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PULSE



Common work-related health problems

Guidance for health professionals in primary care

Foreword

This booklet was written for health care professionals in primary care. Its purpose is to provide information and guidance on how to address health problems which are, or might be, work-related.

It covers a range of the most common occupation-related health problems and aims to support general practitioners and their primary care colleagues in their day-to-day interaction with patients. This booklet will also be of interest to medical students and junior doctors.

The last two sections cover professional development and careers in occupational medicine.

The chapters in this publication appeared originally as articles in Pulse magazine (www.pulse.co.uk), and the Faculty of Occupational Medicine is grateful to Pulse for allowing them to be reproduced in this booklet.

This booklet is available to be downloaded from the Faculty website. Readers can also access CPD credits by completing an online assessment based on these articles; details are available online at www.pulse-learning.co.uk.

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The Faculty of Occupational Medicine sets standards for specialists and supports GPs and other healthcare professionals who are working part-time in occupational medicine or have an interest in work and health as it affects their patients. The Faculty's Diploma in Occupational Medicine, taken by many GPs, covers the effects of work and health, assessment of fitness for work, health surveillance, rehabilitation, workplace visits, ethics and the law. For further details on the diploma go to: <http://www.fom.ac.uk/education/non-specialist-qualifications-and-training/diplomas/docmed> and for information about other diplomas, training and careers, and about occupational medicine and occupational health more generally, visit www.fom.ac.uk.

Occupational asthma

Professor Paul Cullinan and Dr Joanna Szram give advice to GPs on occupational asthma

Asthma is 'occupational' when it has been caused directly by an agent encountered at work – usually an airborne allergen. Repeated inhalation causes a respiratory hypersensitivity in some people, which is similar to ordinary allergic asthma in response to house dust mites or cats.

Occupational asthma needs to be distinguished from work-exacerbated asthma, which is pre-existing or coincidental adult-onset asthma that is provoked, rather than caused, by a workplace agent. This is commonly an irritant dust or fume, cold air or exertion, or even simply an early morning shift pattern. This distinction is important because the implications for patients and employers are very different.¹

Research suggests that 15% of all new or relapsed asthma in adulthood is the consequence of an exposure at work, though only a proportion will be true occupational asthma. The disease is very common in some workforces – such as bakers or those who work with animals.

Having said this, few clinicians will recognise a figure of 15% among their adult patients with asthma. This may be because many people with occupational asthma – particularly young men – do not consult their doctor, perhaps because they don't connect symptoms and work, because they feel it's just part of the job or because they are anxious about the implications.

It may also be because some clinicians fail to ask the right questions – it is difficult to remember all the possible associations.²

Risky jobs

Around 400 workplace agents have been reported to cause occupational asthma. Fortunately, most of these are rarely encountered and about three-quarters of all the cases in the UK are attributable to only a handful of exposures (see box, below).

Identifying occupational asthma

Ask every asthma patient of working age what they do for a living, with details. 'I work

OCCUPATIONS AND ASSOCIATED AGENTS

Job	Relevant exposure
Baking	Flour, 'improver' (amylase)
Work with animals	Animal proteins (research, veterinary)
Motor vehicle repair	Spray paints (diisocyanate)
Electronic assembly	'Multicore' solder fume (colophony)
Hairdressing	Bleaching powder (persulphate salts)
Detergent manufacture	Biological washing powders (enzymes)
Food processing	Seafood proteins, flour, enzymes
Woodwork	'Tropical' wood dusts (for example obeche, iroko, sapele)
Industrial foam manufacture	Diisocyanate
Other chemical processing	Glues, metals, amines
Welding	Stainless steel fume (chrome)

for a supermarket' isn't adequate. It is also worth asking whether their symptoms are better when they are not at work and whether there is anything at work that sets symptoms off. Be especially alert to patients whose asthma has begun – or relapsed – shortly after starting a new job. Also, remember that occupational asthma is often accompanied by occupational rhinitis. Patients may attribute this to hayfever or a cold. See the box, right, for a case history.

Diagnosing occupational asthma

Be wary of making a diagnosis on history alone, since a false positive diagnosis can be disastrous. Tests are generally necessary and are best done by specialists. Many, but not all, asthma consultants will be able to arrange these – the Group of Occupational Respiratory Disease Specialists is a UK network of consultants with a specialist interest. Tests may include immunological testing for specific sensitisation and functional testing for detecting a work-asthma relationship.

Many workplace agents that cause occupational asthma do so through the production of specific IgE antibodies that can be detected in serum or skin-prick tests. Functional testing is usually done by serial measurement of peak flow, at least four times a day (preferably more) for at least a month. Values on days at work can be compared with those when away. Occasionally, patients are admitted to hospital for specific provocation testing under controlled conditions.

I would advise a patient to continue working while the diagnosis is under consideration – except if the asthma is very severe – because staying off work can interfere with the diagnostic process.

There can be some confusion about the role of occupational health physicians here. Most occupational health physicians and nurses prefer to leave investigation of a potential case to a respiratory specialist, but then manage the case themselves. Unfortunately, only about 15% of the UK workforce has any occupational health coverage.



Employers whose workers are exposed to a potential asthmagen are required to arrange routine health surveillance for them. While this does happen in large firms, it is far patchier in small businesses.

Implications of a diagnosis

For the patient

It is usually recommended that patients with occupational asthma avoid further exposure to the causative agent. Even very small exposures will provoke continuing symptoms, and so it is often difficult for patients to avoid the asthmagen while remaining in the job.

For example, wearing a face mask is seldom sufficient even if it is tolerable. Large, well-run firms will attempt to find the employee alternative work in the organisation. Where this is impossible, as is often the case with smaller companies, your patient is likely to lose their job.

Of course, some patients may prefer to carry on working and put up with symptoms.

Employers and their lawyers are rarely prepared to support this course of action, but it often happens among the self-employed. You'll need to make sure these patients understand the prognostic implications of this decision. Patients who do carry on working should try to keep further exposure to a minimum, and you should ensure they use sufficient asthma treatment. Antihistamines and inhaled steroids may help control some symptoms.

Those who do succeed in avoiding any further exposure usually find their asthma improves and there is a strong possibility of complete 'cure' – a rare outcome in asthma of any other sort.

Coming to terms with a diagnosis of occupational asthma and its implications is difficult for most patients, and they should to be allowed sufficient time. A few weeks or even months of further exposure is unlikely to have any lasting adverse impact.

