

Work related disorders

# The importance of cultural factors in the recognition of occupational disease

M Kogevinas

Commentary on the paper by Coggon (see page 281)

A few years ago I complained to my administration about the background ventilation noise at my office in Barcelona. My office was inspected and the administrator told me half-joking, half-serious, that I should go to Sweden to lodge this complaint—that it was not considered a problem in Spain. I had no headaches or feeling of malaise. If I had though, I would have had no chance of them been considered of occupational origin and of preventive measures being implemented. A few months ago, during a short visit to a US research institute, I was located at an office with a very high background ventilation noise. After a few hours work I did end up with a severe headache. My colleagues next to me did not seem to notice, or perhaps had, simply, no alternative. Had I been in a similar environment a decade earlier I probably would not have noticed either and would have considered this work environment as normal; perhaps not ideal, but normal. The moral of the story is that perception of health and wellbeing is related to our expectations and depends strongly on cultural and societal factors. Expectations have changed over the past few years, and consequently we are dealing with new health problems in the work environment.

David Coggon, in his paper "Occupational medicine at a turning point"<sup>1</sup> highlights several issues that should be discussed to help us identify solutions to the serious obstacles in research in occupational health in recent years. We seem to be investigating more complex problems than in the

past. As Coggon rightly notes, our studies have not kept up with the complexity of the problems, and much of the research has little chance of breaking new ground.

Where I feel less convinced, is with Coggon's assertion that frequent complaints such as back pain, headaches, malaise, the whole series of symptoms associated with the sick building syndrome etc, are determined by a very strong psychological (somatising) component without a real organic component. As Coggon remarks, the causes of these illnesses are all too easily ascribed to specific work conditions without having strong evidences for this. I find, however, that the evidence that Coggon questions is more extensive (though admittedly not always consistent) than that evoked by him to refute it. For example, his suggestion that part of the problem may be a reflection of "happiness" in the work environment—to put it simply—seems a reasonable statement, but is founded on limited evidence. Where I also feel less convinced is his assertion that temporal and geographic variation in the report of these "ill defined" symptoms is an indication of them not being real. In Spain I am not even allowed to report some of these symptoms, while workers in Sweden are backed up by years of research.

Workers in the 1950s or 1960s had a different work ethic than those of today. We sometimes forget that it took years for the trade unions to include health and safety as an important concern. Does this mean that back pain did not

exist as an occupational problem 20, 30, or 50 years ago? Its increasing prevalence in a progressively more protected environment could be a reflection of under-diagnosis in the past rather than over-diagnosis now. There are numerous examples of "objective" health problems that are related to the occupational environment and that have been differentially recognised in space or time. Occupational asthma in women is one example. Numerous studies in the past five years identified that women in domestic cleaning have a higher risk of asthma.<sup>2</sup> So why did our surveillance systems, our research, and our clinical services not identify this earlier? Why did the cleaners not identify it earlier, or if they did, why did they not take preventive measures? As Coggon correctly notes, culture may be a factor that motivates people to complain. Culturally mediated beliefs and expectations, however, can also lead workers to suppress real problems.

Coggon may be right in his diagnosis of the problems of occupational health research. More extensive scientific evidence should be accrued, however, to substantiate some of his conclusions, and this is where I find he is entirely right: we are faced with new, complex questions regarding health in the work environment, and we need to change the type of research we are doing.

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# Occupational medicine at a turning point

D Coggon

## The author replies

I agree with Aaron Blair that it would be premature to assume that toxic chemical and physical hazards in the workplace are all under control. The continuing high incidence of disorders such as occupational asthma, contact dermatitis, and noise induced deafness, even in countries with well developed occupational health services, provides clear evidence that this is not the case. Thus, I am not suggesting that we should reduce the resource that we allocate to investigating and managing hazards of this type. However, I do believe that the classical approach to risk management may be quite inappropriate for much of the occupational

illness that now challenges us in developed countries.

Both Aaron Blair and Vilma Santana highlight my suggestion that such disorders might usefully be addressed by attempting to modify cultural beliefs and expectations. This is certainly a possibility, but more important, I think, is the need for us to be aware that the classical approach to risk management may not work for these illnesses, and could even be counter-productive. In other words, at the very least, we should avoid wasting resource and possibly making things worse.

I agree with Vilma Santana that somatising tendency is unlikely to

explain temporal trends or geographical differences in the occurrence of modern occupational illness. However, such variation could reflect differences in cultural beliefs and expectations. I hypothesise that the role of somatising tendency is more as a determinant of which individuals within a cultural group are most susceptible to disorders such as low back pain, non-specific arm pain, and multiple chemical sensitivity.

Manolis Kogevinas correctly points out that apparent temporal and geographical differences in the occurrence of occupational illness may be an artefact of incomplete reporting. However, I doubt that this is the full explanation. Fortunately, the uncertainty, particularly with regard to geographical variation, can readily be addressed by research, and this is one of the lines of further investigation that I propose in my paper.

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