It’s a dangerous occupation health care, or so it would seem from a selection of papers in this issue of *Occupational Medicine*.

Naghavi *et al.* [1] outline the relative risks of needlestick injuries in doctors compared to nurses and particularly in young doctors. Their questionnaire-based study of doctors who had had at least one needlestick injury concluded that as many as 12% of doctors in training sustain such injuries and develop post-traumatic stress disorder as a result. A strong argument for the provision of proactive occupational health support, but if it was there would the doctors use it?

Use of NHS occupational health services is the subject of a paper by Laloo *et al.* [2], who report that 49% of attendances at occupational health departments by doctors and dentists are for blood tests or immunizations/vaccinations and 26% are either management or self referrals. Not surprisingly, mental health problems top the list of the main reasons for referral with an interesting difference in numbers presenting and numbers recorded on management sickness absence systems.

But if you do get into work further hazards lie in wait. Wittczak and colleagues from Poland [3] describe three cases of occupational exposure to chlorhexidine, which is commonly used as a disinfectant. All developed airway allergy to the chemical. They were diagnosed by total serum IgE, skin prick tests, spirometry and methacholine challenge, and then subjected to a single-blind, placebo-controlled, work-like condition-specific challenge first to placebo then to 0.1% chlorhexidine. All three subjects were nurses with 10–23 years of work in their nursing role. The authors conclude that chlorhexidine is an important occupational allergen and that specific serum IgE to chlorhexidine is a reliable tool for assessment, being both specific and sensitive.

Sickness absence is a very topical subject, especially since the publication of the government response to the Frost/Black review. It is a subject which has been extensively studied both academically and operationally, yet relatively little attention has been given to the group, sometimes sizeable in number, who take no absence at all. Schreuder *et al.* [4] from the Netherlands looked at healthcare employees who had zero absence rates (defined as no time off in 5 years) and reflected on their characteristics. In their qualitative study of 47 employees, 46 were women with a mean age of 47.1 years. They used a focus group methodology to explore attitudes and found that the zero absenteees in the study were intrinsically determined to work and actively sought solutions to address setbacks hindering their work attendance. They conclude that personal attitudes and self-efficacy are more important for attending work than the social context. I am sure readers will find this an interesting paper which raises many more questions about this relatively unresearched group.

What makes some people stay off sick and others return to work has long been studied within the context of the biopsychosocial model of disability, and the challenges of chronic pain and workability are likely to increase as the population ages and more people with more chronic ill-health remain in the workplace. Predicting who will return to work following treatment for chronic pain is the subject of Hamer’s paper [5] which promotes the importance of early intervention and treatment.

Finally, for those people who believe that you reap what you sow, two case reports provide warnings for beauticians and squid processors (not necessarily overlapping occupations) [6,7]. Beware, your ‘subjects’ can make you allergic—either to the cyanoacrylate glue used to fix false eyelashes or to the shellfish itself as it is being processed. Occupational asthma, rhinitis and dermatitis can occur even after relatively short exposure times. Beauty and fine dining come at a cost for the worker, but not necessarily for the customer.

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**References**