ASPECTS OF PRACTICE

Occupational health and the general practitioner

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The future of general practice, how much of it is likely to be changed by outside influences and how much from within was debated at a recent annual meeting of the Royal College of General Practitioners in London (January *Journal,* p.53). A Select Committee of the House of Lords reviewing the provision of health and hygiene services in the UK has advocated a much greater involvement of the general practitioner in occupational health surveillance at a primary level.[1] The Asbestos Regulations that came into force in the UK last month will require new medical resources for their implementation. Health and safety legislation coupled with pressure from employees' organizations and the European Community will result in a marked increase in statutory medical examinations. A proposal for a second programme of action on health and safety at work has been made to the Council of the European Economic Communities. The implications of all these developments for general practitioners with an interest in occupational medicine are obvious.

IN the absence of a generally accepted model for occupational health and hygiene services in the UK such as exists for example in France, there are opportunities for experiment. At one end of the spectrum in the UK there are the well developed occupational health services of industries such as coal, steel, electricity and atomic energy. At the other, equally hazardous occupations such as those in the construction industry, agriculture, forestry and fishing have none and employees in them are among the 35 per cent of UK workers who have no access to occupational medical or nursing advice, relying on legislation and first-aiders for their health and safety at work. These hazardous occupations may all benefit more from attention to job safety than to employee health, although a good safety officer needs access to skilled occupational health resources.

The provision of occupational health and hygiene services must take into account a country's medical care system; in the UK the NHS with its well developed primary medical care arrangements. It must also take into account industries which do not have occupational health facilities and also the growing number of small service industries, many of them home-based, which are developing in the UK as in other western industrial societies. The problems of occupational health provision in the civil service reflect those of the country as a whole. Our organization, the Civil Service Medical Advisory Service, is responsible for the health at work of 600,000 civil servants working at home and abroad and for 83,000 employees of other public bodies such as the Forestry Commission and Her Majesty's Stationery Office. There are obvious potential hazards for civil servants working in some posts overseas, for veterinarians in the Ministry of Agriculture, for scientists in the Medical, Science and Engineering Research Councils and for many others, who deserve a high level of surveillance. There are large numbers of civil servants who work in offices and whose need is less. They are, at high or low risk, widely scattered throughout the UK. What our service increasingly needs is local advice on the effects of work on health. We have a network of 1,500 local medical officers; general practitioners on whom we rely for advice on the other side of the occupational health equation, the effect of health on the work of individual civil servants. Our activities in the preventive health field have been recently augmented by an Occupational Health Nursing Service but with, for example, over 120 prisons in England and Wales alone for whose staff we are responsible (the medical care of prisoners being the re-

The Ministry of Agriculture, Fisheries and Food makes grants for land improvement, including drainage, and the work is inspected by Land Drainage Inspectors (civil servants). One machine now incorporates a laser to measure levels and inclines and this picture was taken on a visit to a demonstration site by the Inspectors. The equipment was used by the Ministry evaluation team and Dr Constable, the Deputy Medical Adviser at the Civil Service Medical Advisory Service was involved in assessing possible hazards to staff, operators and spectators.

There are over 600,000 people working in agriculture, forestry and fishing in the UK (370,000 employees and 248,000 self-employed) who are among the 40 per cent of workers in the country whose health at work is protected only by statutory regulations under the supervision of the Health and Safety Executive. All these are industries in which the Gregson Report suggests that the general practitioner has an increasing part to play.

sponsibility of the Prison Medical Services) and over 220 Forestry Commission locations in Great Britain, centrally organized occupational medical and nursing services need support at a local level.

General practitioner involvement

If we need additional health care linked to occupations then it must be of high quality. There can be no doubt that whatever the outcome of the current debate, the general practitioner is bound to become more and more involved in occupational health work. Few would wish a return to the sort of Appointed Factory Doctor system as it existed before 1972, in which the perfunctory discharge of their duties by some general practitioners gave the majority a bad name.