Patients who have developed occupational asthma are eligible, unless self-employed, to claim for Industrial Injuries Disablement Benefit – a no-fault, statutory compensation. If the diagnosis is accepted and they are judged sufficiently disabled – usually if they require regular prophylactic treatment – the benefit will be awarded with a minimum weekly payment of about £30. Patients do not need to have left their job to be awarded this. Some patients with occupational asthma

make a personal injury claim against their employer and they need to do this within three years of diagnosis. If your patient is a member of a trade union they will be able to access legal advice through this route.

For the employer

Employers are required by law to report cases of occupational asthma in their workforce to the Health and Safety Executive. This usually results in a formal, external inspection that can be expensive for a business. And the patient will lose any anonymity they might have had, potentially making it an uncomfortable experience. For all of these reasons, it is easy to see why a false positive diagnosis of occupational asthma is potentially disastrous.

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Professor Paul Cullinan is professor of occupational and environmental respiratory disease at the National Heart and Lung Institute, Imperial College London

Dr Joanna Szram, consultant in occupational lung disease and asthma at Royal Brompton Hospital, London

Occupational asthma case history

John is a baker in the local branch of a large supermarket chain. He was previously fit, but has noticed a constantly running nose and sneezing when he is at work. His symptoms started about six months after he began the job – he had originally attributed this to a cold. More recently he has found himself getting breathless during games of football, which he blames on his smoking. He felt much better on a recent holiday in Crete.

Notes

- At-risk occupation
- Short latent period ('about six months') between first employment and onset of symptoms
- Upper and lower respiratory symptoms, the former starting first
- Attribution to non-occupational causes (a cold and smoking)

Fitness for work after surgery

Dr Tony Williams and Dr Sarah Maxted discuss assessing fitness for work after surgery

This article will consider some of the issues surrounding fitness for work after surgery and the factors that affect individual patients. Detailed guidance on specific operations and their expected return to work times can be found at www.workingfit.com, on the Royal College of Surgeons' website,¹ and on the Royal College of Obstetricians and Gynaecologists' website².

Advising patients

Advising patients on how much time is needed off work after surgery can be difficult. One study found that GPs' recommendations for time off heavy lifting work following hernia repair ranged from two to 13 weeks, while surgeons' recommendations ranged from one to 12 weeks. But evidence showed that open prosthetic mesh repair can withstand any degree of stress immediately³ and post-operative activity does not need to be restricted at all.

Despite this, clinicians' recommendations are the most important factor in determining a patients' length of absence from work,⁴ so if you recommend 12 weeks off, the patient is likely to take 12 weeks off. On the other hand, one study followed up patients after discectomy who were advised to return to full activities as soon as possible.⁵ The mean duration of absence was 1.7 weeks and none developed any complications as a result.

Unnecessary time off unpaid can have a serious effect on a household budget. Also, after weeks of rest, many patients will never regain full fitness. Evidence suggests that many doctors recommend an unnecessarily long time off work, so it is important to consider whether work could be adjusted during recovery instead.

Assessing fitness for work

The issues to consider when assessing fitness for work after surgery can be broadly divided into three categories: capability, safety and motivation.

Capability

Can the patient get out of bed and get to work? Can they cope with work, and what can they physically manage? For many people, work is actually physically less demanding than living at home, and – provided they can get to work – they are capable of working.

Safety

Will patients be harmed or potentially cause harm to others by going to work or by doing any particular activity at work? Safety considerations will vary depending on the patient's profession. If a job involves machinery, the employee must be able to use and control it safely. Anybody who drives at work must be able to execute an emergency stop. The employee must also feel safe, particularly if they have demanding physical duties such as control and restraint of offenders.



Motivation

Does the patient want to return to work? Do they want the opportunity of time off? How well do they cope with pain? Motivation will be governed by what the patient can do, what they believe they can do and what they want to do.

This will vary enormously, even between patients who have had identical procedures. A non-judgmental approach is best and it may be appropriate to simply advise that the patient is medically fit to return. Leave the employer to deal with motivational aspects and suggest a phased return with reduced hours and workload.

Pain or discomfort is a difficult issue. It is not necessary to wait until a patient is symptom-free for a return to work, and in many cases pain does not equate to harm. Analgesia and reassurance can be very important in overcoming worry about pain. But persistent pain should be taken seriously, particularly if it is associated with erythema.

Medical factors

Several medical factors may affect when a patient can return to work after surgery.

Wound healing

Wound healing depends on the reparative ability of the tissue involved. A simple physical assessment of the wound can often indicate whether healing is progressing as expected.

Normal movement around the home or office should not disrupt most wounds, but lifting more than around 5-10kg may do in the first couple of weeks, and the patient should also avoid getting the wound wet or dirty during this time.

Remodeling of collagen starts after a few weeks and wounds will have strengthened enough by four to six weeks to allow manual handling tasks to be done safely. Wound healing may be delayed by infection, malignancy – particularly with associated radiotherapy – and circulatory problems.

Bones take longer to heal completely. Initial healing with fibrocartilage takes around three

weeks, but small bones and upper-limb bones will not be strong enough for significant activity until around eight weeks, and long lower-limb bones generally take 12 weeks.

It is important to know what surgery was undertaken – for example, bunion surgery may involve a distal osteotomy with a walking plaster after a couple of weeks, while a proximal osteotomy may require non-weight bearing for six weeks.

Diabetes

During the initial healing phase, endothelial cells need to mobilise for revascularisation. This is inhibited in diabetes – in some cases, catastrophic wound failure and dehiscence occurs, and in other cases there is failure or delay of complete healing.

Diabetes also affects the immune system and the resulting macrophage dysfunction leads to reduced clearance of dead cells and persistent inflammation.

Obesity

Overexpression of tumour necrosis factor by adipose tissue leads to a state of chronic low-level inflammation, interfering with wound healing and exacerbating symptoms during the healing process.

Obesity is also linked to impaired antibody responses and increased risk of chest infections.

Smoking

Smoking has a profound adverse effect on healing. Carbon monoxide and hydrogen cyanide reduce oxygenation of the blood. Nicotine impairs angiogenesis and so further reduces oxygen supply to the wound.

Smoking also impairs collagen production and maintenance, weakening any scar formation – smokers have four times the risk of incisional hernia of non-smokers. It is important to explain this to patients awaiting surgery.

