General practitioners' knowledge of notifiable, reportable, and prescribed diseases

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See editorial

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For most patients with an occupationally related illness or injury the family doctor is often the first port of call. With recent estimates suggesting that over 90% of registered patients consult their general practitioners over five years,¹ family doctors can play a key part in diagnosing and treating ill health that may be linked with work, in preventing further cases by notifying the right people (reportable diseases),² and in enabling the patient to claim benefit under the Industrial Injuries Scheme (prescribed diseases).³

Subjects, methods, and results

The Health and Safety Executive recently investigated general practitioners' awareness of health and safety legislation and its relevance to their practices. A survey was carried out by means of a telephone questionnaire on 24 randomly selected practices in each of the 20 areas covered by the Health and Safety Executive in Great Britain. These were prearranged, when possible, with the senior partner at each of the practices. Interviewers were employment medical or nursing advisers from each of the area offices. Respondents were senior partners at the practices, or, if this was not possible on the day, practice managers. Included in the survey were three questions designed to compare knowledge of notifiable, prescribed, and reportable diseases. The interviewer asked respondents whether they knew what was meant by a notifiable disease. Respondents who answered yes and gave an appropriate definition were then asked to give two examples. The same process was repeated for prescribed and reportable diseases. A total of 466 questionnaires were completed and included in the subsequent analysis. This represents a response rate of 97%. In all, 323 of the survey respondents were general practitioners, approximately 1% of all general practitioners in Great Britain.

The table shows the proportion of partners who properly defined each disease category as well as the proportion correctly identifying two diseases (or injuries in the reportable category). Only a third of all partners included in the survey could correctly define a prescribed disease. Of these, approximately a fifth

failed to give two relevant examples. Knowledge of reportable diseases and injuries was lower still: only a quarter of partners knew the definition, with less than half of them giving two relevant examples. Almost all partners in the survey correctly defined a notifiable disease, although only two thirds could give two relevant examples.

Knowledge of notifiable, prescribed, and reportable diseases and injuries among 321 general practitioners. Values are numbers (percentages (95% confidence intervals))*

Disease category	Partners knowing definition	Partners correctly identifying two diseases/injuries
Notifiable diseases	318 (99 (98.0 to 99.9))	209 (65 (60.0 to 70.4))
Prescribed diseases	103 (32 (27.0 to 37.2))	81 (25 (20.3 to 29.8))
Reportable diseases/injuries	78 (24 (19.9 to 29.3))	32 (10 (6.6 to 13.1))

*In two completed questionnaires answers to the three questions of interest were invalid.

Comment

While showing that general practitioners knowledge of notifiable diseases is far from complete (already shown by Voss⁴), these results also highlight the lack of knowledge about diseases that are linked to patients' occupations. Although the identification results are somewhat difficult to interpret, general practitioners' knowledge of the relevant definitions can be seen to be poor. Indeed, such a low degree of knowledge makes any subsequent analysis almost redundant. Improving medical practitioners' awareness of prescribed and reportable diseases and injuries (by increasing doctors' training in recognising work as a cause of illness) would not only help improve the quality of life of people with occupational diseases (through disablement benefit) but also improve the quality of information on the incidence and prevalence of occupational disease as a whole.⁵

We thank all the medical and nursing advisers in the Health and Safety Executive who helped conduct the telephone interviews.

1 Office of Health Economics. *Compendium of health statistics*. 8th ed. London: OHE, 1992.

2 Health and Safety Executive. *A guide to the reporting of injuries, diseases and dangerous occurrences regulations 1985; HS(R)23*. London: HMSO, 1986.

3 Benefit Agency. *If you think you have an industrial disease*. London: Benefit Agency, 1991. (Leaflet N12.)

4 Voss S. How much do doctors know about the notification of infectious diseases? *BMJ* 1992;304:78.

5 Boillat MA, Noel B. The need for more reliable information on the incidence and prevalence of occupationally related problems. *Occup Med* 1994;44: 123-4.

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Industrial injury benefit for occupational asthma in north east of England

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Occupational asthma is the commonest occupational lung disease in the United Kingdom, with an estimated 1000 cases identified annually.¹ Industrial injury benefit has been available since 1981 for asthma caused by several defined agents, and since October 1991 benefit has been available whatever the cause, provided that the diagnosis of occupational asthma has been established to the satisfaction of an adjudicating officer of the benefits agency.² We reviewed the data on all

claimants presenting to the Newcastle office of the Benefits Agency Medical Service over a one year period after the October 1991 revision of the regulations. We paid particular attention to the interaction of this service with the other medical services in the region.

Patients, methods, and results

Overall, 205 subjects (180 men) claimed benefit for occupational asthma over the study years. Their median age was 54 years (age range 17-76), 88 subjects being over the age of 60. Only 25 had been advised to apply by a medical practitioner, the others having decided to apply themselves or on the suggestion of a workmate or union representative.

Most subjects had evidence of airflow obstruction, 121 having a forced expiratory volume in one second of less than 80% of predicted values and 100 a ratio of

forced expiratory volume in one second to forced vital capacity of less than 70%; 182 used inhaled bronchodilators or corticosteroids. The agents suspected of causing occupational asthma are given in the table.

