The general practitioners' view

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General practitioners have patients on their lists who work in a variety of occupations, but the doctor is most unlikely to have had any training in occupational medicine. As a result, occupational causes for illness are rarely considered by GPs. Little contact occurs between occupational health physicians and GPs leading to a lack of understanding of the occupational physician's role. These two factors, when combined, may lead to patients receiving sub-optimal treatment. This could be remedied by better undergraduate and postgraduate training, and by greater professional contact.

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I work in the 'City of A Thousand Trades'. The practice is about half a mile from Birmingham City Centre, close to the Jewellery Quarter and surrounded by narrow side streets lined by many old industrial buildings. Some of these contain small factories and businesses. At times it can be difficult to tell whether the premises contain going concerns. Some indubitably do, but many are boarded up with the fading name on the façade of perhaps a ball bearing manufacturer, or on the exterior of what were prosperous premises, the directions to the employees' entrance can be seen created in especially commissioned brick above the sealed elegant door. As one passes by on a home visit small entrances reveal dark interiors, the contents of which are hidden in the gloom, but anything from piles of rags to chains can be seen inside. Forklift trucks, prongs at the ready, come shooting out to pick up a load from a badly parked HGV that obstructs the narrow street. At times these streets are too narrow for mechanical assistance and individual workers can be seen manhandling metal ingots one at a time into the interior.

On the other hand, there are the large employers in the city, with international names, working from large airy multi-storey offices. Shops, restaurants, smaller offices, service industries and educational establishments also employ a large number of our patients.

Each of these environments is necessarily very different and all have their own risks and dangers.

In a practice therefore surrounded by a multitude of different employment, I asked in a 'straw poll' how many of the practice's partners or assistants had been in a factory. Only two of five had any factory experience. One had toured around the works of one of the biggest employers in the city during vocational training and one of the assistants had been on a 'study day' on occupational medicine.

Any experience of work outside the NHS I have had has been restricted to summer jobs as an undergraduate, working in the Civil Service collecting fines, and serving in a bookshop. This 'training' is now 30 years old and has not been updated. While this may prepare one for working with the public it does little else apart from giving a very limited idea of what employers can be like.

My own undergraduate training in occupational medicine was non-existent and I have certainly not set foot in a factory since the days of school trips. The subject was not covered in my vocational training course. I therefore had no experience of occupational health medicine to help prepare me for this aspect of general practice. I do not think I am an exception, and this perhaps accounts for part of the reason that the relationship between general practitioners and occupational physicians is not as good as it ought to be.

In 1995 Graton quoted an example where a general practitioner wrote stating that he thought that he and the occupational physician had conflicting interests, the former to guard the well-being of the patient, and the latter to return the patient to productive work. I fear that in subsequent years these misunderstandings may not have lessened. My own contacts with occupational physicians (or at times the occupational health nurse) are very limited. Unlike hospital consultants where interactions come from patient referrals, committee meetings, telephone calls or postgraduate lectures these contacts come in the form of occasional requests for information on individual patients from a stranger who is working for the patient's employer.

These requests may be for clinical information or prognosis. At times they might be concerning an opinion on fitness to work or early retirement and can engender a lot of anxiety. Quite often it is not clear why the request...
is being made. Is my reply likely to be the cause of the 
patient losing their job? What qualification do I have to 
make the judgement? I have no specialist knowledge and 
often have no information on the working environment 
or what the job entails. Confidentiality issues come to the 
fore. Patients have the right to see reports before they are 
sent, but very few exercise those rights. Am I going to 
alienate my patient and destroy our relationship, which 
may have taken years to create? Occupational health 
physicians should always act in the best interests of the 
patient and be an ‘independent and objective adviser to 
the individual and to the organisation’.2 This message 
needs to be reinforced by improving the communication 
and understanding between occupational physicians and 
general practitioners, as there may be an erroneous 
perception that the first duty of the former is to the 
employer.

How should this improvement in understanding be 
implemented? Perhaps a start should be made with the 
undergraduate medical education. Seaton3 quoting 
Harrington stated that ‘most British doctors qualify with- 
out any real instruction in the subject’ [occupational 
medicine]. Modules in occupational medicine within new 
problem-based undergraduate curricula could remedy 
this. Vocational training for general practice is another 
obvious place, however course overload and lack of con- 
tact between occupational physicians and general practi- 
tioners limits the inclusion of occupational health topics 
in vocational training schemes.4 I would surmise that 
similar reasons exist for the lack of topics in occupational 
medicine amongst general practitioner undergraduate 
education allowance meetings. Greater liaison between 
the Faculty of Occupational Medicine, the Royal College 
of General Practitioners and the universities would 
undoubtedly help and should be a priority.

