Occupational asthma

In asthmatics the airways respond to a wide variety of stimuli in such a way as to produce cough, wheeze, and breathlessness. Among the factors that may induce this response are allergens, irritants, infections, exercise, changes in temperature, and emotion. People exposed at their work to grain dusts have been known at least since the time of Ramazzini to be subject to urticaria and attacks of shortness of breath. Indeed, the harvesting and use of grains give rise to dust containing many different organic particles, and not only do atopic individuals develop asthma in such environments but some non-atopic people also become sensitised. Other organic substances known to provoke occupational asthma include dust from wood, especially hardwoods, in carpenters and joiners, and antigens from rats and locusts among laboratory workers. Certain metals and their salts may also sensitize the airways, the best known being the complex salts of platinum, nickel, and chromium.

Interest in occupational asthma has been reawakened recently by growing awareness that newer industries may be associated with an appreciable hazard and that simple tests of ventilatory function can now measure the responses of the airways to these hazards. Probably the first indication of trouble was the report from France in 1951 of asthma provoked by isocyanates, used in the production of polyurethane foam. These findings, subsequently confirmed by many other reports, identified the risk to workers in a vast and rapidly expanding industry. Recent work has shown that, once sensitised, workers may develop prolonged and severe attacks of asthma even after very small exposures. Other recent technological changes that present a risk of occupational asthma include the introduction of proteolytic enzymes into washing powders, the widespread use of epoxy resins, the production of new antibiotics and pharmaceuticals, and the use of solvents in the manufacture of electronic circuitry.

Occupationally provoked wheezing may occur in a patient who already has asthma or has suffered from it, or in someone who has always been well. In the latter case symptoms will usually disappear when exposure ceases, though there is always the risk that occupational exposure will trigger permanent and disabling asthma. The diagnosis is often made by the patient himself recognising the relation between symptoms and work, though this may be obscured if the bronchial response to the sensitiser occurs several hours after exposure or is prolonged. Confirmation of the diagnosis is straightforward: the patient simply needs to be shown how to monitor his peak flow rate (using, for example, the mini Wright peak flow meter) over a period of work and holiday or sick leave. Identifying the sensitiser may be more difficult, since it may call for intimate knowledge of the chemical processes in a particular factory.

Once the diagnosis has been made the ideal is to avoid the offending agent. Short of this, prophylactic treatment with cromoglycate, bronchodilators, or inhaled steroids may be effective, though in principle this is the wrong approach. At present, industrial injury compensation is not available even to patients who lose their jobs or become seriously disabled by occupational asthma. This question is, however, being considered by the Industrial Injuries Advisory Board. Finally, there remains a considerable challenge to occupational physicians and hygienists—to determine how far concentrations of known airborne allergens need to be reduced to prevent sensitisation.

High summer’s medipolitics

High summer has been short on sun but long on medipolitics. Only history can tell which of the summer’s many medipolitical events will leave a permanent mark on the NHS. At this short perspective all that can be done is to list the likely candidates. Will the new Government’s plans to change the style of running the NHS—will less Whitehall “nannying” and more local power—and to revive the symbiosis between private and state medicine have the effect that Tory politicians hope for? Will the 1979 Review Body report, which destroyed consultants’ hopes for a new work-sensitive contract, go down in history because it prompted a remarkable salvage attempt on the old contract and a thorough reorganisation of the review system itself? Or will any of the decisions made during the BMA’s very successful conference month prove to be a front runner in changing the course of the Health Service? Or could perhaps that imminent event, the report of the Royal Commission on the NHS, yet overshadow all else in 1979?

We have not seen all the details of the Government’s intentions for the NHS, and, despite the inevitable leaks, speculation on the Royal Commission’s report is pointless so close to its publication. But the outcome of the five craft conferences and the Annual Representative Meeting (reported in recent issues) is known and shows that the BMA is as much interested in patients as in pay and is not prepared to sacrifice professional standards in pursuit of unionisation. But what of the context of these decisions? The pattern of the five craft conferences being held in the run up to the ARM was a major part of the BMA’s reorganisation and this year the new machinery was seen to be well and truly run in. The subjects discussed were usually pertinent, the standards of debates were generally high, and there was remarkably little acrimony, which was not for lack of contentious material. Thus the policies approved this summer can reasonably be said to represent the profession’s aims.

And what are these? Well, its aims are many, but a distillation of them would contain the following ingredients. Maintenance of high standards of care under professional control; greater attention to confidentiality, particularly where computers are concerned; the doctor should lead the clinical team; resolution of the manpower, training, and career problems; modification of the Review Body system (though the juniors still reject the Review Body); strengthening of preventive medicine and health education; a proper balance between unionisation and professional objectives; and more power to doctors in the periphery.

For some time doctors have been warily toying with the idea of clinical audit for preserving professional standards,
While adamant that they did not want outside supervision—confirmed again this year by overwhelming opposition to the Ombudsman judging clinical matters—no clear support had previously emerged from audit. This year, however, led by the LMC Conference and the Junior Members Forum, the Representative Body, after an excellent debate, instructed the Council to bring back practical recommendations to the ARM in Newcastle next year. So perhaps the early 1980s will see some doctor-inspired action to maintain standards and to pre-empt any politically imposed regulations.