Age

Counterintuitively, age has only a minimal effect on recovery times. Recovery takes only

an additional one or two days overall between ages 18 and 65.

Most of the delays seen in recovery in older patients are caused by comorbidities.

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Dr Tony Williams is a consultant occupational physician at Medway Maritime NHS Foundation Trust and medical director of Working Fit Ltd

Dr Sarah Maxted, medical student at King's College London





Mental health

Professor Richard Heron advises how to manage mental health conditions that affect, or are caused by, work

In addition to providing income and financial security, work often brings a sense of identity, fulfilment and self-worth. When we are unable to work because of ill health, our sense of purpose and self-esteem can be adversely affected, particularly when a condition is chronic or – as is often the case with mental health – poorly understood by colleagues, friends and family.

This article will consider some common mental health conditions and how they affect patients and their work, and the workplace factors that can have an impact on mental health. As well as advice on support and therapeutic

intervention, it will also discuss the resources available to GPs to help manage patients with mental health conditions in relation to their work.

Prevalence

At any one time, up to a sixth of adults will have a mental health condition and, according to Mind, a further sixth will experience symptoms associated with poor mental health – including problems with sleeping, fatigue, irritability and worry. So mental health problems in people of working age can be a significant element of the GP caseload.

Assessing mental health in relation to work

When assessing the clinical relevance of symptoms and work, it can be helpful to consider:

- **Demands** How well are the demands or workload matched by the current capabilities of the patient? How do they interact with demands from home and family?
- **Control** To what extent does the patient have control over what they do, the pace of their work and scheduling?
- **Support** What support is available from the workplace – colleagues, bosses, human resources and occupational health? And from outside – specialist agencies, health professionals, family and friends?

Benefits of work

There is increasing evidence that work is good for health, and long-term unemployment is harmful in itself. But many employers and health professionals are still driven by an assumption that illness is incompatible with being in work. In many cases, helping patients to stay in employment or facilitating a well-managed return to work in a supportive environment can be an important stepping stone in a patient's recovery from mental illness. Long-term absence from work makes it harder to return.

In 2009, NICE issued guidance for employers on the productive and healthy working conditions associated with promoting mental health.¹ Keeping people at work has the added benefit of reducing the demand on health and social security budgets – depression, anxiety and stress-related mental health problems were estimated to cost £28.3bn in 2009, and 12.8 million lost working days were attributed to stress, anxiety and depression in a year.

Common conditions and management

Anxiety and depression

Anxiety and depression are common and can impinge on fitness to work. While the causes of anxiety and depression may be multifactorial, they often present in occupational settings.

As well as therapeutic and cognitive interventions, GPs should consider whether specific workplace factors could be precipitating or maintaining symptoms. Persistent or continuous symptoms of anxiety (generalised anxiety disorder) may be focused on the workplace – excessive anxiety associated with interactions with colleagues, subordinates, managers or customers can be debilitating for the patient and disruptive for co-workers.

Panic disorders and phobias may also impinge on fitness for work. For someone working in international business, travel anxiety or fear of flying can hinder their career advancement. People with severe fear of flying can benefit from psychological interventions. Several airlines – for example, British Airways and Virgin – run very effective courses to combat fear of flying.

Alcohol and substance dependencies

Alcohol and substance dependence are particularly important if employees are engaged in safety-critical activities such as driving or operating potentially dangerous equipment.² Some employers conduct drugs and alcohol testing, and there are generally three types of programme:

- pre-placement testing as part of a 'fitness for task' assessment
- 'for-cause' testing, after an incident or as part of a standard investigation, or when there is reasonable suspicion
- random testing.

A positive drug test on-site generally requires confirmation, and good practice includes a review by a medically qualified and suitably trained review officer. Most enlightened employers will offer opportunities for rehabilitation, including referral to employee assistance programmes. Indeed, a survey found that over 60% of employees with drug or alcohol problems who were referred for specialist treatment or rehabilitation were successfully kept in their jobs. During this time, restriction from safety-critical tasks is advisable.

The effects of some medications on driving are well known – but it's always worth emphasising this to patients, especially if driving is part of their job. Specific information on when the DVLA must be notified, and when patients with mental health conditions or drug and alcohol dependence are fit to drive, can be found in guidance from the DVLA.³

General management strategies

Mental health problems are often thought to be more difficult to manage than those due to physical ailments. Patients may need continued support during the early days of return to work, and the potential for stigma and prejudice from the employer and co-workers should not be overlooked. Some of the less frequent and more serious mental health disorders, such as chronic schizophrenia, may present with clear or specific functional impairments and work limitations. Other conditions are less clear-cut – patients suffering from stress may actively seek time away from work. When assessing what action is needed in these patients, it's worth asking what support is available at work.

Early contact with an occupational physician or nurse adviser is good practice when considering what the patient can and cannot do at work, especially where poor working relationships need to be addressed. Many employers have employee assistance programmes, which can include access to cognitive behaviour therapy. Nevertheless, in some circumstances a short break from work can provide the space needed for the patient to regain focus. For small and medium-sized employers, however, access to an occupational health service may be limited – with only about 34% of the UK workforce estimated to have coverage – and not all services are consultant specialist-led. In this case, CBT arranged in primary care can be very helpful.

Useful resources

Both the patient and the employer may benefit from signposting to information and guidance. The Department of Health, NHS-Plus and the Health and Safety Executive websites are good places to start for information on stress and work. Further information on a variety of

mental health conditions can be found on the Royal College of Psychiatrists, Mind and the Mental Health Foundation websites.

Whether or not an occupational health specialist is available, GPs can help the employer and patient by using a fit note to advise on what the patient can do.

When you are seeking specialist occupational health advice, a diploma in occupational medicine (DOccMed) indicates basic training, and membership or fellowship of the Faculty of Occupational Medicine (MFOM, FFOM) indicates specialist training.

Nurses with training specifically in occupational health are designated as specialists in 'community and public health – occupational health'. When looking to service providers, accreditation with the Safe Effective Occupational Health Service Scheme is seen an indication that a provider meets nationally recommended standards.

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Professor Richard Heron is vice president of health and chief medical officer at BP, and honorary professor of international business and health at the Institute of Work Health and Organisations at Nottingham University

Dermatitis

Dr Tamsin Radford discusses the diagnosis and management of occupational dermatitis



Occupational skin disease is one of the most common work-related health problems, with around 40,000 cases diagnosed annually. It makes up about 3% of cases of occupational illness where the patient is signed off work, and considerably more patients will have chronic, low-level symptoms.

