



NOTIFICATION OF OCCUPATIONAL DISEASES BY GENERAL PRACTITIONERS IN THE WESTERN CAPE

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Background. Notification of occupational diseases to the Department of Labour (and in limited situations to other agencies) is an important aspect of surveillance and planning for interventions as well as compensation. A survey of general practitioners (GPs) was conducted to assess their knowledge and practice with regard to reporting of occupational diseases.

Design. Descriptive telephonic survey.

Setting. Independent general practices in the Western Cape.

Participants. One hundred and forty GPs were randomly selected from a provincial sampling frame of 1 000 GPs.

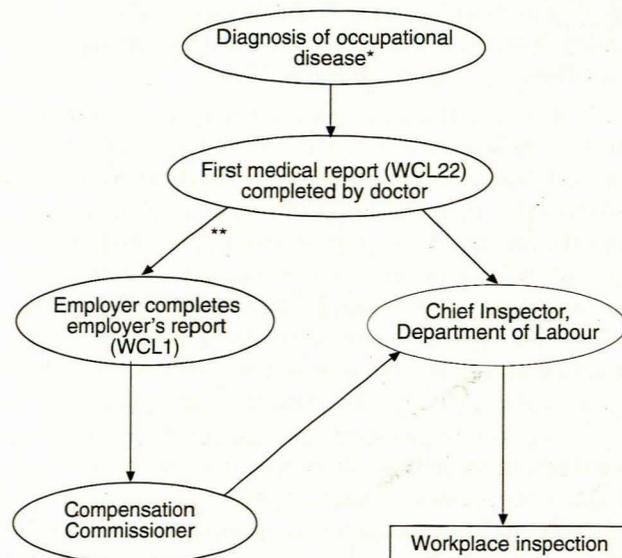
Main outcome measures. Knowledge of notification procedures for occupational diseases, and problems encountered with the reporting system.

Results. Of a total of 109 GPs interviewed, 75% had diagnosed more than one case of occupational disease in the last 6 months. Twenty-four per cent of the total (95% confidence interval (CI) 16 - 32%) indicated that they were aware of the notification requirements, and 5% (95% CI 0.8 - 9%) knew the appropriate legislation. Only one GP notified the appropriate authority once the diagnosis was made. Factors influencing their reporting practice included lack of guidelines for diagnosis of common work-related conditions, lack of information regarding referral channels, problems with communicating with the patient and employer, and poor knowledge of the reporting process itself. Lack of motivation as a result of poor feedback on cases reported and the labour-intensive administration required, were also cited as factors.

Conclusion. Although the majority of GPs diagnose occupational diseases, knowledge and practice regarding notification are poor. Recommendations to overcome obstacles to notification include a simplified, uniform notification system, adequate training and support of GPs, and timeous feedback to GPs.

S Afr Med J 2000; 90: 1012-1014.

Notification of occupational diseases to the Department of Labour is a requirement of the Occupational Health and Safety Act of 1993 (OHSA), and the Compensation for Occupational Injuries and Diseases Act of 1993 (COIDA). Lung diseases in miners have to be notified to the Medical Bureau for Occupational Diseases in terms of the Occupational Diseases in Mines and Works Act of 1993, while the Health Act of 1977 requires that lead and pesticide poisoning be notified to the Department of Health (Fig. 1).



*Lead and pesticide poisoning are notifiable to the Local Authorities in terms of the Health Act. Cases of miners' lung disease should be submitted directly to the Medical Bureau for Occupational Diseases, Johannesburg, in terms of the Occupational Diseases in Mines and Works Act.

**In absence of employer, doctor submits WCL22 direct to Commissioner together with Employee's Claim for Compensation (WCL14).

Fig. 1. Correct notification procedure for occupational disease in terms of the Compensation for Occupational Injuries and Diseases Act (COIDA) and the Occupational Health and Safety Act (OHSA).

The Occupational Health and Safety Act (Section 25) states that 'any medical practitioner who examines or treats a person for a disease described in the Second Schedule to the Workmen's Compensation Act of 1941 [now replaced by COIDA], or any other disease which he believes arose out of that person's employment, shall within the prescribed period and in the prescribed manner report the case to the person's employer and to the chief inspector and inform that person accordingly'.

