and high technology must be shown to be inextricably linked. Leading consultants and senior clinicians must not be complacent and should be worried that their skills are waning. The royal colleges and specialist societies should emphasise the need, and lay down guidelines, for teaching clinical methods in both undergraduate and postgraduate training programmes. Now that the undergraduate medical curriculum is undergoing reform, emphasis on teaching clinical skills is vital. If regular tests of continuing competence to practise are to be introduced these should include an assessment of clinical skills as well as knowledge of the latest advances in diagnosis and treatment.

The problem is urgent because the more complex high technology becomes, the more the basic skills are needed and the more difficult it will be to restore them once they are lost.

We must heed the desperate voice of the patient trapped in technology crying "Speak to me!"

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Diagnosing and managing occupational disease

The prospects are not good for workers

See p 1299

In 1990, a large sample of the British population was asked whether they had suffered from a work related injury or illness in the previous 12 months.¹ In that year some 1.6 million people were estimated to have had accidents at work and 2.2 million to have had an illness attributed to or made worse by work. The net cost of this was calculated to be about £5 billion to individuals and £1.5 billion to employers. The total cost of all work related illness, injury, and other accidents was estimated to be £6-£12 billion—1.2% of the gross domestic product. Given the size of the problem, the mechanisms for managing work related illness in the United Kingdom are inadequate, and the prospects are getting worse.

The labour force survey indicated that about 7% of consultations in general practice are for work related conditions. This figure may surprise some, but it is perhaps less remarkable when one considers that 48% of work related disease is musculoskeletal, 10% respiratory, and 10% psychological. As a microcosm of this, of the first 50 employees referred to me last year by managers of an NHS trust because of absence due to sickness, 15 proved to have a condition, usually musculoskeletal or psychological, caused directly by their work. The message is clear: work related disease is common.

Unfortunately, work related disease is often missed. Indeed, for many doctors there is little point in diagnosing such diseases since few know what to do about them other than provide symptomatic treatment and give unwelcome advice to change the job. Even when it comes to giving advice on benefits and whether the disease should be reported the profession displays considerable ignorance, as shown by two papers in this week's journal (p 1299).^{2,3} Why do our patients get such a raw deal, and, more importantly, what can be done about it?

The implications of diagnosing occupational disease go further than treating the patient. If the patient is to get back to work something usually needs to be done about the cause of the disease. Furthermore, the diagnosis of occupational disease often implies that others in the same workplace have been or will be affected in the same way. Thus, management should include reducing the risk in the workplace. This, of course, requires some knowledge of preventive occupational medicine. Here there are two main problems. Firstly, teaching of occupational medicine in medical schools takes a relatively low priority.⁴ Secondly, there is no well established

NHS network of specialists to whom colleagues may refer patients with suspected occupational disease.

Until recently the appropriate method for achieving action in the workplace has been to refer the patient to the Employment Medical Advisory Service of the Health and Safety Executive.^{5,6} Its doctors are specialists in occupational medicine and have authority to enter workplaces. Moreover, in liaison with their colleagues in the health and safety inspectorate they can oblige recalcitrant employers to take preventive action under the Health and Safety at Work, etc, Act. The Employment Medical Advisory Service is now, however, undergoing fundamental change, including a study into the feasibility of its work being "contracted out."

At its peak in 1991 the service employed some 120 doctors and nurses trained in occupational medicine. As a result of the current restructuring, early retirement has removed about 30 doctors and nurses, and a further 15, including seven senior experienced doctors, are expected to follow. Their union expects the staff to fall to around 60 and promotion prospects for younger doctors and nurses to disappear. Doctors now wishing to refer patients to the service will find it increasingly difficult, and preventive action in the workplace is likely to become impossible without calling directly on an already overburdened inspectorate. Expect many more patients to be driven to civil litigation.

What about solutions? Where they exist the fledgling NHS occupational health services need to spread their wings and provide an outpatient service for local doctors.⁷ Medical schools also have the opportunity of integrating occupational medicine into the mainstream in their new curriculums. In view of the size of the problem of occupational ill health, and its cost, we need to take it seriously.

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