Occupational contact dermatitis

Occupational contact dermatitis – synonymous with occupational eczema – is the most common type of occupational skin disease, comprising about 73% of cases reported to UK reporting schemes.¹

It is defined as inflammation of the skin resulting from, or made worse by, any exposure while the patient is at work.

There are two types of occupational dermatitis – irritant contact dermatitis and allergic contact dermatitis – and it is not possible to distinguish between the two by history and examination alone.

Both present with red, itchy skin which may also have vesicles, papules, bleeding, crusting, scaling or secondary infection. In chronic cases, painful fissuring or altered pigmentation may occur.

Both usually present within the first year of employment, though they can occur at any

stage. They can occur simultaneously and can complicate endogenous dermatitis.

Irritant contact dermatitis

This is more common than allergic contact dermatitis. It is caused by toxins – such as detergents, solvents and cutting oils – acting directly on the skin, by friction or wet working. Continuously wearing gloves can also alter skin hydration and cause irritant dermatitis, though this can be difficult to distinguish from the allergic dermatitis caused by some types of gloves. Simply working in a low-humidity environment can cause drying of the skin and cause exacerbations of dermatitis. People with a history of atopic eczema in childhood are generally more susceptible to irritant contact dermatitis, because of chronic structural skin changes.

Allergic contact dermatitis

This is an immune-mediated – usually type IV – reaction to an allergen. Sensitisation may occur instantly or after repeat contact and will then typically produce an acute attack six to 48 hours after exposure, resulting in a series of acute attacks or a chronic pattern. It tends to have a worse prognosis than irritant contact dermatitis – once sensitised, the problem is life long and further exposure will cause a similar reaction.

The most common cause of allergic contact dermatitis is nickel, which can affect patients who work in retail and have regular contact with money. Other common occupationally encountered allergens include epoxy resins, preservatives, plants, resins and chromates. Latex used to be a common cause in healthcare workers, but its use has reduced significantly.

Risky jobs

The most common occupational causes of reported dermatitis are wet work, soap or detergent, rubber, chemicals and foods.

Beauticians and chemical and glass process operatives are at high risk, as are cleaners, food handlers and healthcare workers who commonly do wet work or wash their hands repeatedly.

Hairdressers are a group at very high risk, and up to 70% may experience skin problems at any one time from irritant (wet work or soap) and allergic (chemicals) exposure. Construction workers, rubber workers and some engineers are also commonly affected.

Identifying occupational dermatitis

Workplaces where occupational dermatitis is possible or probable are legally required to have a health surveillance programme, but workers' compliance with this can be poor because of worries about their employment. So patients will often present first to their GP. In anyone of working age who presents with a skin rash, note the distribution. If only a patient's hands or arms are exposed – for example, healthcare workers who repeatedly wash their hands – then the symptoms are quite likely to follow that distribution, although workers who have hand exposure to an allergen may touch their face or other areas and cause dermatitis there too.

If the worker is exposed to a chemical that soaks through clothing, they may have trunk, leg, feet or groin involvement. If the precipitant irritant or allergen is airborne, then the face – especially the eyelids – and neck are most likely to be affected. Dust tends to cause reactions at the places where it collects – in flexural areas, or in the collar or sock line.

It is important to obtain a history of what the patient's work involves, the irritants or allergens that are encountered and the frequency and routes of exposure that are likely to occur.

Sometimes there is a temporal relationship, with patients showing improvement when they have a holiday. But as symptoms become more chronic, temporary improvements may no longer occur and irritation can predispose

patients to develop allergies to substances they previously used without a problem, such as cosmetics.

A failure to respond to usual treatment should raise suspicion of an occupational cause since continued exposure may be rendering treatment ineffective.

Diagnosing occupational dermatitis

Where an occupational cause is suspected, or the condition is severe or resistant, referral to a dermatologist for patch testing should be considered.

A battery of common allergens are applied to the skin of the back under shallow cups and observed at intervals over one to five days to check for a reaction.

Where a specific substance is suspected it may be used in a patch test, but specialists must ensure that the correct concentration is used so as not to produce a false negative or irritant false positive reaction.

Symptomatic treatment of the skin should follow the same lines as for endogenous dermatitis, and patch testing is unlikely to change the medical management plan significantly. The main aim of patch testing is to try to distinguish between irritant and allergic contact dermatitis so that non-medical management can be optimised.

Managing occupational dermatitis

Patients with a positive patch test will be given advice about checking the labels of products which may include the substance to which they are sensitised – for example, cosmetics and cleaning products.

A patient's employers have a statutory duty to look at the risks and modify where possible, although they can, of course, only do this if the patient is prepared to notify them. Patients working with chemicals who have had sensitisation diagnosed should, with their workplace health and safety representative, look at the safety data sheets for the chemicals

to identify the allergen among the ingredients. The employer will then need to consider whether the substance can be substituted or eliminated. If the substance can't be removed, employers will need to consider if exposure can be controlled – perhaps by installing ventilation to reduce exposure to airborne allergens or providing personal protective equipment.

Patients with a negative patch test, but in whom irritant occupational dermatitis is strongly suspected, will need to go through the same systematic approach with their employer to reduce or eliminate their exposure as far as possible.

Where wet work is the irritant, it is often unavoidable and patients should be advised to be scrupulous about drying hands, using gloves where appropriate and using emollients after hand washing.

It may be possible for the worker with occupational dermatitis to be redeployed if simple measures do not help, but this might not always be realistic and the patient may need to look for different employment. This is a difficult decision to make, especially as there is no guarantee of complete resolution of symptoms – 10% of workers with allergic causes will continue to have symptoms even after removal of exposure.

The patient may feel that continuing in their job with some degree of symptoms is acceptable – whether employers then agree to knowingly expose an employee to something that is harming their health is a decision for them to make on an individual basis, with specialist advice from an occupational physician.

Health and safety legislation has reduced the risk of occupational skin disease, but a low level of symptoms remains common.

Non-infective dermatitis of external origin is a prescribed disease if exposure to agents capable of irritating the skin – including friction or heat – has occurred during employment.

Patients should be assessed by Department for Work and Pensions' advisers to determine if they are eligible for Industrial Injuries Disablement benefit. They will normally be eligible if their assessed degree of disability from the dermatitis or from a combination of work-related conditions exceeds 14%.

