The three faces of *Occupational Medicine*: printed paper, problems in practice, and professional purpose

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The 50-year run of the journal *Occupational Medicine* and its forbears demonstrates the ways in which UK occupational medical practice has developed and changed since 1950. This has been in response to changes in society, technology and medicine. The journal has played an important part in education and professional development. It has also been the voice for the aspirations and concerns of its readers. Two aspects stand out: the development of occupational medicine as a speciality, and the way in which a medical model for occupational health service provision has been championed. A distinguished line of journal editors has been central to the crystallization of ideas within occupational medicine and their editorials map out professional successes and challenges over the years.

*Key words: History; journal; occupational medicine; professional development.*

INTRODUCTION

The journal of a professional society does not stand alone as a record of events and hopes. It is a selective account of the interests and concerns of the society as interpreted by its editor and influenced by the enthusiasms of people who write for it. This history uses the journal as a source from which to identify trends in occupational medical practice. These trends should be considered in the context of wider events: the overall pattern of health care provision;¹ the longer term history of occupational health;² other aspects of the history of the professional society,³ and parallel governmental activities.⁴

Only a selection of the articles which appeared in the journal have been referenced but, where possible, the first and subsequent key contributions on major topics which reflect on the development of occupational medicine are noted. Quotations from the journal are included where they present a concise contemporary view; in this selection editorial material is over-represented as it is likely to be an indicator of collective society views. Fewer articles from recent issues have been referenced as it is not yet possible to assess their importance with the benefit of hindsight.

THE JOURNAL: ORIGINS AND DEVELOPMENT

The first issue of the *Transactions of the Association of Industrial Medical Officers* was published in April 1951. This was 15 years after the foundation of the Association and 6 years after the launch of the *British Journal of Industrial Medicine* (BJIM—later to become *Occupational and Environmental Medicine*). Since 1948, the Association had produced a quarterly bulletin containing news items and commentary but it was soon agreed that a record of Association meetings as well as other papers on occupational medical practice was needed by members, some of whom it seemed, felt that the research and academic emphasis of the BJIM did not reflect their interests. However, as the last issue of the bulletin stated:

*Finally, this new publication will in no way compete with the British Journal of Industrial Medicine; it is hoped that it will be complementary to the Journal and provide a means of disseminating knowledge of the practical side of industrial medicine, and at the same time record the growing activities of the Association.* (1951)⁵

Since its launch, the Transactions, successively known as *Transactions of the Society of Occupational Medicine; Journal of the Society of Occupational Medicine* and *Occupational Medicine*, has had seven editors, five publishers and a number of major changes to its format. At times it has carried advertisements:
The problem... loss of working hours (picture of women on production line)

Works medical officers faced with the problem of reducing the number of hours lost by employees suffering from myalgia, dysmenorrhoea and other such conditions will find that 'Sonalgin' is particularly well suited for use in industrial practice.

'Sonalgin' combines the sedative action of butobarbitone—a valuable drug for the relief of nervous tension with the analgesic properties of codeine and phenacetin.

Special economical bulk pack for industrial use of 500 tablets. (1955)

The journal has also sometimes presented high quality illustrations.

CHRONOLOGY OF THE JOURNAL

1935 Foundation of the Association of Industrial Medical Officers (AIMO)
1948 Quarterly Bulletin of Association of Industrial Medical Officers started
1951 Transactions of Association of Industrial Medical Officers started. Editors: G. Keating, H. Wyers
1952 Editor: H. Wyers
1956 Editor: A. Meiklejohn
1959 Editor: F. Tyrer
1967 Title: Transactions of the Society of Occupational Medicine
1969 Publishers: Livingstone
1973 Title: Journal of the Society of Occupational Medicine
1974 Publisher: John Wright
1975 Editor: P. Pelmear. Society newsletter started
1979 Editor: A.N.B. Stott
1987 Publisher: Butterworth, later Butterworth, Heinemann
1988 Editor: D. D'Auria
1992 Title: Occupational Medicine. International editorial panel created
1995 Publisher: Elsevier Sciences
1996 Publisher: Rapid Science
1999 Publisher: Lippincott, Williams & Wilkins

Is it possible to summarize the ethos and role of this 50-year old publication, of which about 500 copies are sold and about 2000 are circulated to society members, who fondly know it by its cover colour as 'the yellow peril'? It has both reflected the development of occupational medical practice in Britain and has also helped focus a shared vision for the future. It displays the development of the Association of Industrial Medical Officers from its earlier days into the current Society of Occupational Medicine and has been central in developing collective views:

This Association has always been careful to avoid becoming any kind of political pressure group. It has concerned itself rather with the study of the principles of the art we all profess—medicine—and with the local application of that art inside industry and occupations generally. (1957)

The journal originally included reports on national and regional group meetings and on the work of the committees and officers, although this coverage was reduced after 1975 when a newsletter was started. It has also shared in celebrations for the society's 21st and 50th birthdays. Its sparky and dedicated editors have played a major part in this by selecting, commissioning and sometimes even touting for articles as well as by their editorials which are the first port of call for many readers. While they have trimmed and adjusted the style over the years there has been considerable continuity. The bulk of contents are reviews, commentary and assessment of occupational medical practice and of the evidence underlying it. Editors have introduced several series of commissioned articles, including 'Health care in .....' (sectors of industry); 'manufacturing processes'; 'target organs'; 'viewpoints'—extended commentaries, and most recently 'in-depth reviews'. The number and importance of original research papers has always suffered from the premier position of BJIM, although a number of significant surveys of risks, including some exotic ones such as:

A comparative study of chilli grinders with paprika splitters. (1983)

and of the effectiveness of intervention have been reported:

In this series (252 cases in a steelworks) the subjective findings have been confirmed by objective measurements of absences from work due to dyspeptic symptoms before and after operation. Absences from work due to peptic ulceration are effectively reduced following surgical intervention. (1964)

Its coverage of practice has been unrivalled. Because of this it has a major educational role and it has always been seen by its parent organization as a way of spreading good practice among all those concerned with health at work. Authors have come from a range of backgrounds: in addition to the contributions of members many specialists from other disciplines have been featured. This was originally because they made presentations at Association meetings but now it is more often because they wish to communicate with the audience who read the journal. A readership survey in 1987 indicated a generally satisfied readership but suggestions received included making the journal a common means of communication from the society, the faculty and the Royal Society of Medicine. A more heavyweight research contribution was not supported and more case reports were wanted.

Early issues were very much the house journal of a developing professional body but over the years the journal has slowly evolved into a wider scientific journal
of occupational medical, and sometimes health, practice. Contributions have come from a wider range of disciplines and become much more international. A determined effort was made to redirect the journal in the early 1990s to include practice in both developed and developing countries and the success of this has been seen in recent years.

Developing a common body of knowledge and practice has another purpose and this relates to the establishment of a membership, which sees itself as a defined special interest group with a mission to develop this body both in its own interests and for the public benefit. The growth of aspirations for specialist status and the route by which it was achieved can be followed, as can the evolution of a model for occupational health (often taken as being synonymous with occupational medicine) practice which could place members in a dominant and secure position.

Thus, the journal can be thought of as having three faces:

- words on paper published at regular intervals, as described above;
- a record of changing concerns and developing practice in occupational medicine;
- a vehicle for the aspirations of a group of doctors who wish to define their professional status and position in more favourable terms.

The expressions on each of these ‘faces’ give pointers to the interests of authors, readers, and above all, the editors over the last half century.

THE BASIS FOR PRACTICE

One of the clearest features to emerge from the contents lists of the journal is the extent to which technology, health and medicine have changed over the last 50 years. Many of the occupations and industries discussed in early issues have changed beyond all recognition. An article on steam train driving, starts with the comment:

Among small boys the locomotive driver is invested with glamour. (1951)\textsuperscript{23}

The production of coal gas has ceased,\textsuperscript{24} to be replaced with the decontamination of former gas works sites.\textsuperscript{25} Health,\textsuperscript{26–30} education,\textsuperscript{31,32} other service industries\textsuperscript{33} and IT,\textsuperscript{34,35} are relative newcomers to the ambit of occupational health concern. More widely the occupations covered reflect the backgrounds and interests of members, with sectors such as construction,\textsuperscript{36} agriculture,\textsuperscript{37,38} and small enterprises,\textsuperscript{39,40} where there is little medically based occupational health practice, rarely being considered.

Similarly, patterns of disease have changed markedly. Much space in early issues was concerned with TB and occupational aspects of its management\textsuperscript{9} as well as with a long-running dispute with medical officers of health on access to case data from mass miniature X-ray surveys.

