VIEWPOINT

Safe systems of work are needed for the diagnosis of occupational mental illness

C. J. M. Poole

Occupational mental illness is now the most commonly reported illness to the national surveillance scheme, Occupational Physician Reporting Activity, of work related illness [1]. Its diagnosis is problematic as it involves recognizing a pattern of subjective symptoms in a patient that can be causally attributed to work rather than to personal vulnerabilities. As with most psychiatric illness there is no objective test to confirm the diagnosis. The difficulty of verifying the existence of a stressful working environment and of associating it with a particular occupation or job have been given as reasons for not making occupational mental illness a Prescribed Industrial Injury [2]. Neither is it recognized by the Health and Safety Executive in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. This contrasts with personal injury litigation or injury awards for certain pension schemes that recognize occupational mental illness as an injury and require doctors to give an opinion about causality.

Characteristics of workplaces that are hazardous for mental health have been identified from a variety of observational studies and include those where there are high demands on employees, a lack of control over the way the work is done, a lack of social support, an imbalance between effort and reward, job dissatisfaction, a hostile working environment or culture such as bullying or where there is job insecurity due to restructuring or external inspections [3–7]. Less commonly operational aspects of the job are reported as sources of stress but these tend to be in extreme circumstances where there is a risk of personal harm. The importance of obtaining information independent of the patient (known epidemiologically as triangulation) may be helpful for validation purposes. Personal factors associated with mental illness need to be assessed to include a previous personal or family history of mental illness, recent stressful life events and personality traits of neuroticism [8].

An experienced occupational physician is familiar with evaluating relevant personal and workplace factors and with diagnosing common mental illnesses such as anxiety or depression. For example, the victim of unreasonable or particularly stressful working practices with anxiety specific to work or depression, but with no other relevant trigger factor and no past medical history of mental illness or neurotic personality traits, is likely to be suffering from occupational mental illness. Such patients are usually the most vulnerable in an organization and it is one of the roles of an occupational physician to support and protect these patients while simultaneously preventing similar illnesses in other workers. Unfortunately many such patients either leave or are dismissed after a prolonged period of sickness absence on the grounds of incapability.

The benefit of a correct diagnosis needs to be weighed against the harm of a false one. The occurrence of several cases of occupational mental illness from one employer reduces the likelihood of false positives, provided such diagnoses have not been made negligently or there has not been a deliberate attempt to mislead the doctor. It is regrettable that in communicating the diagnosis of occupational mental illness (with the consent of the employee) to the responsible employer it may be met with an angry response to include the threat of loss of contract, a vindictive complaint or attempts to discredit the doctor's diagnostic skills [9]. By contrast, the communication of an occupational physical illness is unlikely to be met with such a response and in some circumstances it is a statutory requirement (e.g. the Lead, Asbestos and Ionising Radiation Regulations). The reporting of occupational mental illness to the employer’s health and safety committee, or by way of an annual report from occupational health, may be met with similar resistance thereby making the integration of certain occupational health data into management statistics and Regulatory compliance problematic [10].

Alternative strategies used by occupational physicians to handle this situation include equivocation over diagnostic aetiology or writing an additional letter to management that is not seen by the patient. However, both these methods can cause the doctor to lose credibility in the eyes of the patient and by so doing he or she will be compromising their professional independence. The Health
and Safety Executive has recommended a risk assessment tool for identifying stressful areas within a workplace [11] but it will not identify cases of occupational mental illness. Such cases are likely to come to the attention of a general practitioner, psychiatrist or occupational physician. Usually such cases occur singly but occasionally they occur in a cluster due to organizational dysfunction. It has been proposed that a cluster of occupational mental illness is made Statutorily Reportable to the Health and Safety Executive for further investigation [9].

Most organizations have a low background rate of occupational mental illness but a method has been described for identifying a cluster of cases on the basis of either the proportion of cases seen from a particular employer with occupational mental illness or if the size of the workforce is known by rate of cases per year [9]. Until the results of additional research become available, a cluster could be defined as three or more clinical cases of occupational mental illness in a department, or more than eight cases per 1000 employees from the same employer, in a rolling 12-month period. Occupational mental illness could be defined as mental illness (usually anxiety, depression or both, but not physiological hyper-arousal due to feelings of stress), which on a balance of probability can be attributed by an accredited occupational physician to a medically recognized hazard related to work or the workplace, rather than to personal factors of vulnerability. Occupational mental illness due to uncertainty or changes to a job or to a disciplinary procedure, provided that management has conducted itself reasonably, would need to be identified separately. Systems of categorization of occupational mental illness have been proposed [11,12].

As has recently been stated by the Judge in the Court of Appeal in the case of Professor Roy Meadow, expert witnesses must feel free to give their true professional opinions without fear of retribution [13]. Similarly, occupational physicians should have such freedom without fear of reprisal from a disgruntled patient or employer. There is a need for safe systems of work such as a written agreement with the employer that the occupational physician is at liberty to make a diagnosis of occupational mental illness and to communicate its causation in broad terms, provided the diagnosis is made in good faith and not negligently. Where there is disagreement, the normal medical process of obtaining a second opinion from an accredited occupational physician should be followed rather than resorting to a complaints procedure.

References