An Introduction
To General Practice

Written and Presented by
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Primary care Occupational Physician
• Occupational Medicine & its origins
• Significance of Occ Med & OHS
• Occ Medicine and General Practice
• Occ Health Clinics & Consultants
• Pre-employment assessments
• Injury Management and RTW
Accidents at work – morbidity and mortality.

Globally:
- Every 15 seconds, a worker dies from a work-related accident or disease.
- Every 15 seconds, 160 workers have a work-related accident - ref www.ILO.org
Occupational Injuries

- Result of single traumatic event
- Short or non existent latent period
• Result of repeated or long term exposure
• Agent or event
• Could be result of long latency eg. asbestos exposure and mesothelioma
• Bernardino Ramazzini (1633-1714), was the Founder of Occupational Medicine and added a new dimension to medicine with his observations, clinical practice and in his writings……

• Occupational medicine has developed significantly and is now recognised as a specialty in its own right with specific training and skills.
The intimate inter-relationships between the world of Work, Health and Well being of the worker.

Paradigm

Work

GAINS

Health

DEFICITS

Disease

Neg.

Pos.
ILO / WHO definition

Occupational Health is the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations by preventing departures from health, controlling risks and the adaptation of work to people, and people to their jobs.

(ILO / WHO 1950)
How does all this fit in with General Practice?

• GP’s with up skilling in Occ Med working in GP Clinics providing limited range of services.
• GP’s with more formal training in Occupational and Environmental Health working in specialised multi disciplinary Occ Health clinics
Quick Survey –
- What do you do?
- What health problems you have related to work?
- Are your symptoms better or worst at home or at work?

More Comprehensive Survey
- Full list past and current jobs & description
- List full WP and Occ Hazard exposure and Risk management include PPE used
- Full past and current hobbies and other recreational activities
- What previous medical monitoring has occurred?
• Limited Undergraduate training
• Limited Post Grad training as part of RACGP training
• Chronic shortage of Trained Occ Doc’s
• Availability of Post Grad self directed course training eg Monash Uni
Competencies

- Clinical Medicine knowledge and examination upskilled
- WP Hazard Assessments
- Critical Appraisal of Research Publications
- Professional Co-operation & Management skills
- Communication skills Pt, Company, Unions, Worksafe, Lawyers. Including Report Writing skills
- Legislation knowledge
- Rehabilitation fitness and RTW planning
- The environment aspects
Components of Occ Med work

- Pre employment medicals
- Injury management
- Rehabilitation and RTW programs
- Health surveillance
- Risk Management
- Company support - advice, information, education, on OHS, hygiene, on ergonomics and protective equipment.
Typical Health Service provides

- Pre employment assessments
- Health assessments
- Medical surveillance programs
- Injury management
- Rehab referrals
- Work Place assessments and audits
- E.A.P
What Happens in Normal GP

Doctor → Patient → Company
Occupational Medicine

- Company
- Occ Doctor
- Worker
Knowledge of employer, employee duties and rights may reduce workplace conflicts

Not just for profit or higher wages but for HEALTH
Can help an Employer

The good health & contentment of the workforce is now seen as the major objective of both Management and Unions.
OHS Maze

Employer Responsibility

- Age Discrimination Act
- Disability Discrimination Act
- Fair Work Act
- Equal Opportunity Act
- OHS Act
- Workers Compensation & Rehab Act Act

Equal Opportunity Act
• An Occupational Health Service is seen increasingly as an essential service for any large employer.

