PERSONAL VIEW

The Triologies in The Practice of Occupational Medicine

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INTRODUCTION

The practice of occupational health and safety, has become part and parcel of a conflict-solving system with the help of :

1. The worker, whether individually, or working community as a whole,

2. The employer, whether of a small establishment, or of a large industrial conglomerate.

3. Professional experts which are deployed by governments at the national or international levels of understanding.

If it were possible to create a system of co-operative co-ordination, with the above participants, the system would have found solutions within the problems, as they arise. A professionally dominated occupational health and safety system is a pre-requisite to be able to deal with most of the work hazards and illnesses. The weakness and deficiency of any occupational health delivery system arises from the following :

1. The medical paradigms, that are not oriented towards picking up the bioindicators of work hazards.

2. The use of regulations, the rights and norm that concern the work place and working conditions.

3. The kind of co-operative conflict solving routines of industrial democracy.

While these three are the keypoints for co-determination[1] the use of medical paradigms suffers the most neglect, mainly because of the difficulty of finding co-ordinative bodily disfunction. This is partly because of the underated importance of preventive measures in medicine, and the overated safety devices engineered into medicines and materials, combined with good salesmanship, of these engineering products.

HISTORICAL REVIEW

The medical methodologies available to us date back to the days of Rammazzini[2] and have evolved into three institutional shapes in its home-ground in Italy : University based, industry based and government based. Italy's first occupational health clinic started in a university. It started a tradition based on a combination of scientific research and political reformism. A little later in 1972, Servizio dimedicina deLavoro or occupational medicine services were linked with the local health units while university based expertise was always made available. A major role has been played by the toxicologist in establishing ascertainable standards of exposure. The university based approach mushroomed with the pioneering work of Dr. Alice Hamilton in 1919 and 1943[3]. While worker movements and industrial advancement have played important roles in moulding occupational health systems of various countries, the most authentic are those that give medical paradigms their optimal weightage. These contribute to newer attitudes within the medical profession. They also counterbalance the conflicts of aggressive worker participation and industrial production.

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An industry based approach emerged with a change, with workers doing highly skilled discrete tasks in large industrial organisations. The craft nature of specific jobs made it possible to evaluate specific hazards and deal with them. These can be based on studies of changes, industrial processes and medical evaluation for specific medical fitness. While this is true for the developed countries, in which skilled workers occupational health programmes have been resolved. It has yet to be resolved for the unskilled worker populations of the Third World.

Here-in lies the importance of the government-based regulatory system by which the medical and non-medical aspects of occupational health need to be well implemented. Some of the ways by which this has been done is to make regional risk maps and another by plotting geographical patterns of disease[2] based on standard mortality ratios (SMR). While SMRs are good indicators of trends in risks, they serve only preliminary analysis for events that have already occurred, to establish patterns of disease. Their preventive value is limited in resident populations and is even less so in migratory populations and must be supplemented by actual periodic clinical observations[4].

GUIDELINES AND CONCLUSIONS

The advantages and disadvantages of various types of studies in occupational medicine have been reviewed extensively[5].

The advantages of a clinical survey are recognisable as; Those that can detect legislated occupational disease and also those that recognise occupational disease for therapeutic follow-up.

The advantages of a generally occupationally related health survey can be; (i) To screen a populations cohorts for occupationally related risks and long term trends and (ii) to promote health and safety measures for prevention.

The three categories of work related diseases are; (i) Those that are a necessary cause of established cause and effect. (ii) Where work is a contributory causal factor, not a necessary one. (iii) When work provokes a latent disorder or aggravates established disease. The work site is the obvious place for controlling work related disease and injury, based on the hygienists reports and regulatory programmes[6].

Besides, a co-operative implementable regulatory safety system, the individual worker remains the primary reponsibility of doctors and scientists. A strong cross referral system, between local health centres and hospitals to occupational clinics, is a good way to follow up detected cases.

In countries like Bahrain, the worker population is under governmental health surveillance.

The objective of the review in this paper is to illustrate the advantages of strengthening the occupational health delivery system, by establishing better links between clinicians and health regulatory authorities.

Following a clinical case study to its work place is a good way to save a lot of time and effort and is good economics. But not all cases are detected early enough. In which case the subthreshold levels of clinical manifestations must be explored, at the cost of a lot of time and effort by the help of surveys from work place to work place. This does require an appropriate outlay of manpower and material. One more effective way of cutting cost, effort and time is to see worker outpatient data at all local Health Clinics at regular intervals. If done judiciously, it could serve the same function as the periodic-medical check up. Occupational awareness amongst physicians, as with the worker, is growing and governmental organisations can effectively guide it to a point of implementation.

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