ensure that such preventive measures are effective—by the appropriate monitoring of the environment and of the exposed workers (which does not imply routine medical examinations). This activity requires a personal knowledge of what goes on in the workplace and the cooperation of those who manage it and those who work in it. In the same way the resettlement into work of a patient with a temporary or permanent disability requires more than either the patient's description or the doctor's imagination of what the job entails. It requires first hand knowledge of the job and of the physical and psychological demands it makes, together with the opportunity and ability to get across medical advice at the place of work.

Some organisations have established occupational medical services to do these things, but many have not. About nine out of every 10 firms have no medical staff; many of these are small firms. Overall, however, some 44% of the working population have no access to immediate medical advice at their place of work.[2] Sadly, the National Health Service, the largest employer in Britain, is among those organisations that has not had a comprehensive occupational health service. Tentative steps are being taken towards establishing one, and at its recent annual meeting in Dundee (9 July, p 154) the British Medical Association decided "to press with the utmost vigour" for such a service, "with an occupational health physician of appropriate experience for each district."

Next, how can more occupational physicians be trained to provide this medical advice? The Joint Committee on Higher Medical Training has approved some training posts and programmes in occupational medicine, while the new Faculty of Occupational Medicine has set as a priority the fulfilment of its object of ensuring the highest possible standards of professional competence. But where are senior registrars to be trained? Who will provide the posts? Will a firm, having taken a doctor through four years of higher specialist training, be willing to let him go to another firm while they themselves take on another trainee? Most training posts, though carefully following the general pattern of higher specialist training, are created for a specific individual when an organisation takes on a doctor untrained in the specialty, and if the now trained doctor stays on at the end of the training period—which he usually does—the post lapses.

The announcement of a small number of senior registrar posts in occupational medicine within the National Health Service is, therefore, a welcome development—though they will be on a single holder basis and are unlikely to be sufficient to meet the need. Furthermore, most occupational physicians work outside the NHS. Will industry provide posts for the training of these doctors and might there be a financial incentive to the firm?

Much occupational medicine is done—and will continue to be done—by general practitioners holding posts with local firms. The undergraduate curriculum does little to equip them. Are short courses (modular or otherwise) sufficient by themselves? Should some period of supervised practical experience be required? Can that be organised without the full ritual of a formal visit and approval of a training post?

Government activity in occupational medicine is widely dispersed. The Health and Safety Executive, with the Employment Medical Advisory Service as its medical arm, looks to prevention. The Department of Health and Social Security,

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in effect, monitors the success of part of this effort by dealing with claims for work related (prescribed) diseases and certain dust diseases. Some of that information is passed back to the Employment Medical Advisory Service. Most cases for resettlement are untouched unless they come within the scope of the Disabled Persons (Employment) Act, which is operated by the Manpower Services Commission, which gets medical advice from the Employment Medical Advisory Service. Alongside all this the larger organisations in both the public and the private sector have their own independent occupational medical services.

What of the Employment Medical Advisory Service? Two recent *BMJ* letters—one from the chairman of the BMA Occupational Health Committee,[3] the other from the past president of the Society of Occupational Medicine[4]—suggest that all is not well. The Employment Medical Advisory Service was the imaginative idea of Dr Lloyd Davies in the Department of Employment. He saw that occupational medicine had more to offer than the Victorian concept of medically qualified inspectors of factories. The Employment Medical Advisory Service was to be a nationwide, independent medical service available to give advice to government departments, government agencies, firms, employers' organisations, trades unions, and individual workers on all medical problems connected with employment. At that time the Department of Employment embraced factory inspection, employment matters, and industrial relations. Lloyd Davies's idea was that the independent medical advisory service would provide medical advice on all these functions, so that for the first time in Britain there would be a professional service capable of giving medical advice relating to all forms of employment.[5]