• Be welcomed by the workers who will take its presence as an indicator of management’s concern - should be less sickness, better morale and in the event of accident or injury proper records, urgent treatment, rapid transfer to secondary care if needed, proper sick leave, compensation and retraining as appropriate.
• Pre-employment medicals
• Return To Work after prolong time off or after a serious medical problem
• Continuing Disability - Fitness to Work capacity assessment
• Performance assessment - initiated due to decline in work performance – continuing employment maybe at risk.
Health Assessments

- Pre-employment Medicals are not primarily to protect the employer from errors through incapacity or sickness, nor is it to prevent other than the young and healthy being accepted into the company superannuation pension scheme.
- It is increasingly about trying to fit the person into the workplace and to minimise the health hazards to him.
- It is also about protecting his fellow worker and indirectly the public who may purchase and use the product or service.
• 1. To determine appropriately the capability to work safely in the internal and external environment of the workplace.
• 2. To assess the physical and mental capability for a particular job or work tasks, including development and advancement in that job.
• 3. To provide a baseline for health so those subsequent assessments can be compared and interpreted.
Harbin & Olsen 2005 Post offer, PEM assessment had 3% injury rate in group that demonstrated suitable capacity compared to 33% in group that did not.


**Source**
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**CONCLUSIONS:**
This study indicates that physical capacity testing that compares lifting ability to job lifting requirements correlates to work injury incidence. The application of appropriate post-offer, pre-placement testing is shown to be a cost-effective method to lower the incidence of work-related injuries.
WHO SHOULD DO PEM’S?

• Health Assessment must differentiate
  • between a candidate’s safe working capacity &
  • speculation prediction about possible future injury

  Alternate to standard “medical model” of assessment is to use
  • Occupational Physicians who are able to offer specialised functional assessments

  • Must deal with inherent requirements of the position only to avoid discrimination
  • Must differentiate between past and current abilities
• An accident follows from a particular combination of events resulting in a particular, unexpected and harmful consequence.

• more common where people are inexperienced, poorly trained, under pressure to work extra fast, cold, hungry and tired. In such situations safety precautions are not enforced, corners are cut and maintenance neglected.
Red and Yellow Flags

- Red flags are clinical indicators of possible serious underlying conditions requiring further medical intervention.
- Applied more broadly in the search for serious underlying pathology in any pain presentation.

Yellow flags are psychosocial indicators suggesting increased risk of progression to long-term distress. Applied more broadly to assess likelihood of development of persistent problems from any acute pain presentation.
Is HEALTH best understood in terms of a combination of biological, psychological, and social factors rather than purely in biological terms?

Bio psychosocial model is a general model that implies and assumes that

**Biological elements**

**Psychological thoughts, emotions, and behaviours**

**Social factors,** all play a significant role in human functioning in the context of disease or illness.
Poor Occ Health Outcomes

- Psychosocial environment at time of injury and afterwards
- Psychological vulnerability of the injured person
- Initial response to claimants by employer and insurers
- Initial treatment management
- Case Management issues—Doctor, Employer, Insurer
- Repeated Medical examinations needed GP, Specialists –treating and for legal purposes – Insurer, Lawyers
- Length of time off work – Large risk!
• Yellow flags are about the **Person** (thoughts, feelings, behaviours)
• **Blue flags** are about the **Workplace** (work and health concerns)
• **Black flags** are about the **Context** (relevant people, systems and policies).
Chance of RTW versus Time Off Work
The chance of a person ever returning to work after a workplace injury is:

- 70 per cent if off for 20 days
- 50 per cent if off for 45 days
- 35 per cent if off for 70 days.
Out of Work Risk to Health

- 2–3 times the risk of poor health;
- 2–3 times the risk of mental illness;
- A significantly increased risk of depression;
- 20% excess deaths.

• Discuss return to work options to the patient, including the health consequences of remaining off work. Talk to his employer!!!!

• Provide sufficient consultation time to address patient issues and concerns.

• Advise patients about the natural history of their condition.