The amount they receive will depend on their degree of disability. Patients may also be able to make a personal injury claim against their employer and should seek advice from their trade union in the first instance.

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Dr Tamsin Radford, consultant occupational health physician and head of the occupational health and wellbeing service at Sandwell and West Birmingham Hospitals NHS Trust

Occupational health investigations

Professor Tar-Ching Aw and Dr Stella Claire Major discuss occupational medicine tests and their impact on GPs

Occupational physicians in the UK deliver a service to a range of industries, and they are mostly employed outside the NHS. They conduct laboratory and other relevant investigations, and the results from these should be communicated the GP, to put you in a better position to manage the health of the worker holistically.

Investigations conducted in the course of occupational health practice fall into two broad groups – those performed on the patient, and those performed on the work environment.

Patient investigations

Lung function tests

Lung function tests such as serial peak flow readings and spirometry are useful in the occupational health assessment of

workers who are exposed to asthmagens – for example glutaraldehyde, isocyanates and flour dust. Serial peak flow readings taken at and away from work can help to detect occupational asthma – considerable variability in the readings indicates reversible airway obstruction. The FEV1/FVC ratio can show obstructive or restrictive lung disease.

In obstructive airway disease – such as asthma, bronchitis or emphysema – the ratio is usually less than 70-75%. In restrictive lung disease there is a decrease in both FEV1 and FVC, but little decline in the ratio. Examples of restrictive lung diseases from occupational exposure are silicosis and asbestosis. A clear history of exposure is key in the confirmation of lung diseases. It is important that this information is shared between the occupational physician and the GP to optimise the management and continuing surveillance of such patients.



The primary role of the GP is in treating the patient's symptoms and referring to a respiratory specialist where necessary – for example, if symptoms appear intractable. The occupational physician can advise on exposure reduction and preventive measures for other workers, and can help the individual to retain the same, or take alternative, employment.

Audiometry

Audiometry is performed for workers exposed to noise – especially where residual noise persists despite control measures. The 2005 Control of Noise at Work regulations outline indications for health surveillance – they can be downloaded from pulsetoday.co.uk/tools-and-resources. Audiometric tracings obtained as part of this surveillance can show temporary or permanent threshold shift. GPs should stress to patients the importance of complying with noise control measures, such as using proper hearing defenders. Where temporary threshold shift occurs, preventive measures are especially important because of the reversibility of the hearing loss.

Urinalysis

Where workplace contact with bladder carcinogens such as β -naphthylamine or benzidine have led to an increased risk of bladder cancer, health surveillance is usually done by occupational health departments for exposed workers.

Investigations include examination of urine samples for microscopic haematuria or malignant cells, followed by referral for cystoscopy if indicated. Continuation of this surveillance after a worker has retired or has permanently left the workplace is important, as the latent period between initial exposure to a carcinogen and the manifestation of a tumour is often as long as 15 to 20 years.

It may not be practical for retirees and workers moving to other employment to continue participating in health surveillance at their former workplace. But with information from the occupational physician, the GP can ensure annual urinalysis for this susceptible group.

Blood lead levels

Workers are exposed to inorganic lead in processes such as reclamation of scrap metal, assembly of lead accumulators (batteries), construction and demolition work, and painting and stripping of old lead paint. In these patients, periodic determination of blood lead levels is performed under the 2002 Control of Lead at Work regulations, which can be downloaded from pulsetoday.co.uk/tools-and-resources. In addition, other laboratory indicators of excessive lead absorption may be ordered – such as urinary delta amino-laevulinic acid, which will be elevated as a result of lead, and haemoglobin, as lead inhibits haem synthesis.

If a patient presents first to their GP with anaemia, and the history and investigations suggest excessive lead absorption, then you should contact the occupational physician at their workplace. If the employer doesn't have an occupational physician, the Health and Safety Executive can investigate and recommend preventive measures. Where an occupational physician first detects a patient with anaemia and excessive lead absorption, they should provide results of investigations – with normal values for comparison – and an interpretation to the GP. A similar approach is used for workers who are exposed to other agents at the workplace such as metals (for example mercury, cadmium or chromium), pesticides (such as carbamates or organophosphates), and solvents (such as styrene, xylene and trichloroethylene).¹

Antibody response checks

Some occupational health services provide immunisation for staff who are travelling abroad, or as part of an employment policy – as with hepatitis B vaccination for exposure-prone healthcare staff. Checking for an adequate antibody response may also be performed by occupational health.

Co-ordination between occupational physicians and GPs is important here to ensure timely provision of immunisation and booster doses of vaccine.

Patch testing

Patch testing is usually done by a dermatologist, usually following referral from a GP. Occupational physicians do not conduct patch testing at the workplace, so if they suspect a case of contact dermatitis, they may liaise with the patient's GP to get an opinion from a dermatologist.

If patch testing identifies a possible occupational allergen, the GP should convey this information to the patient's occupational physician – obviously with the permission of the patient – who can help to ensure a safer system of work for the affected individual.

Environmental investigations

Environmental measurements made by occupational health and safety departments are usually conducted to quantify exposure, which helps with the assessment of risk – for example, noise levels, levels of solvent vapour, dust or fibre counts, or particulates in the breathing zone of workers.

Confirming excessive exposure is essential for the diagnosis of an occupational disease – and occupational physicians are familiar with workplace exposure limits and occupational exposure standards.

There are many other procedures and investigations conducted or ordered by occupational physicians that do not necessarily involve clinical or environmental measurements¹ – for example, investigations into clusters of disease, assessment of individuals returning to work after surgery or assessment of workers with a disability. Occupational physicians should ensure these findings are sent to the GP.

Often patients prefer to seek an opinion from their GP about the possible link between their illnesses and workplace exposures, or advice on job changes, and this is difficult for GPs without information from the occupational physician. Similarly, clinical and laboratory information from GPs can be useful for occupational physicians, especially when they are required to advise on job placement.

Specific information on medicines prescribed, planned hospitalisations, or advice that has already been given on prognosis and return to work is also useful. The patient should be aware of, and consent to, information going from one doctor or organisation to another.

Current initiatives on the fit note² and encouraging patients to return to work necessitate good communication between GPs and occupational physicians, and can assist in management of the patient at work or away from work.

