

Joint working party statement: the patient's occupation

MANY subjects should be considered in the work and training of general practitioners. Occupational health is one of them. However, it differs from other specialities in one important respect. Just as the family background of a patient concerns practitioners in almost every consultation, so should the patient's occupation.

The average working man spends between one third and one half of his waking hours in his occupational environment. The working world of the average woman is less easily categorized, and general practitioners may claim to be better informed about her domestic occupational environment because they enter it. Nevertheless, about two thirds of women of working age also have either full-time or part-time occupations outside the home.

In many countries, primary health care has developed around the workplace, and an acquaintance with the occupational background by the first-contact doctor has replaced that of the family setting. Although general practitioners should also pay due attention to their patients' occupations.

History taking has traditionally included a question on occupation, the answer being recorded in the notes as a single label. But 'engineer' may cover the whole range of activity from button-pushing at a console to great physical effort, carried out in environments varying from seclusion and fresh air to extremes of temperature and noise in atmospheres contaminated by a variety of airborne toxins. Similarly, 'office work' may be undertaken in a small quiet office where heating, lighting and ventilation are under the occupants' control, or in a vast open-plan office where the worst excesses of the sick-office syndrome occur.

In addition, there is now a greatly increased rate of toxic substances which are liable to produce not only conditions like dermatitis or asthma, which have been traditionally recognized as being attributable to the patient's occupation, but other conditions whose occupational causes are less readily recognized. In addition, the expectations of the public about occupational health hazards are also changing.

On the psychological side it is assumed that any competent general practitioner will be alert to the possibility that the patient may be stressed through

unsatisfactory personal relationships or other problems at work. But an understanding of the insecurity of job and prospects in modern industry, or the subtler workings of the Peter principle, may not be so readily communicated by the patient or perceived by the doctor.

Training for general practice should, therefore, increase its emphasis on the interaction of occupation and health. This statement will deal with the objectives in occupational medicine which concern all general practitioners, together with the minimum content of training programmes, methods of teaching and assessment.

Although the statement refers to vocational and continuing education, the scene must be set during the undergraduate period. Enquiry into occupational factors is an integral part of clinical method; the early teaching in the behavioural sciences should draw attention to the impact of the occupation and its environment on the personality, and this emphasis should be maintained in clinical teaching.

The statement does not relate to those general practitioners who will work part-time in industry. The additional training and different educational objectives which they will need is at present being examined within the Faculty of Occupational Medicine of the Royal College of Physicians.

In his clinical work and practice organization the general practitioner should take account of the effect of health on work and of work on health.

The general practitioner should be able to:

1. take up or update an occupational history whenever appropriate in the course of the general practice consultation;
2. modify, as a result of an occupational history, his diagnostic path and his plans for management;
3. describe the major occupational health hazards in the predominant occupations within the practice area;
4. describe how the availability of his practice services have been related to local industrial and commercial work patterns;
5. discuss the patient's health problems with appropriate occupational health staff, and to resolve the ethical problems which may arise;
6. make use of the national and local resources (such as EMAS, rehabilitation centres, occupational physicians

and DROs) that are available to help with occupational health problems;

7. give advice (or to describe where advice may be obtained) about suitable occupations for patients with particular disabilities—for example, epilepsy, diabetes, back pain and visual defects;

8. demonstrate an awareness of current legislation relating to employment protection, health and safety at work, sickness certification and pay;

9. assess a patient's fitness for a particular employment and give appropriate advice.

These objectives apply throughout medical education but may require different emphasis at each stage.

The medical student wants to understand the facts of medicine and the skills of diagnosis and management; he is interested—'What is going on?' The vocational trainee, in contrast, is driven to ask, 'What should I do?' Finally, the established practitioner in continuing medical education begins by asking, 'Have I established appropriate standards of care, and am I meeting them?'

So, during basic medical education, it is necessary for all students to learn about the importance of occupational factors in health care. If the desired attitudes are not acquired during this phase of medical education, subsequent teaching and learning will be more difficult.

In vocational training the major learning environment is the training practice, which should provide a model to help the young general practitioner to prepare and develop appropriate standards for his practice in the future.

When, finally, the general practitioner is established in his own practice, his motivation to learn derives from his own performance review. His continuing education will more easily achieve its maximum potential if the framework from the earlier years is satisfactory.

As the scope of curricula of both trainees and medical students increases, it is unrealistic to add to a trainee course a module on occupational health. For the most

part, the objectives can be accomplished by educational methods already familiar in vocational training and continuing medical education for general practice. What is required by both teachers and pupils is an acceptance of the importance of occupation in considering the patient and the illness. The following methods may be found useful:

1. Case discussions about patients in whom occupation has had a significant bearing on diagnosis or management.

2. Analysis of case records at random to explore the effect of occupation on health and *vice versa*.

3. Small group discussions with appropriate resources, including video.

4. Audit of medical records to review information about occupation.

5. Discussions with full- or part-time occupational physicians and other occupational health professionals.

6. Visits to places of work where there are occupational health services and discussions with representatives of employers and employees: review of the range of work of the occupational health nurse and physician and its interface with general practice.

In the past 20 years general practice teaching has paid increasing attention to the part played by the family in the course and management of illness. Comparable attention should be given to the patient's occupation.

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Record requirements

'The best memory is a record made at the time'

Sir William Gull

THE limitations of doctors in the field of communication were documented with painful clarity by Charles Fletcher in the 1972 Rock Carling Monograph *Communication in medicine*,¹ which should be required reading for every medical student and trainee. Good communication, a *sine qua non* if optimal standards of care are to be achieved, is heavily reliant on well organized records. These have been the subject of much interest in the past decade with the appearance of problem-orientated medical records (POMR)^{2,3} and an increasing recognition of the contribution of good com-

munication to patient care. POMR offered the most carefully designed system available. The emergence of the computer at first promoted interest in records, but has lately tended to overshadow them. One hears the comment, 'We're not bothering about records, we're buying a computer', which is tantamount to running a Jaguar on two-star petrol. After all, the staple diet of computers is good records—we all know the tart dictum, 'Garbage in, garbage out'. However, the primary reason for keeping high quality records is to improve patient care—directly during the consultation, and indirectly through the development of improved means of prevention, teaching, audit and research. A record