In this issue of Occupational Medicine

It could be argued that sickness absence and its management keep our specialty in business: the general practitioner’s poison is the occupational physician’s meat. A significant proportion of that absence is due to low back pain and so it is appropriate that this issue contains six original papers about low back pain or sickness absence and three of those papers address both topics.

One of the holy grails of sickness absence management is predicting who will take time off work. Occupational physicians already offer advice as to who may be at increased risk of long-term absence but this is usually based on past history as those with chronic illnesses often have better than expected attendance. If a screening tool is ever truly achieved then pre-employment assessment may take on a new meaning. In a prospective study, Roelen et al. [1] found that self-reported multiple health complaints predicted subsequent absence. This is possibly not surprising but the use of a 116-item questionnaire to predict subsequent absence might deter general uptake of this screening method. More surprising was that psychosocial and physical factors did not predict absence. This is contrary to the findings of Cunningham who found that occupation was an independent predictor of absence due to back pain in Dublin hospital workers with nursing and support workers reporting the highest levels of absence [2]. This finding is reinforced by a much larger Danish study by Labriola et al. [3] of almost 4000 employees which estimated that 40% of absence was attributable to difference in workplace environment exposures. In particular work with the arms raised and extreme bending predicted absence but then so did poor self-reported health and working in the public sector. They also found unsurprisingly 80% of total absence was reported by 20% of the study population.

Our other papers on low back pain suggest that functional restoration programmes might bring about benefits in reducing long-term absence due to low back pain [4] and we publish studies of back pain in Japanese medical representatives [5] and Iranian car workers [6].

The ‘Why I became an occupational physician’ series started life as an idea jotted down on the back of a train ticket and we invited one or two people to contribute something to fill our white spaces. It seems to have struck a popular chord and occupational physicians have been enthusiastic to tell their tale. In this issue, Sue Robson recounts her own road to the Occupational Health Department and uniquely suggests that it felt like writing her own obituary. In common with many other submissions, her route appears to have been one of serendipity and Brownian motion rather than selection and brow-beaten determination; perhaps, this is an important reminder to us all when entrance and training to our specialty are being actively considered once again.

Elsewhere, our original articles deal with occupational health guidelines for mental ill-health and return to work after ill-health retirement as well as fascinating case reports on a possible case of paraffin-induced pulmonary fibrosis and the hypothenar hammer syndrome. We promote our journal as being practical and for practising occupational physicians and in this issue we think you will agree that we have achieved our aim.

John Hobson
Honorary Editor

References