Although it is our perception that few cases of occupational disease are correctly notified, there is little information regarding the extent of such underreporting. These missed opportunities in occupational health should receive greater attention as the health system moves towards primary prevention in health care. In order to assess the quality of the interaction between general practitioners (GPs), the labour

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force and the authorities, we conducted a telephonic survey among GPs in the Western Cape. The focus was on diseases notifiable to the Department of Labour under the OHS and COIDA.

METHOD

A descriptive survey was carried out using the South African Medical Association (SAMA) database of GPs in the Western Cape (including members and non-members). A systematic random sample of 140 GPs was selected, of whom 125 met the criteria for selection, viz. GPs in independent practice. Of this number, 109 could be traced telephonically. A letter was faxed to all selected GPs briefing them about the study. The GPs were subsequently telephoned and an interview time was arranged. The interviews were conducted by a senior research student.

Respondents were asked via a structured questionnaire whether they diagnosed occupational disease; the frequency of such diagnosis, with examples; and problems encountered in the diagnosis of occupational disease. They were also questioned on the notification requirements and the relevant legislation. Only those GPs who were aware of this process entered the next phase of the interview. They were asked to comment on past experiences and problems encountered in notifying occupational diseases. The data were analysed as simple proportions.

RESULTS

The response rate was 87.2%. The 109 responding GPs qualified between the years 1948 and 1995, and were drawn from all the health regions in the province. Of this total of 109 GPs, 87 (80.7%, 95% confidence interval (CI) 74 - 89%) had previously diagnosed an occupational disease and were questioned further. Of these 87, 59.8% had seen fewer than 5 such cases in the last 6 months, and 34.5% had seen more than 6 cases. Only 5.7% had not seen any patients with occupational disease in the last 6 months.

Occupational respiratory and dermatological disease together comprised more than 75% of cases diagnosed. With regard to diseases of the lung and pleura, occupational asthma accounted for 34% of cases and asbestosis for 24%. Most of the dermatological cases were contact dermatitis. Just over 50% of cases diagnosed in the musculoskeletal category were back ailments. In the eye, ear, nose and throat category, 53% were eye problems, 25% upper respiratory tract conditions (e.g. rhinitis), and 20% hearing-related problems. In the category 'other', 50% of cases were reported as 'allergies.'

Of the group of 87 GPs who had previously diagnosed occupational disease, 60.9% stated that they did not experience problems with diagnosis, 25.3% had problems, and 14% were not sure. Problems mentioned included difficulty in identifying

the exposure and in establishing the link between disease and exposure at work, and lack of experience in the field of occupational health.

Fig. 2 describes the GPs' responses on occupational disease notification. Although 26 (24%) (95% CI 16 - 32%) of respondents stated that they were aware of the notification requirements, only 5 respondents were aware of the legislation governing reporting of occupational diseases, and only 1 respondent knew the appropriate authority for notification.

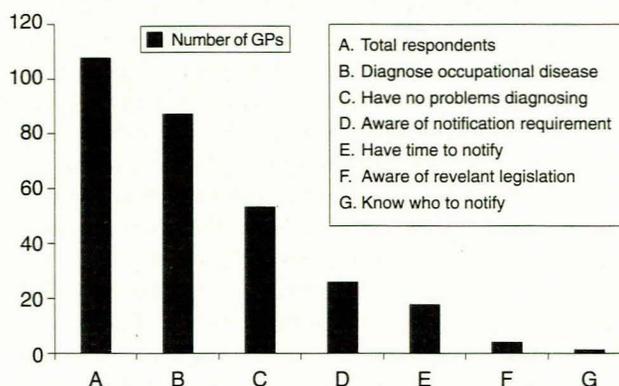


Fig. 2. Occupational disease notification — responses by 109 GPs.

Of the 26 GPs who were aware of the notification requirements, 18 (17% of the total sample) reported that they had sufficient time to notify the authorities. The remainder cited difficulty in accessing the appropriate forms and contact numbers, and the labour-intensive administrative process as reason for not notifying. Factors reported as influencing the decision to notify included duration of exposure, severity of the disease, ability to establish a definite link to work, and whether the disease was a 'listed' condition. Other problems reported in the process of notifying occupational disease included problems in diagnosis and referral and in communicating with the employer, inadequate information regarding the notification procedure, and insufficient feedback from appropriate authorities.