Distribution of claimants for compensation of occupational asthma by agent and outcome

Agent	No of claimants (n=205)	No (%) awarded benefit
Wood/paper dust	30	12 (40)
Soldering fumes	11	5 (45)
Other organic dusts	21	5 (24)
Isocyanates	15	6 (40)
Hardening agents	24	15 (62)
Other chemicals	18	10 (56)
Welding fumes	59	3 (5)
Inorganic dust	27	0

Many claimants had worked in the traditional industries of the region, such as shipbuilding and mining, and attributed their disease to the effects of welding fumes or inorganic dusts. These are not generally recognised as causes of occupational asthma.

Occupational asthma was diagnosed in 56 cases. In most (49) the medical history provided the only information on which the diagnosis could be based. Serial peak flow measurements at and away from work were available in three cases, and inhalation challenge tests had been performed in four. The median duration of exposure to the causative agent was 10 years. Only 16 subjects were under the care of a hospital physician, though a further 15 had been in the past. Twenty subjects continued to be exposed to the agent thought to be responsible for their asthma.

Subjects awarded benefit were younger (coefficient from logistic linear regression 0.08/year (95% confidence interval 0.11 to 0.04)) and were three times (1.8 to 4.1) more likely to have worked with agents recognised as inducing asthma.

Comment

A high proportion of the claimants were fairly elderly and had worked in the traditional industries of the north east of England. They were probably familiar with the benefits system, having made previous claims for other industrial diseases such as deafness and pneumoconiosis, and only a few had discussed their eligibility for benefit with a medical practitioner.

Despite this, their claims were not frivolous. Most were using inhaled drugs or had evidence of airflow obstruction, though in most cases this was probably due to chronic obstructive airways disease rather than asthma.

Almost half the subjects thought to have occupational asthma had never undergone any form of specialist evaluation, and in few had objective evidence in support of the diagnosis been sought. Yet occupational asthma is not always easy to diagnose from the history³ and often leads to irreversible loss of lung function.⁴ It has important financial consequences for people affected, their industries, and the economy. The cost of compensating the workers in this study to retirement age will be about £1.8m. The costs of drug treatment will be about £0.2m and the cost of lost work potential could be £5m-10m.

This study suggests that medical practitioners under-refer cases of possible occupational asthma for specialist evaluation and for compensation. There is a potential for closer liaison between the benefits agency and other medical services, and this could lead to improved management for those who are affected.

PSS is medical adviser to the Benefits Agency Medical Service in Gosforth. Our views are not necessarily those of the agency.

- 1 Meredith SK, McDonald JC. Work related respiratory disease in the United Kingdom, 1989-1992; report on the SWORD project. *Occup Med* 1994;44: 183-9.
- 2 Department of Health and Social Security. *Pneumoconiosis and other prescribed respiratory diseases*. London: HMSO, 1989. (Leaflet NI 226.)
- 3 Luc-Malo J, Ghezzi H, L'Archeveque J, Lagier F, Perrin B, Cartier A. Is the clinical history a satisfactory means of diagnosing occupational asthma? *Am Rev Respir Dis* 1991;143:528-32.
- 4 Chan-Yeung M, McLean L, Paggiaro PL. Follow up study of 232 patients with occupational asthma caused by Western red cedar. *J Allergy Clin Immunol* 1987;79:792-6.

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Correction

Randomised clinical trial of ultrasound treatment for pressure ulcers

An editorial error occurred in this paper by Dr Gerben ter Riet and others (22 April, pp 1040-1). In the table the fourth adjusted difference (95% confidence interval), for volume reduction, should have read -0.72 (-1.32 to -0.12) ml/week and not -0.72 (-1.32 to 0.12) ml/week as published.

ONE HUNDRED YEARS AGO

A NEW DANGER

Hamlet rudely reminds Ophelia that while God has given ladies one face they insist on making themselves another. He says he has heard of their paintings, but he makes no allusion to their teeth, and we are willing to believe that Ophelia's were the gift of Nature. Had she lived in the present day the chances are that they would have been the handiwork of the dentist, and Hamlet might possibly have learnt the fact to his cost. A young lady of New Jersey was recently kissed by her lover with such Swinburnian fervour that the gold filling fell out of one of her teeth. The ungallant swain seems to have been unwilling to pay for the necessary repairs. The result is that the engagement has been broken off, and Chloe is suing Strephon for the value of her damaged tooth. This case adds a fresh terror to love making in these days of breach of promise and of

our particular protégé, the *oacillus basii*, and it opens up a rich vein of legal questions of a novel kind. If Angelina's maiden blushes come off on Edwin's cheek, is the latter liable for the cost of their reproduction? If a deviated septum which has (to use the word of Theophile Gautier) altered the intention of the fair one's nose to be Greek has been rectified by surgical art, is the enamoured wooer liable for the amount of the fee if the structure gives way under the ardour of his embrace? Truly if this be the law the man whose fancy lightly turns to thoughts of love might, as Touchstone says, "If he were of a fearful heart, stagger in this attempt." at any rate, before sporting with Amaryllis in the shade it would be well for the lover to make sure that one of her eyes is not made of glass, and before playing with the tangles of Næra's hair it would be prudent for him to satisfy himself that it is not detachable.

(*BMJ* 1894;ii:509.)