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

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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 recognizing a pattern of subjective symptoms in a patient that is not seen by the patient. However, both these diagnostically aetiology or writing an additional letter to manage a 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