We publish in this issue an article from Dr F.H. Tyrer which shows very clearly the damaging effects of the Ministry of Health’s rule that industrial medical officers shall not receive the results of mass radiography findings . . . In effect the works doctor is not to be allowed to participate in preventive medicine because he is employed by the industrialist. (1957)\textsuperscript{44}

Concerns relating to infectious diseases have shifted by way of food handling,\textsuperscript{45,46} notably with the publication of health standards prepared by food industry occupational physicians and supported by the relevant authorities,\textsuperscript{47} to blood-borne infections such as hepatitis B,\textsuperscript{48–50} and HIV.\textsuperscript{51–54} Some conditions have been presented from different perspectives over the course of time. For instance, an early psychiatry based approach to mental ill-health at work\textsuperscript{55,56} has developed, via employability assessment,\textsuperscript{57} to one focused on ‘stress’\textsuperscript{58} and, with the growth of a group of members interested in mental health, its occupational determinants.\textsuperscript{59,60} Developments in the understanding of allergic conditions as occupational risks can readily be followed\textsuperscript{61–64} as can the fashions in back pain management,

So much has been written in recent years describing the clinical picture (of prolapsed lumbar intervertebral disc) that repetition would be unprofitable. (1952)\textsuperscript{69}

and other musculo skeletal conditions.\textsuperscript{70,71} Papers on health risks from chemicals show the evolving patterns of this fast changing technology, with clinical reports at first, for instance on the skin risks of the newly introduced epoxy resins in 1963,\textsuperscript{72} and then attention being given to epidemiology and the development of toxicological assessment.\textsuperscript{73,74} Genetic modification is first discussed at a surprisingly early stage, in 1982.\textsuperscript{75}

One feature remains remarkably stable throughout and that is the overall content of occupational medical practice. As noted above, many articles are on the prevention and management of work-related disease, others cover fitness for work\textsuperscript{76–79} and absence attributed to sickness,\textsuperscript{80–82} some of which have the feel of a long-past era:

During this first year (after marriage in women) absenteeism is increased in respect of firstly, diseases of the urinary and genital systems, mainly from ‘honeymoon cystitis’ and pregnancy; secondly, rheumatic diseases possibly from the physical exertions of housework and carrying shopping bags . . . Social factors, no doubt play, a large part . . . The solicitous attitude of the bridegroom who will encourage his precious young bride to take a few days off unless she is quite sure that she is ‘feeling up to the mark’ may be a factor. (Tobacco workers, 1955)\textsuperscript{83}

Treatment at work features heavily in early issues with discussion of sepsis\textsuperscript{84–86} and methods of artificial resuscitation as mouth to mouth techniques and closed-
chest cardiac massage gained acceptance. Health promotion comes in a range of guises, from executive medics via participation in studies of heart disease prevention, to behavioural and educational techniques. At times, topics such as vision and work are reviewed as a whole, considering occupational risk, performance requirements and the role of the working environment in both. Facets of practice, such as ethics, which were for long assumed but not discussed became subjects for invited lectures by experts and editorial comment:

*Ethics and etiquette are frequently confused.* (1997)

The place of research in informing practice is a topic which is agonised over on several occasions, especially in relation to the activities (or lack of them) of the society's research panel. A 1962 editorial, which also discusses the lack of immediate relevance of much research to practice and the dearth of practice related research, stated:

*In the final analysis the acceptance of occupational health as a valid medical discipline will depend to a large extent upon the contribution its practitioners make to the general body of medical knowledge. In the last decade a small number of distinguished people have produced some notable advances; during the next, with wider interest and support, a larger number may be able to contribute still more.*

A few research panel studies were undertaken and reported but individual members were more active and the general problems of support for occupational health research came to the fore in the late 1980s, following closure of the Institute at the London School of Hygiene and Tropical Medicine and have remained a cause of concern:

*If research is so important to our speciality, why do we not expend more time and effort in teaching the necessary skills?* (1998)

The final aspects of practice discussed on several occasions are developments in the health care system in general, especially as they relate to medical specialisms and training, and the regulatory aspects of occupational health and safety. Regulation and proposals for it often come in for critical comment or at best faint praise, as the following quotations illustrate. In 1964 there was editorial comment on the lack of a requirement to measure atmospheric mercury levels because of the cost:

*It is hard to believe that the present draft regulations represent the current ethic of a once fiercely proud and independent tradition of factory inspection. None will question the prudence of cutting ones coat according to the cloth. The present policy, however, seems to be to throw away the cloth and extol the virtues of nudity.*

In 1965 there was editorial comment on the proposed government review of the Appointed Factory Doctor Service. (AFDs were doctors who performed certain statutory functions under factory law.)