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Professor Tar-Ching Aw is professor of occupational medicine at the faculty of medicine and health sciences, United Arab Emirates University, and visiting professor of occupational medicine at Canterbury Christ Church University, Kent

Dr Stella Claire Major, GP in Wandsworth, south-west London, associate professor at the faculty of medicine and health sciences, United Arab Emirates University, and honorary senior lecturer in the department of primary care and social medicine at Imperial College London School of Medicine

Work-related upper limb disorders

Dr Steven Ryder discusses these common complaints

The Health and Safety Executive estimates that work-related upper limb and neck complaints affect 186 per 1,000 adults per year, resulting in 4.7 million lost working days per year.

Recently, there has been some confusion and controversy surrounding these conditions. The term repetitive strain injury has justifiably fallen into misuse, as the term 'injury' is not always true and implies fault. Work-related upper limb disorder is an umbrella term for conditions thought to be caused by exposure in the workplace. These include well-defined syndromes such as tenosynovitis, carpal tunnel syndrome and epicondylitis, and the non-specific, less well-defined syndrome of non-specific diffuse forearm pain. These can also all have causes other than work.

Diagnosis

Diagnosis is usually made on history and examination. The diagnostic criteria for these are well recognised¹, and key tests include:

- **Finkelstein's test** Positive when ulnar deviation of the wrist with the fingers flexed over the thumb placed in the palm produces pain over the distal radius and radial side of the wrist. This suggests De Quervain's tenosynovitis.
- **Tinel's test** Positive when tapping over the carpal tunnel causes tingling in the thumb and radial two and a half fingers. Points to carpal tunnel syndrome
- **Phalen's test** Also for carpal tunnel syndrome, in Phalen's test both hands are held tightly and palmar-flexed opposite to a prayer position, creating at least a 90° angle between forearm and hand. It is positive if numbness and tingling are produced when the position is held for about 30 seconds.

Nerve conduction studies are useful for confirming carpal tunnel syndrome. Other

conditions to consider include rheumatoid arthritis, diabetes and trauma.

Management and prognosis

Analgesics and NSAIDs are, of course, useful in managing all of these conditions.

Shoulder conditions

These usually respond to physiotherapy and steroids. Surgery may be useful if conservative measures don't help. Frozen shoulder can last 12 to 18 months.

Epicondylitis

This is treated with physiotherapy. Local steroid injection may be beneficial early on – but recurrence rates are high. Acupuncture, exercise therapy and ultrasound are also effective. Surgery can be successful in resistant cases. These conditions are self-limiting and some patients improve within one year – with or without treatment – but a majority still have symptoms after this. Recurrence is more common in manual workers.

Tenosynovitis

Patients with tenosynovitis should avoid aggravating movements. Topical anti-inflammatory agents can be useful, as can intra-synovial injection of steroids and local anaesthetics. Splinting is often recommended, but prolonged use can cause muscle wastage and local osteoporosis. Surgery may be required to relieve tethering.

Carpal tunnel syndrome

Patients should avoid possible work-related factors, such as:

- prolonged and extreme wrist flexion
- forceful and repetitive wrist movement
- direct pressure on the carpal tunnel
- the use of hand-held vibrating tools.



Steroid injections may relieve symptoms temporarily. There is little evidence that wrist splinting is beneficial. Where the diagnosis is confirmed, surgical decompression of the carpal tunnel usually relieves symptoms.

Non-specific diffuse forearm pain

This is a diagnosis of exclusion and needs to be distinguished from generalised pain syndromes such as fibromyalgia. Psychological factors are important and cognitive behavioural therapy may be helpful. Rehabilitation combining CBT with physiotherapy can be beneficial for workers who have been absent from work for over four weeks.

Upper limb disorders and work

These conditions are not exclusively related to occupation and causation by work should not be assumed until a workplace risk assessment has been carried out by an occupational health specialist. The known associations between mechanical factors and upper limb disorders are listed in a National Institute for Occupational Safety and Health critical review, which can be downloaded from pulsetoday.co.uk/tools-and-resources.

Posture, degree of force, repetition and vibration are all important. Sports, hobbies and DIY can also be a cause, either exclusively or in combination with work.

Prevention

Prevention depends on the findings of the risk assessment. Consider:

- improved ergonomics of tool design, equipment and work layout to improve posture, reduce forces and repetition
- employee training
- job rotation to reduce time at a repetitive task
- an induction programme to enable a new employee to work at a slower rate initially
- rest breaks to allow recovery time
- rehabilitation of affected workers
- redeployment if the above measures aren't effective.

The role of the GP

It is important to identify the potential that the disorder may be associated with work – although you can't firmly establish

causation until a workplace risk assessment has been carried out. Treatment alone without workplace modification is likely to be ineffective. I recommend the following approach:

- Establish the anatomical diagnosis.
- Consider work-related risk factors by asking the patient what they do at work in functional terms.
- Exclude recreational risk factors.
- A short break from work may be beneficial, although I wouldn't advise a long time off. Using the fit note (Med 3), suggest to the employer that work may be a factor and recommend a workplace risk assessment. Many employers have access to occupational health specialists. If not, you can contact the local Health and Safety Executive officer.

Patients may be keen for you to write 'RSI' on the sick note – but I would avoid doing this, saying something like: 'We tend not to use this term any more.'

If you think that the disorder may be caused by factors at work, it is more useful to call it work-related upper limb disorder rather than something vague such as 'forearm pain' – but prompt the employer to investigate. A recent literature review highlighted that:²

- Early return to work is important, though some work may be difficult to perform for a while. Work should be comfortable and accommodating.

- Upper limb disorders can be triggered by everyday activities and over-attribution to work can be detrimental to recovery.
- Many cases settle with self-management and this should be encouraged, though some need treatment. Intervention should take a stepped approach.

The Health and Safety Executive³ provides useful resources, including a risk assessment worksheet, guidance for using display screens and a booklet for employers who run small businesses – download these from pulsetoday.co.uk/tools-and-resources.

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Dr Steven Ryder, consultant occupational physician and director of occupational health services for NHS Highland

Low back pain

Dr Steven Ryder advises on the features and investigation of low back pain

Low back pain is the most frequent musculoskeletal complaint in working people and the most common cause of absence from work, with 4.9 million days per year lost because of it. It is the most common cause of work-related ill health, with 468,000 people affected. Low back pain is an extremely common episodic symptom, often short-lived but sometimes becoming persistent. See the key points box (following pages).

