THE birth pangs of occupational medicine

By Dr John Quintner

'Medicine, like jurisprudence, should make a contribution to the well-being of workers and see to it that, so far as possible, they should exercise their callings without harm. So I for my part have done what I could and have not thought it unbecoming to make my way into the lowliest workshops and study the mysteries of the mechanic arts.'

From Bernadino Ramazzini, *De Morbis Artificum Diatriba,* 1633-1714.

In 1970, Professor (then Dr) David Ferguson, lecturer in occupational health at the University of Sydney, noted that industry had up to that time largely ignored the welfare of the community from which it sprang. Occupational health services in Australia were then quite sparse, mainly because its employers could not see their benefits.

Professor Ferguson looked forward to a new era for occupational medicine, but warned that it 'will need to keep pace with changes in work and in society'. He predicted that 'some old hazards will remain, but may appear also in new guises' and that some new hazards may be discovered.

To meet these challenges, the occupational physician of the future would not be just a tool of management, but 'a physician first, with responsibilities to workers, profession and community, as well as to management'. In other words, he would function as the conscience of industry, thereby assisting it to become 'a good corporate citizen'.[1]

Twenty-four years later, when Professor Ferguson was invited by the *Medical Journal of Australia* to review 80 years of Australian occupational medicine, he lamented the lack of progress in the speciality:

> 'Occupational physicians have had to battle indifference, if not active opposition. Political expedience, not science has tended to determine outcomes ... a poor quality of working life often still exists ... Unsafe conditions are still accepted when the means of their prevention have been known all the *Journal*'s life.'[2]

These disturbing words are reminiscent of those penned in the early part of the 19th century by Leeds surgeon, Charles Turner Thackrah:

> 'In many of our occupations, the injurious agents might be immediately removed or diminished. Evils are suffered to exist, even where the means of correction are known and early applied. Thoughtlessness or apathy is the only obstacle to success. But even where no adequate remedy immediately presents itself, observation and discussion will rarely fail to find one.'[3]

Without doubt, Thackrah was an idealist. He called for a new approach to the study of occupational medicine, and a commitment to the prevention of occupational illnesses 'rather than to the relief of evils, which our civic state so widely and deeply produces'.[4]

He had also noted the almost universal inattention to health:

> 'We rarely think of health till we have lost it ... people are less thought of than the machinery: the latter is frequently examined to ascertain its capabilities – the former is scarcely ever.'[5]

Until this time, the doctrine of *laissez-faire* ('let men do as they please') had prevailed over the attempts by reformers to get the British Parliament to pass legislation dealing with occupational hygiene.

The principal argument against such interference was advanced by the dominant economic theorists of the time: 'each individual in a state of liberty would, by following his own interests, advance the welfare of the whole'.[6]

There was indeed 'freedom' between master and man, but it was 'freedom for power to compete with weakness; the cry of *laissez-faire* merely protested against any interference with the liberty of oppression'.[7]

Thackrah spelled out the responsibility of the master to his servant:

> 'It is especially incumbent on masters to regard the health of persons they employ; to examine the effects of injurious agents, to prevent and provide remedies and to enforce >>

their application. This appears to me not only a case of humanity but a direct duty.'[8]

Between 1802, when Sir Robert Peel first alerted Parliament to the miserable condition of apprentices in the cotton mills, and 1832, when the Report of the Commissioners on the Factory Bill was handed down, it was said that 'nearly two generations of miserable beings' had literally 'gone through the mill' in hopeless toil and untold suffering.[9]

Even though the true situation of workers was not uniformly bleak, the evidence that had been gathered by the Commissioners was thought sufficient to justify parliamentary legislation in order to improve those conditions that were adversely affecting the health of workers.

By the late 19th century, the British Parliament had enacted a great number of *Factory Acts*, each of which had been vigorously debated. These Acts were all directed at improving the conditions of employment for women and children, particularly those employed in the textile trades. These Acts placed no restriction upon the employment conditions of male workers.