*What happens to the 500 or so lousy adolescent girls forbidden in this way each year to work in factories? Do they gravitate instead to shops and serve the public with its groceries or cooked meat?*

In 1966 there was further editorial comment on the report about changes to Appointed Factory Doctor Service:

*Unfortunately the attitude of the Ministry of Labour to works medical officers ... seems still to be rooted in the past, when a salaried doctor was suspect as having been 'bought' by the employer, and could not therefore be relied on to exercise his judgement impartially.*

While in 1985, an editorial concerning COSHH appeared:

*The Commission seems to have ducked the vexed question of competency.*

These topics all relate closely to the aspirations of members about their status and security.

**THE PROFESSIONAL ASPIRATIONS OF OCCUPATIONAL MEDICINE**

Two main but linked sets of aspirations can be traced: to obtain the professional standing of a recognized medical speciality, and to make a medically led model for occupational health a part of public policy. Occupational medicine has long been unusual in that doctors practise largely outside the National Health Service and hence have been denied the ready benchmarks of service grades, such as consultant, by which to define their status in their own eyes and that of their medical colleagues. Society membership was always diverse in that commitment to occupational medicine varied from those with full time salaried posts to a those who undertook a few sessions a week but who were primarily general practitioners (GPs).

There are, however, a number of parallels for this in some of the earlier developments among other practitioners seeking a recognized specialist status and security, notably in public health. In the late nineteenth century, doctors working in public health tried to make common cause on a range of issues and found that there was a fault line between those who worked full time and were salaried by local authorities, and those who were clinicians with part time contracts. This weakened their ability to develop a coherent professional position as the leaders, in the main salaried, could not carry the rest with them. More recently, the same group has witnessed, with reluctance, what was once a medically led public health function (their professional ideal), change into one where a range of new and separate professional groups such as environmental health officers and social workers...
take the lead in defined areas and call for medical skills when required. Surprisingly these parallels have not been the subjects of discussion in the journal.  

PROFESSIONAL STATUS

It is easy to trace the content of practice through the pages of the journal, but identifying the professional 'mission' of members, as expressed in writing, is more obscure and open to several interpretations. It has to be looked at in the context of activities elsewhere in the medical profession and in society. Nonetheless, the journal does provide a unique record of the views and opinions of members, as well as sometimes the comments of others, on the way in which a group of doctors strove to develop, from a disparate band of practitioners concerned with a common set of workplace related issues, into a specialty accepted as such by the rest of their profession. This can be seen as their goal even prior to the start of the journal:

We have our own Diploma and are entitled to be regarded as specialists. (1948)

The attitudes of other specialities to occupational medicine, and of occupational medical practitioners to other specialities and their competence in handling workplace problems are sensitive topics.

It may be that a few of us have a mote in our eye that blinds us to the help that public health teams can give to the groups we serve and to us as individuals because we feel that a vigorous and critical Medical Officer of Health might have harsh things to say of some of the work places in our factories. ... With our colleagues in hospitals, consultants and others, I feel, perhaps I am over-optimistic, that our ties are getting closer. (1956)

In 1959 an editorial commented on the rules drawn up by the BMA, originally in the 1930s, on the demarcation between GPs and IMOs particularly in relation to providing treatment.

The average doctor is impatient with inter-union disputes about who drills the holes: would the managing director and shop steward be entirely wrong in imagining the existence of a similar mentality behind the Ethical Rules.

The development of the discussions on training and specialist status can be traced in society submissions and news items. For instance, suggesting to the GMC in 1967 that there should be a statutory general diploma relevant to a range of community health skills. A year later, editorial views supported the Royal College of Physicians response to proposals for changes in the Appointed Factory Doctor Service which suggested the concept of specialist status within the NHS.

A career structure for doctors engaged in all branches of occupational medicine ... should be planned within and/or external to the National Health Service, depending on future developments. (Society response, 1969)

The United Kingdom is one of the few countries which appears to have some reluctance to acknowledge the need for occupational medicine specialists. (1969)

Representatives of the Society attended a dinner at the Royal College of Physicians, at which the Presidents of the three Colleges were present, when it was decided to form a committee to consider the setting up of a Faculty of Occupational Medicine. (1971)

The need for recognized training arrangements as a pre-requisite for creating an accepted specialty became a big issue in the mid-1970s, and one that had the potential to exacerbate the split between members who were in full time occupational medicine and those who were primarily GPs. The need for a place within the medical firmament was seen as acute:

There is widespread concern that unless the profession sets up its own standards of training and professional competence for the practice of occupational medicine, the Health and Safety Commission may feel obliged to do so. (1976)

The creation of a specialist training committee, as part of the Joint Committee on Higher Medical Training soon provided a basis for this. The society's education panel was critical of some of the detail, especially the proposals for procedures which could cause problems for doctors working part time. In 1983 the president of the society (unusually) wrote an editorial which emphasized the lack of training courses for part timers but incidentally pre-empted the term 'occupational health' to apply solely to medical training.