Occupational factors

Whether an individual attributes their lower back symptoms to work or whether they report the symptoms as 'injuries' and seek healthcare or time off depends on complex individual psychosocial and work organisational factors. Low back pain is often blamed on various work activities – but the reality is complex. The following points are worth considering:

- Lifting may be the cause, or may simply be the trigger, of symptoms. Back symptoms

are more commonly reported in those undertaking heavy lifting, lifting bulky objects away from the body, lifting from ground level or repetitive lifting. But it is unclear whether these activities are causal, or if low back pain just has a greater impact on people undertaking these duties. It is often assumed that reducing manual handling activity will reduce the prevalence of low back pain and reduce incapacity, but the evidence doesn't support this.

- Twisting has no correlation with simple back pain.
- Sitting at work is not significantly associated with low back pain.
- Driving for long periods is associated with increased rates of low back pain, but the strength of the association is unclear.
- There is little evidence for association of repetitive actions with low back pain. Most employees who appear to develop low back pain because of repetitive actions have usually already undertaken similar duties for many years.

Types of back pain

Most back pain is 'simple' – meaning a pathological cause cannot be identified. Less than 5% of the lifetime prevalence of low back pain is due to nerve root pain, and less than 1% is due to serious spinal pathology.

The traditional medical approach is to look for a pathological cause to explain the physical symptoms. But this does not work at all well for low back pain, since clinical findings can be as common in people who do not have back pain as they are in people who do. So effective clinical management of low back pain requires a triage approach where cases are managed according to the nature of the presentation. There are three triage groups.

Simple back pain

Other terms used to describe this are 'non-



specific low back pain' and 'mechanical back pain'. Factors and symptoms suggesting simple back pain include:

- pain limited to the lumbosacral region, buttocks and thighs, though it can extend below the knee
- pain is 'mechanical' – it varies with physical activity and over time
- the patient is systemically well.
- Patients with simple back pain can be reassured that there is no nerve damage or any serious spinal pathology.

Nerve root pain

This term is preferable to 'sciatica', since it recognises that different roots may be affected and there are different causes for the pain. These include disc prolapse, spinal stenosis and surgical scarring. Symptoms suggestive of nerve root pain include:

- unilateral, linear leg pain that is worse than the back pain
- pain generally radiates to the foot or toes
- numbness and paraesthesia in the same distribution
- signs of nerve irritation – straight leg raise is reduced and replicates the pain
- sometimes motor, sensory or reflex changes, limited to one nerve root.

Serious spinal pathology

Causes include infection, inflammation – such as ankylosing spondylitis – trauma and spinal tumours. Features suggestive of this are red flags, and include:

- age younger than 20 or older than 50 – back pain is common across all ages in primary care, but in secondary care it is those younger than 20 or older than 50 who are disproportionately like to have serious causes
- violent trauma such as a fall from height or a road traffic accident
- constant, progressive, non-mechanical pain
- a past history of cancer, HIV or systemic steroids
- the patient is systemically unwell – for example, with unexplained weight loss

- widespread neurological abnormality
- structural deformity.
- Cauda equina syndrome, where there is compression of the nerve roots in the lower spinal canal, is a surgical emergency. Patients with the following features should be referred to a spinal surgeon as an emergency:
 - problems with micturition or loss of anal sphincter tone
 - saddle anaesthesia around the anus, perineum and genitals
- widespread or progressive motor weakness.

Clinical features and investigations

Pain radiating to the thigh is common, and is reported in approximately 40% of cases presenting with low back pain. In most cases, pathology is not defined (non-specific or mechanical low back pain). But a small minority – fewer than 10% of cases – have identifiable pathology, such as nerve root compression.

Disc degeneration has also been suggested as a structural cause for low back pain, but there is no causal association between degenerative changes and symptoms.

Investigations aim to distinguish cases of serious spinal pathology. This is done mainly on the basis of clinical markers. X-rays and MRI are not useful in most cases of mechanical back pain because changes seen on these scans are often incidental, and are seen as commonly in individuals without low back pain.

Management

Biopsychosocial factors

It is clear that biopsychosocial factors are involved in the causation of back pain – and research has suggested that beliefs are key determinants of disability (reduced daily activity) and incapacity (not being able to work).

A flag system has been developed to identify and categorise these biopsychosocial factors, and assist with a stepped approach to managing low back pain (see table below).

Clinical and psychosocial factors in low back pain	
Red flags (Serious spinal pathology)	Blue flags (Workplace)
<ul style="list-style-type: none"> • Sphincter disturbance • Gait disturbance • Saddle anaesthesia • Age <20 or >50 • Non-mechanical pain • Thoracic pain • Past history of cancer, steroids or HIV • Unwell, weight loss • Widespread neurological abnormality • Structural deformity. 	<ul style="list-style-type: none"> • Fear of re-injury • High physical demand job • Low expectation of return to work • Low job satisfaction • Low support • Lack of adjustments • Poor communication.
Yellow flags (Person)	Black flags (Context)
<p>Thoughts:</p> <ul style="list-style-type: none"> • Catastrophising – focusing on the worst possible outcome • Inaccurate beliefs about the condition, pain and harm • Negative expectations about the future. <p>Feelings:</p> <ul style="list-style-type: none"> • Worry, distress or low mood • Fear of movement • Uncertainty about the future. <p>Behaviour:</p> <ul style="list-style-type: none"> • Extreme symptom reporting • Passive coping strategies • Repeated ineffective therapy. 	<ul style="list-style-type: none"> • Misunderstanding between key players – patient, employer and doctor • Financial or compensation problems • Process delays – such as waiting lists • Sensationalist media reporting • Spouse or family beliefs • Social isolation • Unhelpful company policies.

It is a tool for identifying and tackling the obstacles to recovery – covering features of the individual and their workplace. Considering the different flags in your clinical assessment can facilitate the rehabilitation process.

There are two types of flags: clinical flags and psychosocial flags. Clinical flags such as red flags for musculoskeletal disorders indicate possible serious pathology – if suspected, these require urgent further investigation and often surgical referral.

Psychosocial flags reflect the different factors that can affect recovery. Important ones include yellow, blue and black flags.

Yellow flags refer to the person and how they manage their situation with regard to their

thoughts, feelings and behaviours.

Blue flags are about the workplace and the employee's perceptions of health and work.

Black flags are about the context and environment in which that person functions, including other people, systems and policies. To help rehabilitation of patients with low back pain, GPs should:

- encourage activity – early physiotherapy, analgesia and reassurance
- advise early return to work – job adjustments and redesign can be considered, and this can reduce employment costs and litigation
- only recommend restriction from work or redeployment rarely, in recurrent or persistent cases.