Another indication of the profession’s support for high standards was the LMC Conference’s agreement to lift its ban on the start of mandatory vocational training, despite reservations about the 1979 award on trainee GPs’ pay. (The unsatisfactory pay of trainees had originally prompted the ban in 1978.) So from 1980 a career in the profession’s biggest craft will require a minimum training of about eight years from entering medical school. Quality of care may appear to have little in common with National Insurance certification. But the decisions to advise GPs to charge for NI certificates and to stop short-term certification from January 1980 reflect the views of many GPs who see certification as a duty that too often diverts valuable professional skills from the care of the ill to post hoc judgments on fleetingly indisposed patients. Whether the Government, which is firmly committed to GPs doing certification, will see the decisions in that light remains to be seen. But the Health Departments would do well not to look on the new Charter proposals in the light of just another GP pay claim. The tenor of the special conference, from the opening speeches, through support for audit, rejection of continuity payments (care of the chronic sick was seen as an integral part of general practice), wariness about introducing too many item-of-service fees, and demands for better health education, showed that the GPs’ traditionally hard-headed representatives were taking a responsible, professional approach to the new charter. For them it meant better medicine as well as more pay for more and better work.

The consultants’ new contract, on the other hand, has been the prominent casualty of this hectic month. But some consultants have always had reservations about it, foreseeing a possible threat to standards. They, at least, and possibly others, will welcome an improved “old” contract as better protection against administrative encroachment on professional freedom—and hence on standards—in the hospital service. Standards are also worrying the medical teachers, for fears of a fall in teaching standards because of poor recruitment were apparent in the Conference of Medical Academic Representatives. The cause is the adverse pay differential with NHS staff, especially among preclinical staff, where doctors are increasingly rare. Medical schools must attract and retain sufficient high fliers to guarantee that the academically able entrants will swell medical student numbers are properly trained. Let us hope that the new negotiating machinery for teachers will quickly sort out the pay anomalies.

The swelling student ranks bothered the ARM, which demanded a freeze at 1979 intake numbers while the effect of the recent rapid increase is being assessed, including the financial implications for the NHS. This priority motion will prove a good deal more difficult to implement than to pass, given the momentum of manpower policies. An easier request to fulfil is a feasibility study for a BMA standing committee on manpower, which the RB agreed after having approved in principle the Wilson report on manpower. Given the sharp differences among doctors about this subject, such a committee is necessary to provide the basis for a coherent strategy supported by the whole profession. The BMA, with its broad craft representation, is well suited to fulfil this responsibility.

The Association also showed its capabilities as a forum for the profession in the debates on ethics and the draft ethical handbook. Informed and often passionate views were declared from all quarters and the ARM made its judgments. Doctors are particularly worried about the erosion of confidentiality and the meeting welcomed the report of the Committee on Data Protection; it reaffirmed the Declaration of Tokyo, and “would decry any Government interference with a doctor’s right to express his ethical beliefs.”

The ethical section also saw the passage of a resolution the sentiments of which were clear despite the all embracing wording “that this meeting unequivocally condemns the kind of industrial action which increases the sum of human suffering.” Indeed, clearly the events of last winter, when the damage caused by staff management confrontation was all too clear, had left their mark on doctors. On several occasions in the various meetings the profession was prepared to chart a course that would minimise the risk of confrontation. This was nowhere more apparent than in the career doctors’ continuing support for the Review Body system, albeit modified, despite a pay award that shattered consultants and left several other groups less than happy. Only the juniors spurned the Review Body, as they had done last year.

The fact that one major group within the Association can disagree on so fundamental an issue as pay negotiations and yet remain on amicable terms with their colleagues says much for the political maturity of the BMA. It also speaks volumes for its leaders’ capabilities: in steering so complex a ship as the BMA personalities can be just as influential as policies. The Association has been fortunate in having the considerable mediopolitical wisdom of Sir James Cameron as Chairman of Council during three difficult years when the profession was having to come to terms with unionism. His unrivalled experience at the top of the profession—he was elected GMSC chairman 15 years ago—his approachability, and his diplomatic ability to coax sensible compromises from the most unpromising circumstances have served the profession well. Doctors owe him a great debt: without him their present lot might have been a good deal less agreeable. That his departure from the chair of Council will be followed so soon by the early retirement of Dr Elston Grey-Turner—about which the RB unanimously expressed its regret, as well as recording its appreciation for his sterling service—is a severe blow. But the BMA’s strength in depth is shown by the quality of their successors. Mr A H Grabinham has ably chaired the CCHMS for four years and his cool handling of the crisis which followed the Review Body’s Ninth Report augurs well for his tenure as Chairman of Council. And Dr J D J Havard, appointed Dr Grey-Turner’s successor in a special Council meeting before the ARM, is no stranger to readers of the scientific or the mediopolitical parts of the BMJ. Even his broad talents, however, will be tested by probably the most demanding post of its kind in medicine today. As the two men who will carry the greatest responsibility during the coming year for translating the ARM’s decisions into action, we wish them well.

1 British Medical Journal, 1979, 1, 1584.
2 British Medical Journal, 1979, 1, 1800.
4 British Medical Journal, 1975, 1, 638.
5 British Medical Journal, 1979, 1, 564.