LETTERS TO THE EDITOR

Re: Occupational mental ill-health and stress

Dear Sir,

The September 2006 edition of the Journal itself, as well as three of the articles within it, appears to raise a number of important questions regarding occupational medicine’s consideration of work-related mental ill-health and stress. The yellow cover has a bullet point ‘common symptoms are attributed to work: Oslo health study’. This appears somewhat like the display board of a street seller of evening newspapers, providing little or no information, but a clear stimulus to buy or read. I will admit to
being quite excited at the prospect of some real scientific information regarding the diagnosis of work-related ill-health, but unfortunately this was dispelled by the first words of the title of the paper in question [1]. The words clearly identify this as ‘self-reported’ work-related health problems. The attribution here is therefore by the patient or the employee themselves, and as such represents employee perception. While perception is important, it is not necessarily true.

The paper itself spends some time looking at the potential for selection bias for individuals with perceived work-related health problems and considers them to be unlikely. I accept this. It acknowledges that they have no further information on the type severity and work relatedness of health problems. The use of this paper therefore is, in my view, to do no more (important as it is) to provide referenceable evidence of what practising occupational physicians know, that is that our patients perceive their ill-health relates to work.

Mehlum et al. [1] do include a single reference reporting acceptable agreement between patients and physicians reports and this leads on then to consideration of Cherry et al. [2]; the report of work-related stress and mental ill-health. Here, we are provided with occupational physician and specialist psychiatric diagnoses and an interesting and expert evaluation of the UK data. While it is clear that these groups should have knowledge of the criteria for the diagnoses of the conditions in question, there are in fact no such referenceable criteria for the diagnosis of work relation. As a most basic principle, I have suggested [3] that it is not possible to diagnose work-related conditions without confirmation that the relevant exposure took place. Over many years, I do not recall many cases where the psychiatric opinion sought or had the benefit of information from a workplace investigation. One wonders, therefore, how much of this data are related to worker perception as the only source of input to the doctor making the diagnosis.

The third paper [4] looks at work-related life events and psychological well-being in workers. This too is an excellent piece of work, but raises questions as to what aspects of life could be considered work-related. Traditionally, the occupational health and safety model in the UK revolves around the duty of care to protect workers from injury and illness. Failure in this duty can result in both common law litigation, as well as regulatory action. In terms of mental health and stress, therefore, focus has been on interpersonal relations, over work/under work and work exposures. This Swedish paper’s work-related life events feature a number of considerations, which could be summarized as job change or promotion. Are these events which we should regard as the causes of occupational illness?

In summary, looking at three quality pieces of work, we have evidence of worker perception but not truth, we have an analysis of doctor reporting, although in the UK we have no criteria for the diagnosis, and it is questioned whether we need to define terms such as occupational illness and work-related events in a more useful way for us to consider as occupational physicians.

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References