Why I became an occupational physician

I can still see him now after >70 years! He was a collier, a preferred title for a coal miner, in the South Wales valley where I was born in the mid 1920s. He was only about halfway up a short incline to the house where I knew he lived. He was resting on his haunches and was breathing with great difficulty. In fact, he was gasping, and with each breath the whole of his chest, shoulders and neck were involved. His face was bluish in colour, and where he had been spitting the pavement was discoloured black.

In reply to my greeting, he could only nod his head in reply. Not long after this he died.

At that time, disease and death were the most overheard conversations in the village of my birth. In the collier’s case, I knew that the cause was ‘the dust’ because so many colliers had it. However, at that time, one’s vocabulary was also sprinkled with diphtheria, pneumonia, TB, scarlet fever, infantile paralysis, meningitis, rheumatic fever, mastoid, measles, mumps, whooping cough to name just a few! Prevention initially rested with one’s parents ensuring cleanliness, warm clothing and a good diet with added vitamins, and later in the early 1940s with the school doctor vaccinating us against diphtheria. With regard to the ‘dust’, ‘Dai Top House’ was a deputy at the Tower Colliery, he was a self-educated man with a natural air of authority. On asking him, his answer was ‘hard headings, waving coal seams sandwiched between stone. It’s the price we, the miners pay for coal.’

At the Welsh National School of Medicine, the social medicine lectures included those from the local medical officer of factories and a full term of biometrics. At least two factory visits were also arranged. Professor Gough was an authority on the pathology of coal workers pneumoconiosis, and each morning at post-mortems, there would inevitably be a cadaver of an ex-coal miner.

Later in general practice in an isolated part of the Preseli Mountains, occupational respiratory medicine raised its head with the appearance of Farmer’s lung. Rehabilitation with treatment became obvious for the hill farmer, whose success or failure depended on his or her health state.

Initially, little help was provided by the TB officers as their experience related essentially to TB, cancer and bronchiectasis. The farmers themselves provided the cause as being hay harvested and stored when wet, and the dust later produced when it was disturbed. A wet face band provided little protection, so yet again patients suffered because of enforced contact with their environment.

‘Industrial Medicine’ seemed to have been ever present in my experience and those early memories crystallizing as diseases of occupation became foremost in my professional thinking. My desire was to find employment in that field, and in a setting of a well-established department but how I did it as an isolated single-handed doctor is another story!

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