Psychiatric disorder and the role of occupational health

In October 2000, Dr Daksha Emson, a junior psychiatrist from the UK, took her own life and that of her 3-month-old daughter. Dr Emson had been diagnosed with bipolar affective disorder during her undergraduate training resulting in several hospital admissions. During her 10 post-registration years, she had no further significant relapses or hospital admissions, remaining under the care of a consultant psychiatrist and being maintained on lithium carbonate and Prozac. The recently published Independent Inquiry [1] arising from her death is critical of the clinical care received by Dr Emson, including her withdrawal from prophylactic antidepressant treatment prior to a planned pregnancy, following which she developed a postnatal depressive relapse which led to the extended suicide.

Whilst not a factor leading up to her death, the role of the occupational health services (OHS) is severely criticized. During her postgraduate years, Dr Emson concealed her health problems from her co-workers for fear of stigmatization and impaired career prospects. The OHS was aware of her diagnosis during the initial pre-employment health clearance and satisfactory reports were obtained from her treating specialist, but the OHS is criticized for not offering subsequent ‘... help, support, or advice ...’. The Inquiry heard evidence that the OHS was perceived as the ‘enemy’ by Dr Emson, apparently as a result of the advisory function of the OHS to the employer. Other comment and conclusions regarding the role of the OHS drawn by the authors of the report are perplexing. The report does, however, acknowledge that the OHS involved provided a level of service no different from that of other OHS involved in the provision of advice regarding health care workers.

The report raises issues of considerable significance to occupational health. What is the purpose of the pre-employment health assessment? Should OHS seek to establish a therapeutic relationship with staff? Should staff with relapsing mental health issues in particular occupations receive extra attention? Where an employee deals with vulnerable client or patient groups—doctors, nurses, teachers, social workers—where impaired concentration or short-term memory could have a significant and perhaps catastrophic effect on care, should follow-up of affected staff be routine? What would such assessment consist of and how often should it occur? If it is to be undertaken, which specific categories of psychiatric disorder—recurrent, mild, moderate, severe, non-psychotic, psychotic—should be included?

Whilst a theoretical case can be made for these interventions, examples of significant lapses in care standards in the social and health care sectors attributed to psychiatric disorder are rare. Previous inquiries touching upon the role of occupational health services have led to recommendations on the exclusion of nursing students with a wide range of psychiatric diagnoses with little or no objective basis [2].

The report recommendations undoubtedly raise important and basic issues regarding the purpose of the OHS. These are principally the need for the UK Department of Heath to set standards within the profession, including OHS responsibility for the support of individuals with chronic mental health problems in their jobs. Additional recommendations include monitoring of service quality, appropriate resourcing to enable the OHS to act as a supportive ‘interface’ between the clinical needs of staff and the operational issues of their employers, and anti-stigma training for all senior clinical and management staff.

The implication that managers should know of any mental health issues in their staff, counter to current legal and ethical confidentiality principles in UK occupational health, is highly contentious [3]. Is there sufficient evidence from risk assessment, with the best available data, of an overriding public interest for disclosure in such employees? Would such disclosure in any way address the perception of OHS as the ‘enemy’?

This report does serve to emphasize a mismatch between the expectations of what the OHS should do and what it actually does and can do. An increasing number of reports relating to the mental state of health care workers have simply served to blur the boundaries between the rights of the individual and the operational requirements of employers. The current report promotes inter-agency working and an end to the informal support of care workers with mental health problems. Should a subsequent formal ‘care programme’ implemented by treating physicians include routine communication with the OHS?

There will undoubtedly be actions arising from the inquiry, and some of these will influence the future practice of occupational health in the UK. We have already seen this following previous high-profile incidents involving health care workers, but often no real sense is made from the ensuing confusion until many years, or even decades, afterwards. It is suggested that the
appointment and ongoing employment issues arising out of health and social care staff with chronic or relapsing psychiatric problems are subject to discussion between representatives of the occupational health profession, the Royal College of Psychiatrists, the Department of Health, the Health & Safety Executive, and employment law and personnel specialists. A consensus statement relating to the interaction between the OHS and primary and secondary care should be based on the evidence for adverse effects of ‘work on health’ and ‘health on work’ in such employees, the prognosis for a range of psychiatric disorders, the effectiveness of pre-employment, and periodic ‘in service’ screening to detect incipient mental health problems, human rights and disability issues. If we are to prevent ourselves being driven by events, we must produce the evidence.

References

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