What one hopes may emerge and what the Select Committee has endorsed is a cadre of motivated and well trained general practitioners able to call upon the Employment Medical Advisory Service, academic departments of occupational medicine and specialist occupational medical and hygiene services for support in providing primary occupational health care.

The place of general practice in occupational health provision is at present under review. A working party of the Faculty of Occupational Medicine of the Royal College of Physicians is looking at the particular problems and training needs of general practitioners working part-time in industry. A working party of the Royal College of General Practitioners, the Faculty of Occupational Medicine and the Civil Service Medical Advisory Service has recently reported on 'the patient's occupation' (February *Journal,* p.67).

Facilities for training general practitioners in occupational medicine already exist but are greatly undersubscribed. Ever since 1969 the DHSS has contributed generously to long study leave of up to an academic year for general practitioners. Since then fewer than 10 doctors have undertaken a degree in occupational medicine and less than 40 the Diploma in Industrial Health. Section 63 courses in occupational health attracted 128 doctors in 1969/70 and 236 in 1979/80.

Increased commitment

Any model of general practitioner provision of occupational health services at a primary level must take into account nursing and other staff attached to general practice. It was apparent during the discussion at the College's annual meeting that all is not well with the team concept in general practice. The role of the health visitor was one that was particularly debated. In practices that are to become involved in the provision of primary occupational health services an expanded role for the health visitor in providing occupational health advice can be envisaged.

An increased commitment to occupational health training in general practice is necessary if resources for occupational health activities, which are bound to grow, are to be deployed in the primary medical care sector rather than elsewhere.

Reference

1. House of Lords. Occupational health and hygiene services. Select Committee on science and technology, **Vol. 1**—Report. *HMSO:* London, 1983.

Guidelines in the management of hypertension in general practice—drug treatment of hypertension

THE LOTHIAN HYPERTENSION GROUP*

The Lothian Hypertension Group has drawn up guidelines and presented them in a booklet in an effort to assist colleagues in their management of patients with raised blood pressure. We published the first part of the booklet, *Detection and assessment of hypertension,* last month. The remaining section appears below.

1. In general, older people respond better to diuretics than those in the younger age groups. This makes a reasonable starting point for therapy. Since all thiazides are equipotent one should use the cheapest, this at present being bendrofluazide; there is probably little merit in increasing the dose beyond 5 mg/day. On their own, loop diuretics such as frusemide and bumetanide have probably less effect in lowering blood pressure and certainly need to be given more than once a day.

2. Surgically curable forms of hypertension are rare and it is not reasonable to search for them unless there are findings in the history, physical examination or initial biochemistry which suggest a specific cause. Since the development of hypokalaemia during thiazide treatment is sometimes a pointer to primary aldosterone excess, referral to a specialist clinic should be considered if this occurs. Currently there is no good evidence that potassium supplements are necessary or desirable when prescribing a diuretic for the treatment of hypertension; also, we do not recommend thiazide preparations which are combined with potassium.

3. The large number of available beta-adrenoreceptor blocking drugs poses a problem in selection. Each drug in this group is probably equally effective in lowering blood pressure and choice should revolve around other features of these drugs. Some of the side effects of beta blockers (see table) occur less frequently when a cardioselective drug is used. Also, because of the need to ensure compliance, long-acting (once daily) drugs should be prescribed where possible. While a 24 hour action is claimed for many beta blockers, few achieve this in practice, hence our recommendation of only two main drugs; atenolol (Tenormin) and sustained release metoprolol (Betaloc SA). There is probably some merit in a dose titration of both these drugs in that they can be started at 50 mg (atenolol) or 200 mg (sustained release metoprolol), and increased if necessary after a month to 100 mg and 400 mg respectively.

If either a beta blocker or a thiazide are relatively contraindicated (see table) a change from one to the other would be the next step.

4. If adequate blood pressure control cannot be attained on

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