The Faculty of Occupational Medicine—The first decade

In May 1988, the Faculty of Occupational Medicine celebrated its tenth anniversary within the College. That this event should coincide with the fortieth anniversary of the formation of the National Health Service is not inappropriate.

In 1948, the responsibility for all the major aspects of health care was given to the Ministry of Health, all that is except one, the care of people at work. This responsibility remained with the Ministry of Labour. Whether this decision was right or wrong has often been debated, but it did have the effect of isolating the practice of occupational medicine from the mainstream of medicine at a time of major development in the specialty.

The interest in occupationally-related disease as a particular aspect of medicine largely arose in the wake of the industrial revolution. The diseases associated with the appalling conditions in the mines and factories in the nineteenth century were not clearly differentiated from those arising from squalid living conditions of the new expanding towns. Both public health and occupational medicine grew out of the moral and professional concerns of those doctors who worked in these areas of the country. Inevitably, a number of physicians, of whom perhaps the best known is Charles Thackrah of Leeds, began to associate specific illnesses with particular trades. The study of the pathology and aetiology of these conditions led to a scientific basis for elimination or control of the offending agents.

Under growing social pressure the Government, in 1833, created the Factory Inspectorate and in 1898 appointed the first Medical Inspector, Sir Thomas Legge. That initiative is currently represented by the Medical Branch of the Health and Safety Executive, responsible ultimately to the Department of Employment. The identification and study of occupationally related disease leading to prevention through the control of the causative agents remains the cornerstone of occupational health practice.

At the same time as the Government was taking action in terms of the early Factories Acts and the associated Inspectorate, some of the more enlightened employers began to retain local doctors to provide medical care for their workers and their families. But although these physicians were mainly concerned with primary care, they also developed a special role in the preventive aspects of medicine.

The drain on manpower and the drive for efficiency in the munitions factories in the first world war gave a boost to the interest in the human factors of industrial production which was developed further during the second. It was in this period between the wars that the doctors working in industry felt sufficiently identified to form their own group and in 1935 started the Association of Industrial Medical Officers. The post war phase of the 1950s and 1960s saw the growth of large complex industrial companies in both the public and private sector. Many of these companies, encouraged by the social climate of the time, developed comprehensive medical services, headed by doctors committed to a career in industry. Although still providing some element of therapeutic care, the 1948 National Health Service Act had separated them from the mainstream of medical organisation and this encouraged industry-based medical services to concentrate on the preventive health aspects of their work.

By the middle of the 1970s, the number of doctors working full and part-time in the field had grown to around 2,000 and a sufficient body of specific expertise had been defined to justify the definition of a specialism with an associated postgraduate training programme. In 1976, the Joint Committee on Higher Medical Training (JCHMT) accepted occupational medicine as a speciality and formed a Specialist Advisory Committee (SAC) to oversee training posts and programmes.

But occupational medicine still had no home within the professional structure of medicine and so in 1977 some senior members of the Society of Occupational Medicine, the successor of the original Association of Industrial Medical Officers, approached the Royal College of Physicians with a view to forming a Faculty. Due largely to the tremendous support of the then President, Sir Douglas Black, and the other Officers of the College, the Faculty was inaugurated and held its first meeting in the spring of 1978.

The newly-formed Faculty immediately set about tackling two issues: standards of training and qualification for its Membership, and ethics.

Traditionally, occupational physicians had come into the specialty from all walks of medical life, general medicine, surgery, general practice and even obstetrics and gynaecology. This pattern had brought to the specialty a range of skills and attitudes that had acted as a major stimulus to the developing discipline. It was felt important not to do anything that would close the doors on doctors developing an interest in occupational medicine at a relatively late stage in their career by setting rigid entry criteria for higher specialist training in the subject. The necessary background is good clinical skills, breadth of outlook and a significant degree of maturity; the Faculty, following the lead of the SAC on occupational medicine, is ready to accept any doctor into training whose experience has developed these basic qualities. Like all other specialties, occupational medicine requires knowledge in specific areas, many of which, such as industrial legislation, are covered poorly, if at all, in the medical curriculum. The Faculty’s Associateship examination covers these subjects as well as general clinical skills. Membership of the Faculty is granted following success in this examination, a four-year period of approved supervised training and a dissertation. This accords, in
Guidance on ethical issues is of particular importance to occupational physicians. It is not that the principles of good ethical behaviour are different from those in other medical disciplines but, because of the nature of the employment contract, doctors in industry are more vulnerable to criticism. Most doctors are contracted to individual patients or to an organisation dedicated to the provision of health care. Occupational physicians, on the other hand, are paid by the employers of those under their care. The differentiation between paymaster and client is, therefore, particularly important when considering issues of confidentiality. In practice, conflict of loyalties seldom arises because most employers accept the ethical constraints of doctors without demur.

Ten years on from its inception, the Faculty has developed in confidence and recognition. It is now seen as the professional focus for the practice of occupational medicine in the country and a significant voice in the development of occupational health as a whole. But what of the future? The last two decades have seen the decline of the traditional manufacturing base in Great Britain. The coal, steel, shipbuilding and cotton industries have diminished so that instead of employing millions of people they now only employ a few hundreds of thousands. The workplace has also changed. New factories and new technology have revolutionised the working environment in most sectors of industry. Gone are the black satanic mills, replaced by modern premises and controlled atmospheres. The machines and processes demand it. With these changes have disappeared the traditional industrial diseases, and to see a new case of lead poisoning or even pneumoconiosis is an increasingly rare event.

But new materials and new processes bring new problems. There is a growing fear about the long-term effects of the new industrial chemicals such as pesticides and other complex organic materials derived from the petrochemical industry. Modern machines and processes may control the environment but the physical and mental strains of a high-productivity society take their toll. These problems are as common in the commercial and service industries as in manufacturing and in offices as much as in workshops. There is a growing recognition of the value of medical advice in banks, stores and even in the National Health Service itself. Nor does unemployment or early retirement make the need for occupational health awareness any less necessary. The rise in ‘do-it-yourself’ activities can be a cause of concern as untrained, unskilled people tackle complex tasks and use hazardous materials.

Perhaps, therefore, one of the most important tasks for the Faculty over the next decade will be education. The necessity for a greater awareness of occupation, paid or unpaid, as a significant factor in health is needed not only by the public at large but within the medical profession itself.

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