When offering reasons for the then widespread neglect of the principles of occupational safety and health, Dr JT Arlidge, consulting physician to the North Staffordshire Infirmary, adopted a similar approach to that of Thackrah:

'If undeniable, the evils are minimised, and masters and managers are prone to close their eyes to conditions of labour that loudly call for a remedy, and cast the blame, more or less, upon the work-people … Unhappily, this is too frequently justified by the conduct of the latter. For it requires no lengthened acquaintance with workmen to discover their recklessness in dangerous occupations, their neglect of cleanliness, their refusal to adopt preventative measures against evident evils, and, above all, their widespread habit of intemperance.'[10]

His views were endorsed by another prominent occupational physician, Dr Thomas Oliver, at the Royal Victoria Infirmary, Newcastle-Upon-Tyne:

'Many of the present defects in our factory life and methods are therefore to be considered as less the result of the system than the outcome of want of knowledge on the part of the workpeople, and of an unwillingness on the part of employers to recognise the fact that capital has duties as well as rights.'[11]

By the end of the century, Parliament had also enacted the *Workmen's Compensation Act* of 1897, and then extended it in 1906. From this time on, the state was irrevocably committed to regulating the complex relationship between master and servant. But Dr Oliver did not seem to be overly impressed by the results of this new legislation:

'In this country industrial legislation is based upon experience and expediency, so that no sooner is an Act in operation than its weak points become apparent and a fresh Act is required to remedy defects and remove flaws, but it too generally ends in introducing controversial matter and in providing employment to lawyers and doctors.'[12]

The situation in the USA regarding occupational health and safety issues was evidently no better than in the UK. Alice Hamilton, Professor of Industrial Medicine, Harvard University, who publicised the danger to workers' health of industrial toxic substances, recalled her many struggles in the cause of protecting workers:

'It is a pity that I cannot recall any instance of help from the organized industrialists … they fought the passage of occupational disease compensation as they fought laws against child labour, laws establishing a minimal wage for women and a maximum working day. Yet members … are many of them humane and benevolent employers. But as an organization they have shown themselves to be as devoid of a sense of responsibility to the public as the most self-seeking of the trade unions.'[13]

Occupational medicine does occupy a rather unique place alongside other medical specialities. As the great medical historian and sociologist, Henry Sigerist observed in 1958:

'Occupational diseases are socially different from other diseases, but not biologically.'[14]

Thus the occupational physician has always had to struggle to not only master the art and science of medicine but also to withstand the antagonism from those whose behaviour he seeks to change, albeit for the good of humankind.

Tension has always existed between safety and productivity – the fundamental conflict being between, on the one hand, production and cost-containment and, on the other, the safeguarding of the workers' health and safety. Herein lies the eternal dilemma for the occupational physician. It is certainly not a job for the faint-hearted. ■

Notes: **1** D Ferguson, 'Occupational Medicine for the 1970s in Australia', *Medical Journal of Australia*, 1970, I, pp810–70. **2** D Ferguson, 'Eighty Years of Occupational Medicine in Australia, *Medical Journal of Australia, 1994, 161, pp35-40.* **3** CT Thackrah, *The Effects of the Principal Arts, Trades and Professions and of Civic States and Habits of Living, on Health and Longevity*, 2nd edn, Longman, Orme, Brown, Green & Longman, 1831, p40. **4** *Ibid*, p41. **5** *Ibid.* **6** GT Warner, *Landmarks in English Industrial History*, Blackie & Son Ltd, London, 1930, p265. **7** *Ibid*, p266. **8** Thackrah, *Op.Cit.*, p42. **9** Warner, *Op.Cit.*, p267. **10** JT Arlidge, *The Hygiene, Diseases and Mortality of Occupations*, Percival & Co, London, 1892, p5. **11** T Oliver, *Diseases of Occupation from the Legislative, Social and Medical Points of View*, 3rd edn, Methuen & Co Ltd, London, 1916, pxix. **12** *Ibid*, pxvi. **13** A Hamilton, *Exploring the Dangerous Trades: Autobiography of Alice Hamilton*, MD Boston, Little, Brown & Company, 1943, pp114-26. **14** LA Falk, 'Medical Sociology: the Contribution of Dr Henry E Sigerist', *J Hist Med Allied Science*, 13, 1958, pp214-28.

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