OCCUPATIONAL HEALTH IN THE NHS
What it is, why is it there and could it be better?
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"I don’t know what the Occupational Health Department in my district actually does, or who is in charge. They send me all their problems and just duplicate a service that could be given by GPs . . ."

– an A&E Consultant in a district (thankfully!) many miles from Lancaster.

One area of medical practice guaranteed to stimulate comment, uncertainty and even direct antagonism (at least among other health professionals) is occupational medicine, particularly when practiced in the NHS. This reaction is curious in view of the aim of occupational health services which is simply “to promote and maintain the highest possible degree of physical and mental well-being of all staff.” This aim (formulated by the International Labour Organisation as long ago as 1950) is hardly controversial and is one to which all health professionals should aspire. Why then should there be any difficulty in applying this fine principle to the UK’s, and probably Europe’s, largest employer? I would suggest that several things conspire to make occupational health services in the NHS poorly understood:

1 Poorly perceived need for occupational health services.

2 Poorly developed definition of what constitutes legitimate occupational health practice in some NHS units.

3 Poor relationships with other health professionals.

4 Poor resources and a poorly developed professional structure.

Not all of these problems apply in Lancaster, but discussion of them will shed light on the nature of occupational health practice in the health service generally.

1 The need for Occupational Health Services in the NHS

Whether we like it or not, this is to be the decade when the “business environment” will become fundamental to the NHS. The achievement of greater efficiency by improved productivity and cost control, declining labour availability and the trend towards earlier retirement will force the NHS to look carefully at how it recruits, trains and retains enough appropriately skilled staff to serve the local community. Part of that system must be attention to health, safety and welfare.

The hazards to which staff in the NHS are exposed are no less important than any other large industry and have been well catalogued.1 The legislation covering control both of hazard and of working practices grows daily (mostly via the EEC), and the Health Service no longer has Crown Immunity to hide behind. NHS managers are just as likely to face prosecution under the Health & Safety at Work Act (and its associated legislation) as managers of any other industry. A list of recent industry-based disasters (Bhopal, the Piper Alpha fire, the sinking of the Herald of Free Enterprise, the BBC Legionnaire’s disease outbreak and the King’s Cross Underground fire to name but a few) has heightened public awareness of health and safety issues and should be enough to cause a twinge of anxiety in all health service managers.

The Control of Substances Hazardous to Health Regulations (1988) has forced a major review of all substances used in the health service, from floor cleaner to cytotoxic drugs and from upholstery adhesive to weed-killer. Included in the review have been microbiological hazards from blood and body fluids, from pathological material and even from animals. (How many people know that there is a ferret – amongst other delightful creatures – at the Royal Albert Hospital?)

The incidence of back injury amongst nurses is comparable with that amongst coal miners and the health service is known to cause asthma with the uncontrolled use of sensitizing agents. The transmission of tuberculosis and hepatitis B (although rare) is not unknown and the cumulative (life-time) risk of a surgeon contracting HIV from his or her occupation has been estimated as high as 1:800.2

Physical hazards such as ionising and non-ionising radiation, heat and noise all exist in the health service. Strict controls need to – and do – exist on the use of radioactive sources in radiography and medical investigations. Boiler-men work in hot and dusty environments, many health authorities have not completely cleared asbestos and the noise close to wood-working machines and heavy plant make the wearing of hearing protection mandatory.

There is an obvious need for treating the health and safety of the work-force as a “quality” issue in a system which aims to deliver “quality” care to the consumer. There is no excuse for management, staff organisations or individuals to be complacent about health and safety or to assume that “someone else” will take responsibility or blame. Why should a health authority, an NHS trust or for that matter a GP practice behave any differently from ICI, Nuclear Electric, the Post Office or Marks and Spencer when it comes to the health, safety and welfare of staff. Indeed, why can’t we be better . . . ?

Unfortunately, in many parts of the health service, information on accidents in particular the RIDDOR3
accidents which have to be reported to the Health and Safety Executive, information on both the trends and the detail of absences attributed to sickness, and information on the causes of medical retirements or death in service are simply not available. Even where managers understand the importance and cost implications of these data, there is difficulty in formulating coherent strategies for tackling problems.

These are all issues in which the occupational health service is, or should be, deeply interested.