• Be aware that a patient’s attitude to their injury or illness has a huge impact on their recovery.
Evidence-based messages include:

- Work is an important part of rehabilitation
- The longer someone is off work, the less chance they have of ever returning
- Most common health conditions will not be ‘cured’ by treatment
- Work is a therapeutic intervention, it is part of treatment
- Even when work is uncomfortable or difficult, it usually does not cause lasting damage
- Typically, waiting for recovery delays recovery
- Staying away from work may lead to depression, isolation and poorer health, and
- Employer-supported, early return to work helps recovery, prevents deconditioning and helps provide patients with appropriate social contacts and support mechanisms.
Acute Common Lower Back pain

- Thorough Hx incl. Occ Hx and Physical examination vital. Look for Red Flags! Check Yellow Flags screen early.
- Medical Imaging ONLY if there are Red Flags
- Explain and reassure the patient
- Keep the analgesics simple. Minimal need for narcotic, diazepam etc
- Advise to stay active. Avoid Bed Rest
- Early RTW with suitable duties
- Engage the Employer! Work site “walk through” - prevention
- Risk factors - heavy physical work Psychosocial risk factors common. Don’t medicalised the disability thru “Dxíc Labelling”.
- Symptoms, pathology and Medical Imaging in common LBP poor correlation.
Evaluation of Low Back Pain

- **Recommendation 1**: Clinicians should conduct a focused history and physical examination to help place patients with low back pain into 1 of 3 broad categories: nonspecific low back pain, back pain potentially associated with radiculopathy or spinal stenosis, or back pain potentially associated with another specific spinal cause. The history should include assessment of psychosocial risk factors, which predict risk for chronic disabling back pain (*strong recommendation, moderate-quality evidence*).

- **Recommendation 2**: Clinicians should not routinely obtain imaging or other diagnostic tests in patients with nonspecific low back pain (*strong recommendation, moderate-quality evidence*).

- **Recommendation 3**: Clinicians should perform diagnostic imaging and testing for patients with low back pain when severe or progressive neurologic deficits are present or when serious underlying conditions are suspected on the basis of history and physical examination (*strong recommendation, moderate-quality evidence*).

- **Recommendation 4**: Clinicians should evaluate patients with persistent low back pain and signs or symptoms of radiculopathy or spinal stenosis with magnetic resonance imaging (preferred) or computed tomography only if they are potential candidates for surgery or epidural steroid injection (for suspected radiculopathy) (*strong recommendation, moderate-quality evidence*).

- Ref US Department of Health & Human Services
Summary - Take Home Messages

• Work and the environment are significant factors in the life of most adults.

• All employees right to a safe and healthy working environment.

• Work-related illness and injury can have dramatic
  – financial consequences
  – social consequences
  – significant impacts on work productivity.

GP can play a critical role in OHS but needs upskilling to be successful
Further Information & Resources

- AFOEM - http://www.racp.edu.au
- ANZSOM- http://www.anzsom.org.au
- Safe Work Aust www.safeworkaustralia.gov.au
- Lower back exam review http://meded.ucsd.edu/clinicalmed/joints6.htm
- Clinical Guidelines
  http://guidelines.gov/content.aspx?id=11515
- Yellow Flags - Lower back exam review http://meded.ucsd.edu/clinicalmed/joints6.htm
• David Snashall “ABC of Occupational and Environmental Medicine
• Joseph LaDou “Current Occupational & Environmental Medicine”
• Raymond Agius et al “Practical Occupational Medicine”
• John B. Sullivan “Clinical Environmental Health and Toxic Exposures”
• Gordon Waddell “The Back Pain Revolution”
• Linda Rosenstock “Textbook of Clinical Occupational and Environmental Medicine
• Various WorkCover authorities for your state publications e.g.
  *Victorian WC Authority Guidelines for Management of Employees with Compensable Low Back Pain
• Various Aust/NZ Standards – Risk Management, Audiology etc
• www.imagingpathways.health.wa.gov.au
Monash Certificate in Clinical Occupational Medicine
To be held in Melbourne, June 17th – 21st 2013
For occupational medicine trainees, GPs and other medical practitioners who assess and manage patients with work-related problems

Aims and objectives
To provide medical practitioners with the knowledge and skills to:
• Diagnose and manage occupational injuries & diseases
• Perform a medical assessment, including history and examination, aimed at pre-placement, medical surveillance or return to work
• Write a medico legal report

See web page at:
http://www.coeh.monash.org/com.html
Beavers

Sometimes they fail.
Confusion hopefully sorted out