The position of the society and its journal on training and professional recognition was radically altered by the creation of the faculty

With the setting up of the Faculty of Occupational Medicine it can (very nearly) be said that 'isolation from the mainstream of medicine' is a thing of the past. The problem of training is still with us, but at least we can now see the mechanism through which it will ultimately be solved. Thanks partly to the Faculty, but also through the accumulated experience of the work of occupational physicians, it can surely be said that we have fully achieved 'respectability' in the eyes of our professional colleagues. (1983)

Subsequent commentary on training included a renewed interest in training for GPs in occupational medicine. The development of distance learning methods suitable for use by part-timers was reviewed, and there were critical comments on proposals for National Vocational Qualifications in health and safety, which could undermine traditional professional boundaries. More generally, the growth in arrangements for continuing medical education was welcomed. The
THE MEDICAL LEADERSHIP OF OCCUPATIONAL HEALTH

The other main aspiration, which is repeatedly expressed, is for general acceptance of a medical model for occupational health provision, which is one where the doctor is in the dominant position. This was seen as the best, and by many writers as the sole, solution to managing the health problems which arise in connection with work. While the acquisition of specialist status was mainly concerned with the politics of the medical profession, attempts to secure acceptance of what might be termed the ‘medicocentric’ model for health at work required a rational justification accepted by others:

Environmental control on its own will seldom be wholly successful, even in preventing work-related disease and injury. It has little to offer in preventing the much larger burden of non-occupational disease carried by the workforce. (1984)\textsuperscript{141}

Let’s keep our white coats and stethoscopes. (1993)\textsuperscript{142}

It also depended on interactions with government,\textsuperscript{143} employers,\textsuperscript{144,145} and trade unions,\textsuperscript{147} occupational hygienists, ergonomists and safety advisers who work in related areas of occupational health and safety.

When the ethics of practice in these sister professions (ergonomists, hygienists) are considered, however, other issues arise. We as doctors are ethically bound to promote the ultimate best interests of our patients. Our code of conduct is demanding, rigid, respected and widely understood. Where environmental hazards are concerned this can and does lead to awkward situations and crises of confidence for some, if not all of us, from time to time. As yet, however, neither the ergonomists nor the hygienists have general ethical codes which a worker at risk can appreciate as his fundamental and ultimate safeguard.

Our new colleagues are managerial specialists, which in some measure we also are, but when pressing the acceptance of their decisions on management they are not supported as we are by our somewhat awesome and altruistic code of conduct. (Editorial, 1962)\textsuperscript{151}

The value of medical men, occupational hygienists and nurses in industry has often been mentioned in the literature. The purpose of this paper is to indicate what may be achieved by a physiotherapist. (Joint article by IMO and Physiotherapist, 1962).\textsuperscript{152}

Our Society may not always be in complete accord with the BOHS, the Royal College of Nursing, the Institution of Industrial Safety Officers and other allied bodies, but our separate existences and the multiplicity of views which we represent are the best safeguard against imposed uniformity. (1980)\textsuperscript{153}

The rise of pressure groups and media interest also began to be felt, with groups such as the British Society for Social Responsibility in Science producing their own critiques of professional appraisals of risks much to the discomfort of members.\textsuperscript{154}

The promulgation of an approach to occupational health based on the medically led department or service can also be traced, but not to such a clear conclusion as that on specialist status, although the two sometimes interact.