2 The legitimate practice of Occupational Medicine in the Health Service

The one important thing to remember about occupational health is that it is not primary care.

Unfortunately, this occasionally gets forgotten by both consumer (staff member) and provider (occupational physician/nurse). In a survey of local general practitioners, 81% of fifty-two respondents said that occupational health services “sometimes” meddle in primary care, and 17% said occupational health services “never” meddle. One GP indicated that he/she thought the meddling was “frequent” and went on the indicate his/her opposition to occupational health involvement in health screening and health promotion. In a larger survey, 26% of 252 GPs believed that occupational physicians “frequently” give primary care advice and 45% believed that occupational health nurses “frequently” give primary care advice.

Regardless of the discouraging signals given out by occupational health departments, some staff will always attempt to use the service to short-circuit a GP’s appointment or to obtain a second opinion. For those occupational physicians who have escaped from general practice, the temptation to offer gratuitous advice is real but eminently resistible.

Other health care workers may perceive the role of the occupational physicians as little more than a GP service in disguise. A recent (small) national survey of hospital consultants elicited comments along the lines of “(OH is) . . . mainly a GP service”, “OH duplicates much of the work a GP does”, “problems can be dealt with by other service providers”.

What, then, is the medical role of the occupational health department?

Pre-employment screening:

Although there is little real justification for a doctor to see every new entrant (the pick-up and ‘reject’ rates are so low), it is important that all new starters have some form of health assessment before appointment, usually by health questionnaire, followed up by interview where necessary. The aim is to ensure that people with specific health problems are not inappropriately deployed, and that staff are not exposed to inappropriate hazards. For example, drivers may be subject to criteria as strict as those for PSV/HGV, severe eczema sufferers would not get jobs as food-handlers, and those allergic to detergents would not be recommended for employment as domestics. Similarly, nurses with an admitted history of back problems would be restricted from lifting.

Some new entrants believe that they will meet only prejudice if they declare certain health problems, and may even be ill-advised by others to be economical with the truth. Other health professionals (including doctors) occasionally share this anxiety about obstructive and uninformed discrimination, but a good NHS OH Department will always look at each case on its merits. A good example of this is the employment of people with epilepsy. A history of epilepsy (even well controlled) might stop someone from working on scaffolding, but would probably not stop someone from nursing. Mythology about epileptic nurses dropping things (including patients), or injuring themselves, still exists and take some breaking down by enlightened OH Departments.

Health Surveillance:

There is probably little difficulty in accepting a role for occupational physicians and nurses in specific types of health surveillance. It is unlikely that GPs or chest physicians have the time or inclination to test the respiratory function of staff exposed to glutaraldehyde (Cidex) fumes, and the monitoring of staff exposed to other hazards such as tuberculosis, asbestos, and noise falls naturally within the occupational health remit. What does cause some difficulty, however, is the extension of workplace health surveillance to include such things as cholesterol testing, hypertension screening and cervical cytology. These are frequently done as part of an effort to improve the general health of the working population, but GPs feel that these areas are less acceptable for occupational health involvement (particularly if there is an item-of-service payment involved), and occupational physicians themselves are ambivalent (Table 1). It is extremely interesting to note that slightly more GPs think it acceptable to do workplace cervical cytology than do occupational physicians, but that the occupational physicians are rather more keen on general health screening that the GPs. The advantages and disadvantages of general health screening, health promotion or health education in the workplace could be the subject of another paper, but however useful, they cannot take priority over the detection and control of specific occupational health problems.

<table>
<thead>
<tr>
<th>Subject for screening</th>
<th>% GPs (n=252)</th>
<th>% Occ Physicians (n=209)</th>
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<tbody>
<tr>
<td>Glycosuria</td>
<td>74</td>
<td>92</td>
</tr>
<tr>
<td>Hypertension</td>
<td>79</td>
<td>95</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>58</td>
<td>77</td>
</tr>
<tr>
<td>Hearing</td>
<td>93</td>
<td>97</td>
</tr>
<tr>
<td>Vision</td>
<td>90</td>
<td>98</td>
</tr>
<tr>
<td>Cervical Cytology</td>
<td>38</td>
<td>36</td>
</tr>
<tr>
<td>HIV Testing</td>
<td>22</td>
<td>28</td>
</tr>
</tbody>
</table>

Table 1. Percentage of GPs and Occupational Physicians finding these subjects acceptable for occupational health involvement in screening.
Specific medical problems:

Occupational medical professionals are usually the best people to assess the effect of specific medical problems on ability to work, work performance and future employment. GPs may simply not have time to assess fully all the relevant facts (including options for redeployment) when deciding someone's fitness to work, and liaison with the occupational health department optimises the chances of getting it right for the individual. This does not always work in practice, and this will be discussed again below in the section on professional relationships.