In the early '70s both the government and the opposition foresaw that the Employment Medical Advisory Service might not always remain associated with the Department of Employment.[6] The government argued that when the NHS was reorganised the proper home for the Employment Medical Advisory Service would need to be looked at again by the departments concerned. That view was supported by the then opposition front bench spokesman, Dr David Owen, who stated that "This is where the reorganisation of the Health Service becomes of major significance. An area health board could take responsibility for occupational health just as much as it is now planned it will take the new responsibility for community health, and in areas of high industrial development I believe that an area health board should have a specialist in occupational health."[7]

The passing of the Health and Safety at Work Act appears to have eclipsed that undertaking. The Health and Safety Commission and its executive were established outside the Department of Employment and took the Employment Medical Advisory Service with them—back among the inspectors who operate the Health and Safety Act. Other parts from the Department of Employment moved out to become the Manpower Services Commission, Advisory, Conciliation, and Arbitration Service, and so on. The Employment Medical Advisory Service is left providing medical advice from inside the Health and Safety Executive and not as an independent medical advisory service. Could the Employment Medical Advisory Service operate satisfactorily from outside the Health and Safety Executive? There may be differing views, but we should remember that, just as the Health and Safety Commission has statutory responsibility for occupational health, the local authorities have statutory responsibilities for environmental health. In the 1974 reorganisation of the Health Service and local government their medical officers were moved into the NHS. That has not been an unqualified failure, and the recent reorganisation of the NHS saw no demand for them to be moved back again out of the mainstream of medicine.

Occupational medicine—as its practitioners have shown—has a core of knowledge and skills to justify its emergence as a specialty. Yet the organisation of occupational medical services, both statutory and non-statutory, is still uneven and sporadic. One consequence is that, while the faculty attempts to establish standards of training, no organisation takes on the responsibility for providing training posts, as the DHSS does for other specialties. Much remains to be done, and it is encouraging to know that a subcommittee of the House of Lords is presently looking at the subject.

W R LEE

Professor of Occupational Health,
University of Manchester,
Manchester M13 9PT

[1] British Medical Association. *The doctor in industry*. London: British Medical Association, 1980.
[2] Employment Medical Advisory Service. *Occupational health services. The way ahead*. London: HMSO, 1978.
[3] Kearns JL. Employment Medical Advisory Service. *Br Med J* 1983; **286**:1286.
[4] Tyrer FH. Employment Medical Advisory Service. *Br Med J* 1983;**286**: 1444.
[5] Davies TAL. Employment Medical Advisory Service. *Health Trends* 1973;**5**:45-7.
[6] House of Commons. *Official Report (Hansard)* 1971 December 13;**828**: col 126.
[7] House of Commons. *Official Report (Hansard)* 1971 December 13;**828**: col 165.

# Flushes in women—and men

Hot flushes are the most common symptoms of the menopause, being found in at least 70% of women,[1 2] and causing many of them considerable distress. The flushes may be no more than intermittent over a few weeks—but they may persist for years. The Victorian view[3] that "robust women of a sanguine temperament are more troubled with flushes" contrasts with more recent reports[4 5] that professional women and those active outside the home have fewer and less severe climacteric symptoms than housewives, particularly in the lower socioeconomic groups.

A hot flush is essentially a vascular phenomenon. It is difficult to study, both because of the rapidity of the circulatory response and because women who claim they flush frequently may not always do so in the laboratory. Nevertheless, plethysmographic techniques have shown that an appreciable rise in blood flow in the hand occurs with the onset of symptoms.[6] The increased flow is sustained over three to four minutes and then falls to control levels six to seven minutes after symptoms have abated. Blood flow in the forearm and the pulse rate rise simultaneously but to a less extent and for a shorter time, falling to control levels while hand flow is still raised. The blood pressure remains unchanged during the flush. The pattern of circulatory response during the flush (which indicates a substantial increase in blood flow in the skin), the sensation of increased heat, the sweating, and the fact that women often feel warmer after the menopause than before (even if they do not experience hot flushes) suggest a disturbance of thermoregulation at this time, though the aetiology is unknown.

Gonadotrophins have been implicated in the genesis of the

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