Do we agree that, as the Labour Party seems to suggest, an occupational health service is best staffed almost completely by general practitioners with a thin regional consultative and laboratory service? What do we think of the recent proposal made in a review of health services by the New Statesman that an occupational health service—being mainly preventive in character—should be an arm of the local authority services? (Editorial, 1960)\textsuperscript{155}

There are contributions discussing successful services,\textsuperscript{156} making comparisons with practice in other countries,\textsuperscript{157–171} often, it seems, as a way of highlighting shortcomings in Britain, and proposing ‘ideal’ models for future service provision.\textsuperscript{172,173}

The scheme would be based on a system of registration and licensing by an appointed Authority. Every employer would have to register with this Authority and obtain a licence or permit to operate. A necessary requirement for obtaining a licence would be that the employer had provided to the satisfaction of the Authority such items of an Occupational Health Service as might be necessary to safeguard the health of his employees. (Paper to association meeting, 1962)\textsuperscript{174}

There is, by contrast, less discussion of the key objectives of occupational health practice and how best to meet them,\textsuperscript{175} or of the importance of each objective for different stakeholders\textsuperscript{176–181} such as employers, with their concerns about cost, personnel management and liability; trade unions, which wish to secure workers...
Occupational health services are mainly preventative in function and the National Health Service is mainly therapeutic. Nevertheless, occupational medicine is a branch of clinical medicine and has been recognised by the formation of the Faculty of Occupational Medicine within the Royal College of Physicians.

The (Society's) Advisory panel does not believe that occupational medicine should become part of the NHS in the foreseeable future.

Relationships between existing occupational health services, the Employment Medical Advisory Service and the National Health Service should be improved.192

These rather variable responses indicate some of the tensions within the society, which could do little except be critical of any divergence from the model espoused by members, one which was rarely articulated clearly or presented in terms of an analysis of the health care needs of people at work. Employers, authorities and counties were styled 'enlightened' when they had medically led occupational health services, but the case for this accolade was made mainly in terms which failed to disguise an element of professional self-interest.

Hopes for medically led services being required as a matter of public policy were again dashed by the report of the House of Lords Science and Technology Committee in 1984, which recommended 'a voluntary code of practice', something which then sunk into an administrative black hole because it was incompatible with the approaches of the Health and Safety Commission.193

In more recent times the journal has carried many fewer contributions on the grand design of national occupational health services and an ever increasing number of articles on the management of occupational health and its quality.194,195 Could this reflect greater security among members now that they have their own faculty? Was it a consequence of a long period of government which was both deregulatory and anti-professional? The development of evidence based methods for practice and their application has been discussed.196

The dilemma for occupational medicine is whether to stake our place in the company of science-based medicine (by undertaking review, guideline preparation etc.) or continue as we have done, responding as the need arises with the best quality information available. One way of resolving the dilemma might be to educate our colleagues in business and industry in the value of evidence-based occupational medicine. Better still, we might demonstrate its capacity for cost savings. But where is the evidence? (1997)197

A preoccupation with the changing structure of industry and its implications for readers is also apparent.198,199 showing both potential threats to existing arrangements for practice and the opportunities being grasped by some forward looking writers. This has led to greater consideration of justification for
practice, in close liaison with other functions in an organization.

Splendid isolation in the human resource or employee relations department will not allow maximisation of corporate value. (1999)²⁰⁰

The new millennium shows promise of a questioning approach, but with claims being laid to additional areas of competence for members!

Occupational medicine is evolving to meet the needs of the 21st century. There is a need to define the remit of occupational and environmental medicine in order to facilitate the development and maintenance of the requisite professional competencies, the establishment of educational goals for practitioners and production of a professional product for the global market place. The delivery of occupational health services will be underpinned by quality assurance systems.²¹

CONCLUSIONS

What does the 50-year run of a journal tell us about occupational health and its practitioners? I believe that the following general points can be made.

1. That a substantial body of knowledge, both about risks and about practice has been developed, although the interest of the editors and, probably, the readers, has focused on the immediate and practical problems rather than on the academic base and the rigorous evaluation of effectiveness.

2. That this body of knowledge has formed the basis for the differentiation of a group of doctors, working on health at work, into a recognized specialty.

3. That in the course of this differentiation there were both internal tensions and areas of challenge from a range of other bodies.

4. That the editors have played a key role in the development of the vision and the speciality, both by their editorials and by the papers they published.

5. That, much to the frustration of commentators from within occupational medicine, the medically led model of occupational health practice which members developed and supported, was adopted selectively by some large organizations but did not become a model for public policy.

6. That in the last two decades, following the resolution of professional status, by the creation of the faculty, and through a long period of government which was unsympathetic to professional advancement, and to the need for regulation of working conditions, there has been less emphasis on campaigning and more on the knowledge base of practice and its effective application.

7. That any journal reflects that which is fit to print rather than the totality of emotions within a professional society; hence more could be told but will never be written!

REFERENCES

(Note. When no journal title is given references refer to the AIMO/SOM transactions/journal.)


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