Chronic ill-health and ill-health retirement:

Occupational health involvement – either at the request of management or the individual – can lead to appropriate redeployment or to retirement. It has to be said that redeployment in the health service is increasingly difficult. What can be done with a porter who cannot bend or lift? What can be done with a food-handler with chronic hand eczema? While the occupational health department will fight long and hard to keep an individual at work (to the point of being considered positively obstructive by management), it would be naive in the extreme to think that the organisation can create “light” work where none exists, or that an individual can be “carried” ad infinitum. The occupational health physician is required to give, and takes some pride in giving, an honest and unbiased view of a person’s fitness to do certain tasks.

Other functions:

Alongside medical assessment, the NHS occupational health department has a specialist role in health and safety education, environmental monitoring, health protection and first aid training. Properly trained occupational health nursing staff and occupational physicians have expertise which often goes unrecognised. They are able to undertake quite detailed and technical environmental surveys. It often surprises NHS managers that a doctor or nurse should know how to use a noise meter, or assess lighting levels, or understand the toxicology of organic chemicals, or give advice on the ergonomics of work-station design and VDU use. Interpretation of legislation and medico-legal reports are increasingly necessary in a legalistic and litigious society, and OH professionals often have the necessary knowledge and overview to assist both managers and unions.

Specific and on-going programs of health protection are vital. In this district, we have vaccinated some 3000 staff against hepatitis B—a logistical nightmare given the amazing capacity of health care workers to procrastinate, forget appointments and generally avoid the important issues of their own safety.

In training first aiders, OH departments enable the health service to fulfil its legal requirements under the First Aid at Work Regulations. It may seem odd to have to teach first aid in an organisation with so much “medical” knowledge, but a large proportion of staff have no medical or nursing skills. Equally it is quite ludicrous for a staff member to wander into the A & E department to get a plaster for a cut finger, simply because it is seen as one of the “perks” of working in the health service! Some NHS occupational health units actually provide an emergency treatment service for minor illness and injury. This might be sensible in central London, where GPs are often unavailable and the aim is to keep the individual at work, but in a district like Lancaster, with readily available primary care services (and other OH priorities), it would be difficult to justify.

The areas of legitimate professional interest for occupational physicians and nurses therefore cover almost every area of health service activity and stray into a grey area bordering primary care. This inevitably leads to some confusion and tension in professional relationships.

3 Relationships with professional colleagues

In industry, the occupational health professional is used to being regarded as “the expert”. Managers and staff request professional advice and then either accept it or ignore it, but seldom presume to disagree with it. In the health service, however, there is an ever present danger of “do-it-yourself” occupational health, with the advice of the OH professional passed over in favour of that from another professional source. This can range from the relatively innocuous investigation or treatment of minor ailments in staff by well-meaning junior doctors, through to positively disruptive and contradictory advice given to managers. Thankfully, this sort of thing is rare in Lancaster but can generally undermine the credibility and effectiveness of NHS occupational health.

Relationships between NHS OH departments and GPs are variable, but absolutely crucial to the proper care of individuals. GPs’ suspicions of OH involvement in grey areas associated with “primary care” have been mentioned previously and probably stem from the UK model of primary medical care. In making the general practitioner the first point of contact for all medical advice this model induces a belief (rightly or wrongly) that the GP should have control over all medical care. This has obvious advantages in terms of continuity of care, avoidance of duplication and so on. In other cultures, shared care with OH services would not cause so much tension. Coronary risk factor screening (for what it is worth) and health education are common in the work-place in the USA, and occupational health units have been used to improve the treatment of hypertension in Israel. This would be quite a novel suggestion here. Having said that, 87% of 252 GPs questioned said they would like closer links with occupational health. This is a relationship which is worth building on to try to dispel suspicion and improve patient/employee care, but will always depend to a large extent on local experiences and personalities.

