BRITISH MEDICAL JOURNAL

SATURDAY 13 SEPTEMBER 1975

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NO. 5984 BRITISH MEDICAL JOURNAL 1975 VOLUME 3 605-660 ASTM CODEN: BMJOAE 3 (5984) 605-660 (1975)
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR. SECOND CLASS POSTAGE PAID AT NEW YORK N.Y. WEEKLY 70p

CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Occupational Health

SIR,—In your leading article "E.M.A.S. Gets Going" (23 August, p. 449) you ask whether occupational health is a specialty in the sense that cardiology, neurology, and surgery are. Two of these specialties are based on anatomical systems and one on a technique. Occupational health is based on two techniques: (1) the taking of an occupational history, both present and past, and making a diagnosis and giving advice in the light of this; and (2) the scientific assessment of the working environment and its correction if necessary by the techniques of occupational hygiene. You ask, moreover, what is the scope of occupational health? This is to apply medicine at the interface between a man and his work or, put more simply, to study the reciprocal relation between job and health. We must be a little on our guard against the conservatism of our profession, which tends to greet any innovation by saying either that there is no such thing or alternatively that we have been doing it all the time.

It is, of course, not unknown for governments to spend money in the medical field for what look like political reasons, but it is surely a little unlikely that the Treasury would sanction the Employment Medical Advisory Service budget if there was really nothing to do. Moreover, in the same issue as your article are advertisements from three industries for occupational health doctors at salaries within the consultant range. Now, industry earns the money it spends and its attitude is different from (and possibly a bit more responsible than) publicly funded organizations such as the N.H.S. or the universities. On the whole industry does not spend money on things which it does not consider worth while. By the same token the clinical and hygiene service, the North of England Industrial Health Service, attached to our Newcastle department, is earning about £80 000 p.a. from industry.

Whatever the doubts of our more conservative colleagues, there seems to be something here which the hard-headed feel is worth paying for.—I am, etc.,

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Myocardial Infarction and H.G.V. Drivers

SIR,—In your leading article on "Rehabilitation after Acute Myocardial Infarction" (16 August, p. 394) you question the recommendation of the Joint Working Party of the Royal College of Physicians and the British Cardiac Society that heavy goods vehicle (H.G.V.) drivers are among "several occupations not open to those who have had myocardial infarction, because of the risk to the public.[1] The following points seem pertinent:

(1) H.G.V.s are vehicles designed to carry goods which are more than three tons (3·05 tonnes) unladen weight or are articulated vehicles. They are therefore not light vans or light delivery vehicles.[2]

(2) H.G.V. drivers are professional drivers who often spend most of their working day at the wheel. The longer any driver is at the wheel, the greater must be the risk that acute illness, though generally regarded as a rare event, will occur while driving. H.G.V. drivers often work on schedules and find it difficult to stop driving if they feel unwell. H.G.V. drivers tend to drive on trunk routes where they are surrounded by more people and vehicles to collide with if they do lose control. The greater the mass of the vehicle, the more damage it does to other vehicles or people in a collision. The load carried can also be important; a tanker of 100-octane petrol is potentially very hazardous.[3]

(3) Weinblatt *et al.*[4] reported in a study of 55 000 men of all occupations (insured under the Health Insurance Plan of Greater New York) that men under 55 had 9·1 times the risk of a first recurring myocardial infarction compared with the risk for a first myocardial infarction in the same population. Peterson and Petty[5] reported that three-quarters of 81 sudden deaths at the wheel were due to ischaemic heart disease.

(4) Car occupants are more likely to be killed or seriously injured in a collision with an H.G.V. than in a collision with another car. Gissane and Bull[6] reported that of 564 deaths of car occupants, 40% were from collisions with lorries, in spite of the fact that lorries are outnumbered by cars by 7:1.

(5) There is no means of ensuring that the holder of an H.G.V. licence will stick to a particular type of vehicle. H.G.V. drivers tend to move jobs fairly frequently, and, though a good employer would limit a driver rehabilitated from an acute ischaemic episode to certain types of vehicle or certain hours of driving, there is no means of ensuring that the driver would stay with that employer and not move to an unsuitable job. The trained H.G.V. driver who can no longer drive an H.G.V. as defined still has the choice of driving light vans.

Public safety considerations of this kind give strong support to the working party in including H.G.V. drivers among "occupations having to do with public safety such as heavy goods vehicle driver, passenger service vehicle driver, airline pilot and all holding flying licences, and air traffic control officer." The Medical Commission on