There is no statutory duty on an employer to provide 
an occupational health service or to provide access to 
occupational health services. Thus for most employees 
without such provisions their general practitioner will be 
the first consultation. There is therefore a serious risk 
that significant diagnoses will be missed. Few general 
practitioners have had training in taking an occupational 
history and certainly they will not be familiar with the 
industrial processes, chemicals and working environ- 
ments that their patients are exposed to. Most will be 
familiar with occupational hearing loss, the concept of 
vibration injuries and will have come across patients 
complaining of ‘RSI’. All of us will have several patients 
a day with musculoskeletal disorders but I would guess 
that few will go far along the road of considering work 
causes, and those that do will not have much of an idea 
with whom to discuss it. Our aim is to get the patient 
cured but we are not good at identifying causes related 
to occupation. We all have patients with unusual non- 
specific symptoms related to tiredness and malaise. 
There is often an element of depression to these cases, 
which may indeed be related to workplace stress, but it is 
difficult to determine how many are due to industrial 
processes or the work environment. We may possibly 
suspect ‘sick building syndrome’ but how does a general 
practitioner make this diagnosis? As undergraduates or 
postgraduates we are taught about some of the more 
memorable industrial diseases, but a glance through the 
index of any occupational health journal reveals how 
many potential toxins there are to which workers may be 
exposed. It is frightening to think that general practitio-
ners have so little instruction in the topic and how little 
contact there is between us.

If we do consider industrial causes then we may be 
fortunate in having local hospital consultants with an 
terest in the subject, but one has to think of an occupa-
tional cause first. There is of course the Employment 
Medical Advisory Service but few general practitioners 
have information about it. We are doing our patients a 
great disservice by this lack of liaison.

Many patients could continue to work if general prac-
titioners were aware of the scope of the services that are 
available in the workplace. I recently had a patient who 
was temporarily disabled by a foot condition that could 
easily have been managed by a podiatrist. The patient 
wasn’t aware of any such provisions made by his employ-
ers but he preferred to be managed outside the work-
place, even though a work-based solution would have 
been a very satisfactory alternative. It would be very use-
ful if bigger employers with occupational health facilities 
were to provide local general practitioners with an up-
dated list of the services that they provide. Sickness 
absence certification is a substantial part of the general 
practitioners workload. Frequently one is uncertain, 
particularly when the patient has been off work for a pro-
longed time how much further improvement is likely to 
be expected. At present what tends to happen is that 
Med3s are issued until the Benefits Agency calls the 
patient for a medical and an assessment of their fitness to 
work is made. This may sometimes be the arbitration that 
one is seeking. I would surmise that in most cases the 
general practitioner would want to wait until the patient 
is completely fit before giving the final Med3. With some 
larger employers having access to physiotherapy and 
nursing services I am sure many patients could be 
returned to work earlier than they are at present if family 
doctors were made aware of the possibilities for rehabili-
tation at work. Those who have an occupational health 
service are lucky in that their work’s doctor may have 
assessed them and made recommendations which 
resulted in an offer of redeployment. Where there is no 
such service this may not happen. How much better it 
would be if general practitioners felt confident enough to 
speak to the work’s doctor or were able to refer directly 
to a consultant in occupational medicine at the local 
hospital. But do all doctors working in industry have the 
qualifications that would allow general practitioners to 
have faith in this sort of dialogue?

General practitioners have a duty, it could be argued, 
to prevent further cases of occupational health related 
ilnesses by reporting cases and to advise patients about 
work related issues. Again, lack of training in awareness 
and lack of training in the subject make this very diffi-
cult. This must be addressed by better liaison at a high 
level.

It is the practice of some employers to provide health 
promotion services. Occasionally we receive a note from
a works nurse informing us that one of their employees has had a blood pressure measurement. This is of course important information and is even more important considering that the group who attend their general practitioners the least — that is middle-aged men — are most likely to benefit from instruction in coronary risk factors. Anecdotally, we receive fewer of these notes than we used to. This may of course be due to an exceptionally good record of heart disease monitoring, but I doubt it. I do not know whether the practice of health promotion in the workplace has lessened but sharing that information where it exists would be eminently sensible.

I have not mentioned the many of my general practitioner colleagues who have an occupational medicine qualification and who work in industry. They must feel themselves very fortunate, because as a result they will be more effective in consultation.

So long as the majority of occupational health doctors work outside the NHS the risk of general practitioners misunderstanding their role will continue. This misunderstanding is to the detriment of our mutual patients. Better communication and awareness is vital. Ideally all persons in the workplace (including general practitioners, although they may not desire such a service) should have an identifiable occupational health doctor to whom they can relate and with whom the general practitioner can liaise. This must be at a personal level so that general practitioners can understand the roles, duties and expertise of local occupational health doctors and vice versa. The relationship should be the equal of the relationship general practitioners have with local consultants.

With improved education, communication and shared understanding, our mutual patients will, whether they work in small dark factories off side streets, large city centre offices or the kitchens of fast-food outlets, receive the improved quality of care all of us wish.

REFERENCES