Only one GP knew who to notify, viz. the Chief Inspector in the Department of Labour. The rest of the notifying GPs mentioned notified various other authorities, including local authorities and the Department of Health.

DISCUSSION

A labour force survey conducted in the UK indicated that approximately 7% of visits to the GP are work-related.¹ This is not surprising as 48% of the work-related illnesses seen were musculoskeletal, 10% respiratory and 10% psychological, all common reasons for visiting doctors.

In South Africa in 1991 only 104 claims for occupational



disease were accepted by the Compensation Commissioner out of a total of 256 992 'injury' claims accepted under the COIDA.² Although work-related illnesses are therefore common, they are often missed, and the opportunity to influence preventive action in occupational health is lost.³ This unfortunately results in disease presentation at a later stage when disability is much greater and management more complicated and understandably more costly.⁴

Appropriate and accurate reporting is necessary for hazard surveillance to play an important role in predicting work-related health problems and to prevent occurrence of further occupational disease.⁵ However, this process is dependent on the availability and accessibility of data and the capacity to utilise this information at a public health level in the management of occupational hazards. The main current source of this information is the claims for occupational disease submitted to the Compensation Commissioner, who is in turn supposed to provide details of these claims to the Occupational Health and Safety division, the enforcement arm of the Department of Labour, for investigation. The effectiveness of this 'internal loop' is unknown. Also, statistical reports from the Commissioner's office are published only some years after the occurrence of events, the latest published report dating from 1991.

The requirement under the OHSA for medical practitioners to notify the Department of Labour directly is relatively new. The findings of this study suggest that this requirement is largely unmet.

In many settings the GP is the first port of call for workers with work-related illness or injury. The GP as gatekeeper can therefore play a significant role in diagnosing and treating work-related illness, preventing new occurrences by notifying the appropriate authorities and enabling the worker to claim benefits. According to a recent editorial in this journal,⁶ 'the role of the GP is to make the correct diagnosis and manage the patient in a holistic way, and secondarily to exercise 'a social duty to assist the authorities to regulate workplace conditions in order to ensure that workers remain healthy and able to provide for their families'.

The results of this study highlight the deficiency in the notification of occupational diseases by GPs. These results are supported by other findings which indicate that the GPs' knowledge of notifiable diseases is far from complete.³ The finding that more than 80% of GPs diagnose occupational disease, but that only 5% have knowledge of the legislation governing notification, has major adverse implications for the prevention and control of occupational diseases in South Africa.

In an attempt to solve the problem of underreporting of occupational diseases, additional warning systems in the form of sentinel networks have been proposed to complement the existing notification systems. An example of such a network is

the collaborative project initiated by the National Centre for Occupational Health (NCOH) in 1996, called the Surveillance of Occupational Respiratory Diseases (SORDSA),^{7,8} aimed at developing a model surveillance programme for occupational respiratory diseases.

The poor knowledge of practitioners with regard to notification procedures may be partly a consequence of the limited attention paid to the process of reporting notifiable conditions during undergraduate medical training. Additional factors that may play a role in underreporting are the inaccessibility and complexity of the notification forms, lack of motivation owing to poor or absent feedback from the authorities on reported cases, and possibly a lack of monetary compensation.

This study highlights the need for a simplified, user-friendly notification system, which is uniformly acceptable and understandable. A study at King Edward VIII Hospital looking at underreporting of notifiable conditions under the Health Act, alluded to the need for a short, simple and accessible form to improve the reporting rate.⁹

In the sphere of occupational health, the following could be done to improve the reporting of occupational diseases: (i) the Departments of Labour and Health should provide support to GPs regarding notification procedures, including feedback on reported cases; (ii) the reporting format needs to be simplified; (iii) the importance of notification for occupational disease control and surveillance should be included in undergraduate training and continuing medical education for doctors; and (iv) GPs should consider notification as part of their holistic management of patients.³

The authors acknowledge the assistance of the South African Medical Association for access to their database and all the GPs who selflessly made time for the interviews.

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Accepted 18 June 2000.