Key points

- Some 60-80% of people will get notable low back pain at some point in their lives.
- Most episodes settle rapidly, but residual symptoms and recurrences are common.
- Some 35-40% of people report low back pain lasting over 24 hours each month, and 15-30% of people report symptoms every day.
- The best predictor for future low back pain is a past history.
- A small proportion of people develop persistent pain and disability.

Workplace adjustments

Workplace adjustments can include:

- eliminating the need for manual handling by redesigning the task
- undertaking a suitable and sufficient assessment for those manual handling operations that cannot be avoided
- providing mechanical assistance as much as possible.

GPs can use the 'fit note' to recommend that a workplace risk assessment be conducted. You can also suggest the patient uses their employers' own specialist occupational health services, physiotherapy and counselling services if available. You can suggest adjustments to work routine, as discussed above, and restriction from certain duties if necessary.

Prognosis

- Most episodes of mechanical low back pain are self-limiting.
- Over 50% of episodes resolve completely within four weeks, but up to 20% have some symptoms for a year.
- There is a marked tendency to recurrence – 70% of those with low back pain go on to experience three or more attacks.
- Some 20% of patients with low back pain develop chronic symptoms.
- Individual beliefs, pending compensation and attribution to work are strong predictors of outcome. Clinical examination and investigations are poor predictors.
- Probability of return to work reduces with increased duration of sickness absence.

Go online to see a table of common patient myths about low back pain and to download an NHS Plus document on its management from pulsetoday.co.uk/tools-and-resources.

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Dr Steve Ryder, consultant occupational physician and director of occupational health services for NHS Highland

Careers in occupational health

Dr Michael Lambert – a GP who has trained in occupational medicine – advises on why it is worth considering as a career

Occupational medicine is a fascinating, multidisciplinary, wide-ranging speciality covering health and safety and employment law, public health, disability and work-related disease – making it an ideal choice for GPs looking for a new skill set and an additional income stream. It also lends itself particularly well to sessional work.

Training

The increasing complexity of occupational medicine – especially the legislative aspects – means additional training is a must. The RCP's Faculty of Occupational Medicine provides high standards of training and also publishes guidance, for example, on ethics and confidentiality. Its website provides information on training and academic qualifications and is a good first source of information for GPs interested in opportunities within occupational medicine.¹

For most GPs, the diploma exam (DOccMed) would be sufficient. For entrance to the exam you need proof of satisfactory completion of a recognised course. There are three courses geared towards GPs looking to do sessional work in occupational medicine, all priced at around £2,000:

- The Royal Society for Public Health in London offers a concentrated, two-week course²
- The University of Birmingham offers a course divided into two one-week modules.³
- The Centre of Occupational and Environmental Health at Manchester University offers a six-month distance learning course.⁴

The advanced diploma course covers the subject in more detail and is ideal for GPs keen on further training. Beyond this, there is the opportunity of doing a two-year MSc followed by becoming a member of the Faculty of Occupational Medicine, which is normally



achieved by entering approved specialty training.

Opportunities and benefits

There is little doubt that the opportunities for GPs in occupational medicine will increase as the needs of organisations change. Though the heavy manufacturing base of the UK has diminished, there has been a steady growth in small and medium-sized businesses that need advice on occupational health, including sickness absence, rehabilitation to work, workplace adaptations and disability, which is now covered by the Equality Act.

Training in occupational medicine can also benefit our daily practice – particularly in musculoskeletal problems and stress-related disorders – by helping our patients return to work earlier.

Many practices have developed sophisticated occupational medicine services, set up limited companies employed trained nurses, and now have a strong business model to add to the practice portfolio. In our practice we are looking to expand our services to our local university. Another benefit of occupational medicine training has been the improvement in our own health and safety procedures, which now feel more robust.

Occupational medicine could be a fascinating adjunct to a GP's or practice's portfolio, and I would encourage anyone to look seriously at this as a career opportunity.

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Dr Michael Lambert, GP trained in occupational medicine in Winchester

Why I chose occupational medicine

Dr Jayne Moore, consultant occupational physician, RPS, talks about making the leap in to occupational medicine.

Background

My journey in to occupational medicine really began when I came across an advertisement for a 'store doctor' at a local branch of a retail chain. The practice I was working for encouraged clinical assistantships, so I took the plunge and accepted an assistantship in the world of occupational medicine.

I enjoyed working in the speciality immensely, and for a number of years I shared my time between general practice and my occupational post. I even took an introductory course in occupational medicine at Manchester University.

But with the constant bombardment of contract changes in general practice, I started to question whether this was really the place I wanted to be. I eventually found the courage to join the Manchester University MSc to prepare for the Associate Faculty of Occupational Medicine exam (AFOM). But I hadn't sat a formal exam for years. I didn't know if I could study the way I used to, the 'memory cogs' might have become jammed. So I convinced myself that I would continue my position as GP principal, just in case I didn't pass the AFOM.

Fortunately, the other students on the course were really helpful and happy to share their knowledge with me, and after passing the AFOM I made the career switch. I joined the Independent sector of OM as a Specialist Registrar, where I have now been for nine

years; four as a trainee and five as a consultant. The company seems to have every industry covered, from manufacturing to chemical industries, food processing, government departments and the NHS. Every day we work in different places doing different tasks. It's constantly changing, so there's no fear of stagnation in this profession.

Advantages

The advantages are the variety, autonomy and the opportunity to influence, even if in a small way, the health of people at work.

Do I enjoy my work? Do I feel I make a difference? My answer would be yes to all. I do not regret moving to occupational medicine. I do occasionally miss the ongoing relationship I had with patients as a GP. But this was a good move, and one that I wouldn't wish to change.

Challenges

Moving from a position of advocacy to one of impartiality was quite a tricky transition. I had to learn how to balance the general duty of care to the employer and the ethical duties to the worker. As an occupational physician, I also have to make sure that company policies promote the health and wellbeing of workers and the public. There is the potential for disagreement between the worker, manager or the union. I also have to do a lot of travel, which some might see as a downside.

Dr Jayne Moore is a consultant occupational physician



Faculty of Occupational Medicine
3rd Floor
New Derwent House
69-73 Theobalds Road
London
WC1X 8TA

F: 020 3116 6900

T: 020 3116 6910

E: fom@fom.ac.uk

W: fom.ac.uk

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