Relationships with senior hospital staff are just as variable. After all, NHS consultants usually have little experience of— or specific training in— occupational medicine. There are exceptions to this generalisation, with (for example) chest physicians, particularly in industrial centres, tending to see so much occupationally-induced lung disease that they become experts on the industries in their areas. This is not to say that consultants are not a source of expert knowledge in their own speciality. However well trained, an occupational physician can only ever hope to be a jack-of-all-trades, and must learn to rely on the mastery of others when sorting out the occupational implications of difficult medical conditions.

Fifty NHS consultants (none from Lancaster) were recently asked some questions about their contact with OH departments; thirty-seven doctors (74%) replied. Table 2 shows their responses to some of the questions. The
responses are both encouraging and discouraging. It is most disappointing that less that 100% of consultants had actually been offered hepatitis B vaccine, and that only half the physicians had chosen to accept the vaccine (does this mean the others never actually touch a patient?) More reassuringly 11 out of 12 surgeons had accepted the vaccine.

Inevitably, professional status is an important factor; why should a consultant physician take the slightest bit of notice of the advice of a clinical assistant in occupational health? However experienced and competent they are, clinical assistants will never be on genuinely equal professional terms with senior hospital staff, which is a good case for encouraging and promoting higher specialist training for occupational physicians in the NHS.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Number</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Have you used an OH department personally?</td>
<td>Yes</td>
<td>11/20</td>
<td>55%</td>
</tr>
<tr>
<td>- Physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surgeons</td>
<td></td>
<td>11/17</td>
<td>65%</td>
</tr>
<tr>
<td>Have you been offered Hepatitis B vaccine?</td>
<td>Yes</td>
<td>12/20</td>
<td>60%</td>
</tr>
<tr>
<td>- Physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surgeons</td>
<td></td>
<td>12/17</td>
<td>71%</td>
</tr>
<tr>
<td>Have you accepted Hepatitis B Vaccine?</td>
<td>Yes</td>
<td>6/12</td>
<td>50%</td>
</tr>
<tr>
<td>- Physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surgeons</td>
<td></td>
<td>11/12</td>
<td>92%</td>
</tr>
<tr>
<td>Have you ever used Occupational Health to help in the management of one of your patients?</td>
<td>Yes</td>
<td>1 out of 37</td>
<td></td>
</tr>
<tr>
<td>Have you ever used Occupational Health to help with a staff or environmental problem in the hospital?</td>
<td>Yes</td>
<td>10 out of 37</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. NHS Consultants' contact with OH Services (n=37)

4 Resources and training in NHS Occupational Health

Despite the doctor's carefully cultivated air of omnipotence, training in occupational medicine at undergraduate level is close to zero (actually amounting to one site visit and two lectures at one North West medical school). Occupational medicine is no longer part of the series of qualifying examinations, and has largely been absorbed in to public health teaching as pressure on the curriculum increases. Students have less time and opportunity to get direct workplace experience, as long vacations and job opportunities disappear. This is a pity, as work in the real world is very educational. The editor of the British Journal of Industrial Medicine dates his interest in the speciality from breaking his arm on a building site and the author of this article traces his interest back to testing dimethyl formamide levels around the polyurethane plant at Storey's of Lancaster. He subsequently gained experience in working in hot conditions on the dryers at the Moor Hospital laundry. Occupational Health input to GP vocational training schemes and other higher specialist training is not much better, and so most "fully trained" doctors have little knowledge of occupational health practice.

Occupational Health medical input is extremely patchy in the NHS, with some consultant-led centres of excellence, and many districts relying on part-time (clinical assistant) input. Occupational Health nursing is also variable, with some districts (like Lancaster) committed to maintaining high standards with fully trained nursing staff leading the team.

CONCLUSION

It would be easy to be down-beat and pessimistic about the state of Occupational Health in the NHS, but there is actually much to be optimistic about. With management goodwill (and a few more tangible resources), together with the cooperation of staff, improved communications with primary care and further contacts with hospital medicine, occupational health in the health service can become a vital element of the overall improvement in standards in the next decade.

Hopefully, the A & E consultant quoted at the start of this article will one day get the opportunity to find out what NHS occupational health is about.

REFERENCES

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