In this issue of *Occupational Medicine*

Since I began working in occupational medicine in heavy industry nearly 25 years ago the speciality has changed almost beyond recognition. Many occupational physicians now spend their entire careers in white collar industries and see primarily the effects of work-related stress and workplace conflict. However, there are still plenty of blue collar industries where the effects of physical hazards remain important.

The health effects of working in compressed air were described in caisson workers in the 18th century. Diving is an inherently dangerous occupation and not only because of the risks of breathing air under pressure. Heavy physical exertion in a hazardous environment with the effects of cold, strong currents and high pressure is challenging for the most robust individual. Irgens et al. [1] compared overall mortality in divers with mortality in the general population. Overall mortality was lower in divers, perhaps due to healthy worker and survivor effects, but divers had a higher risk of dying in work-related accidents or suicide. Divers with higher levels of qualification were most at risk, perhaps reflecting that they undertake the most difficult and hazardous tasks.

Ramazzini described noise-induced hearing loss (NIHL) in copper hammering also in the 18th century, although there are even earlier reports. It remains one of the commonest work-related disorders. Train workers are potentially exposed to noise levels sufficient to cause NIHL. A Norwegian study [2] compared the audiograms of train drivers and conductors with non-exposed controls and found no difference. This supports the conclusions of earlier studies. It appears that, at least in Norway, train workers do not have a higher prevalence of NIHL.

Musculoskeletal disorders (MSDs) are also among the commonest occupational illnesses and are one of the commonest causes of poor performance and attendance in the workplace. Examination, diagnosis and management of these disorders are vital skills for occupational health professionals. Madan et al. [3] looked at the effectiveness of a training package in managing MSDs aimed mainly at nurses. The study concluded that most had had no previous training in examining the musculoskeletal system and that most improved their skills and confidence as a result of the training.

The UK system for sickness certification changed in April 2010. The change in name from ‘sick note’ to ‘fit note’ reflected the intention to change the emphasis from what the patient could not do to what they could. While doctors previously had the option to complete a comments box on the old form to suggest amended duties, it was rarely used. The biggest change in the form was an expanded comments section with tick boxes for modified duties, reduced hours, etc. The question of course was whether generalist doctors without training in occupational medicine could or would make use of it. Coole et al. [4] looked at the comments made by UK general practitioners (GPs) on a sample of fit notes and compared them with comments made by a fitness for work service. Perhaps unsurprisingly the GPs were significantly less likely to recommend amended duties and less likely to make comments on function that would guide the employer on planning amended duties. Changing the form may not have had the desired effect for many reasons including lack of training in occupational medicine and the fact that the 10-minute GP consultation is simply not long enough to address work issues in sufficient depth.

Physical hazards in the workplace remain an important cause of morbidity and mortality as well as an important cause of poor attendance and performance at work. And occupational diseases first reported two centuries ago remain relevant today.

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References