

## Editorial

# Occupational health for health workers

Two recent reviews by Gestal in this journal<sup>1,2</sup> have served to remind us how potentially dangerous it is to care for the sick. Many hazards await those who work in hospitals, of which the risk from infection tends to come first to most people's minds. The increased prevalence of tuberculosis among hospital staff has been known about for a good many years and although it is still common in some countries, in others different infections have assumed a greater importance. The risk of contracting hepatitis B is now the most serious in the United Kingdom. Cases arise from what are generally referred to as needle stick injuries, although injury with any sharp, blood stained instrument is equally serious. Lately, hospital staff have become increasingly anxious about the risk of becoming infected with the human immunodeficiency virus (HIV), but present evidence suggests that HIV is much less infectious than hepatitis B and only a very small number of health workers have become HIV antibody positive after high risk accidents.

Many needle stick injuries occur because needles, giving sets, and other instruments are disposed of carelessly and in a way that puts others at risk—portering, domestic or laundry staff, for example. This is completely unacceptable, and it is by no means impossible that a doctor may find him or herself the subject of an exemplary prosecution by the Health and Safety Executive if it can be shown that a member of staff injured themselves as the direct result of their carelessness; if another member of staff thereby contracts hepatitis B the matter will be considerably more serious.

One of the most frustrating aspects of following up needle stick injuries is the apparent unconcern of junior medical staff and the fact that many do not readily understand that blood is a very dangerous material. Hepatitis B and AIDS are by no means the only infections which may follow an injury that results in inoculation of blood; Collins and Kennedy in their review list 21 infections that have followed such accidents and, in addition, they cite cases of malignancy which seem to have resulted from the accidental injection of material aspirated from patients with cancer.<sup>3</sup>

Gestal's reviews highlight a number of other areas in which hospital staff may be at risk. The hazards may be physical, from radiation in one form or another; chemical, from, for example, cytostatic drugs and

anaesthetic gases; stress; and alcohol and drug addiction. Gestal tends to concentrate particularly on the risk to doctors; he understates some of the more important occupational risks to nurses, including such common matters as backache and dermatitis and he almost completely ignores the health of the large numbers of ancillary staff to be found in any modern hospital. The ancillary staff are almost invariably tucked away in basements or outbuildings, out of sight of the patient care areas. And out of sight may well be out of mind, certainly so far as occupational health provision or supervision is concerned. Recourse to Denning's comprehensive annotated bibliography<sup>4</sup> is recommended as a means of redressing the shortcomings in Gestal's otherwise useful papers.

Given the ample evidence of the hazardous nature of caring for the sick, one might expect that the occupational health needs of those working in hospitals would be amply provided for. Sadly, this is far from the case.<sup>5</sup> And here one encounters the ambivalent attitude of the medical profession itself; on the one hand, they are overwhelmingly interested in disease and its cure but—in general—strangely *disinterested* in its prevention. Their attitude with regard to their own health serves to exemplify Samuel Johnson's stricture that there "is scarce any [folly] against which warnings are of less efficacy, than the neglect of health" (*The Rambler*, 1 September 1750). There seems to us to be little doubt that it is the doctors' neglect of their own (occupational) health that has prevented the inauguration long ago of an effective occupational health service for those who work in the national health service (NHS).

To date, the provision of occupational health within the NHS in England and Wales has proceeded piecemeal. At one time it seemed to be the Department of Health's intention to require the regions each to appoint a consultant in occupational health but this intention was never converted into a directive with the result that few regional consultants have been appointed and many districts have "gone it alone." The lack of regional consultants means that broad occupational health policies cannot be developed and it has to be said that some of the appointments at district level have left much to be desired. Occupational physicians have been appointed who do not have higher qualifications in occupational medicine and may not even have any experience; this is a disgraceful state of affairs that

would not be tolerated in any other specialty and gives an indication of the regard in which the subject is held by those outside it.

The occupational health units that have so far been established in the NHS lack a common form and purpose, they lack common policies and, perhaps most seriously of all, there is no structure that allows potential recruits, be they nurses or doctors, to be trained within the service. There has also been, in our view, too much emphasis on the medical input and too little on the contribution that occupational health nurses can make. There are not enough trained occupational physicians to permit the development of a service that is heavily dependent on a medical input; it is much more realistic to see a service that is effectively run by occupational nurses with limited medical input as appropriate.

It is high time that the Department of Health took the health of its employees seriously. If this means a confrontation with doctors who seem to resent any diversion of funds away from patient care then this must be faced. The morale within the NHS is now at a low point and a firm commitment by the DHSS to develop an effective occupational health service for its employees could be one factor that might begin to improve morale for it would show that the Department did care for those whom it expects to work under increasingly adverse conditions. The case for providing an adequate occupational health service is overwhelmingly self evident to anyone who is attempting to provide it at the moment.

What it required is the development of a national service with an agreed policy on matters as, for example, pre-employment requirements, on rehabilitation back to work, on the provision of immunisations; things that are routine in any large industrial occupational health service. Occupational health units should have a common form—so far as is reasonably practicable; obviously there are some special needs that have to be recognised and catered for—and the staffing strategy determined. Our view is that the units should be based on the concept of occupational health nurses providing day to day advice. They would not provide a treatment service so that the frequently held notion that the occupational health department is just an extension of casualty or the nurses' sick bay might finally disappear; emergency treatment would be provided by first aiders

whose training could well be within the remit of the occupational health staff. Properly qualified occupational physicians will be needed to provide a medical input at both regional and local levels and there may well be a case for the provision of some limited hygiene input.

To attract men and women of a high calibre into such a service, however, it is most important to provide them with adequate higher medical or nursing training. At present, there is little prospect of career development for an occupational nurse who works in an occupational health unit; the doctors who work in occupational health units are either appointed directly as consultants or are part-timers whose principal interests are elsewhere. In neither case is there any requirement for career development. An expanded service, however, would need to attract doctors in at, say, senior registrar level and provide higher specialist training. In a national service there would be the opportunity for both doctors and nurses to train in different units and at different grades. It is not without significance that of all medical specialties, occupational medicine and nursing are the only ones for which the DHSS does not provide training posts.

Obviously, we cannot expect that a national occupational health service for the NHS will be established overnight—or perhaps even over a good many nights—and the form and content of the service will occasion much debate and discussion before it can be settled. What could be done immediately, however, is for the DHSS to make a firm commitment to providing such a service and setting up a working party that would report on how this could best be done. We hope that at least this limited objective can be achieved in the very near future.

## References

- 1 Gestal JJ. Occupational hazards in hospitals: risk of infection. *Br J Ind Med* 1987;44:435–42.
- 2 Gestal JJ. Occupational hazards in hospitals: accidents, radiation, exposure to noxious chemicals, drug addiction and psychic problems, and assault. *Br J Ind Med* 1987;44:510–20.
- 3 Collins CB, Kennedy DA. Microbiological hazards of occupational needlestick and "sharps" injuries. *J Appl Bacteriol* 1987;62:385–402.
- 4 Denning JV. *Health hazards to health care workers*. Dorking: John V Denning, 1986.
- 5 Smyth E. Caring for the carers. *BMA News Review* 1987;13:14–16.