Responding to Change: The View of a Company Doctor

ANN FINGRET, MB, FFOM
Regional Medical Officer, Yorkshire Water Authority, Leeds

Unemployment has produced a major response at both government and community levels, whereas the problems of those remaining in paid employment have been comparatively ignored. People are having to cope with a bewildering variety of changes. In the UK the average employed person can expect to change his or her job two to three times in each decade—and to change occupations three or four times in a lifetime. Few can expect the 50 years of steady progress that many joining at 15 years of age and leaving at 65 years used to experience. Employees, particularly in the public sector, where security of tenure was traditional, may feel that they started work equipped for a gentlemanly cricket game and now find themselves in the running battle of a soccer match.

Change increases the environmental demands made on the individual and is perceived as ‘stressful’. In a recent survey of a number of organisations each employing over 4,000 people, carried out by the Stress Research and Control Centre at Birkbeck College[1], the majority of respondents cited change as being the most important current stressor. The organisational events listed in Table 1 were considered to come within the category of change.

Table 1. Transitions in the workplace.

| Event                                      | Mean Value |
|--------------------------------------------|------------|
| Increased legislation                      |            |
| Role change in management and staff function |            |
| Increased competition or competition as a new phenomenon |            |
| Technological changes: different outlooks  |            |
| Reorganisation                             |            |
| Relocation                                 |            |
| Rationalisation                            |            |
| Redundancy                                 |            |

Effects of Change

Change in the work environment is now inevitable, and it is likely to be a continuing process in which previously identified security factors, such as security of tenure and job expectation targets, no longer exist.

If we are to accept Maslow’s hierarchy of needs[2], these changes will affect fundamental requirements of well-being. If the increased demands made by change are prolonged, pronounced or often repeated, the adaptive capabilities of the individual may be exceeded and disease may result. The relationship between psychosocial stimuli and disease is well known. A review by Kagan and Levi[3] of research in this field showed an associated increased incidence of specific diseases such as cardiac disorders, hypertension and peptic ulcers.

Holmes and Rahe’s findings[4] on life changes and health have been authenticated in many cultures, from Japan to Scandinavia. Life changes are scored for degree of experienced severity. Table 2 indicates the scoring for some of these changes (out of a total list of 43). The significance of work factors is clear. Scores of over 300 were found to be strongly associated with serious ill-health in the succeeding two years.

Disorders identified as psychological are a major cause of absenteeism from work. More than 30 million days of work are lost each year through ‘psychoneurosis’, and an additional 10 million days for psychosomatic disease. This represents 13 per cent of all sickness absence. The cost of this absence alone has been estimated at £3,000 million. The unseen cost of ‘presenteeism’, that is of those at work but not working efficiently, is probably even higher.

Government Responses

It might be expected that these staggering figures would have elicited a response from society. Norwegian, Swed-
lish and American health and safety legislation already includes references to the psychological aspects of the work environment. Norwegian legislation actually lists job aspects that are particularly hazardous to psychological health, such as piecework, and monotonous and machine-paced work. Certain companies in the UK have included mental health in their Health and Safety Policy Statement required by the 1973 Health and Safety at Work legislation. But too often 'health and safety' is seen in terms of machinery hazards or toxic chemicals. Psychological damage has yet to be the subject of an industrial accident claim, but it seems inevitable that it will come. I have personally seen an argument with a senior officer recorded in the accident book.

**Trade Union Response**

The Trades Union Congress has stated: ‘A common view of stress-related illness is that it is the product of some kind of individual personality defect. The Trade Union approach rejects these views and concentrates on locating the potential sources of stress within the working environment’. In other words, trade unions acknowledge that aspects of the work environment may be stressful. This has not prevented individual trade unions negotiating for their members patterns of work such as piece rates and shift work, which clearly fall into this category[5]. If unemployment has any part to play it is a negative one. Already there is evidence that individuals or trade unions are less likely to demand improvements in the working environment if these may prove to be financially embarrassing to a struggling business, or if the employed are only too glad to have a job, whatever the long-term health consequences.

**Management Response**

There are still a significant number of management teams with the attitude ‘If you can’t take the heat, get out of the kitchen’. There is little discussion of ‘stress problems’ at senior level, where there is a strong preference for dealing with tangible, preferably quantifiable problems. It is not readily accepted that increased sickness absence, complaints about the air conditioning and complaints about new technology may be simply behavioural manifestations of stress problems. However, some management teams are becoming aware of the effect of reorganisation on individuals. The Work Research Unit[6] recently published a number of studies of major changes that had occurred in organisations. In all of them there had been significant efforts to reduce the deleterious effects of such changes. It was concluded that the way change is carried out is often at least as important as the end result. Table 3 shows components of change programmes which are associated with successful organisational change.

**Occupational Medicine Response**

It cannot be said that the response of occupational physicians to what could be an epidemic of change-induced disease has been significant. Of the 600 doctors employed full-time in occupational medicine in the UK, less than 50 have shown any continuing interest in occupational mental health. Two active groups meet regularly in London and Manchester; the former is now celebrating its twentieth anniversary and has itself changed from a medical to an inter-disciplinary group, in which representatives of all professions with an interest in occupational mental health can exchange ideas and increase their skills. There is an International Committee on Occupational Mental Health which has members from 15 nations and is also multi-disciplinary. There is a Mental Health Section of the Permanent Commission and International Association on Occupational Health, chaired by the President of the Society of Occupational Medicine. It continues to be lamentably difficult to stimulate interest in this section.

Senior occupational physicians, trained in the 1960s or before, were not encouraged to consider mental health as a significant area of interest. In 1966, when I attended the Diploma of Industrial Health course, I do not actually remember having any training on mental health, though no doubt something about the psychology of work was included in the industrial relations section. Although it is now recognised in the syllabus of Occupational Medicine courses, the acknowledgement is slight, and it might be said that we ourselves are resistant to change. As a specialty we are facing the same changing scene as the work-forces we serve. The new work environment will need a different balance of occupational health skills.

Health standards in the work environment have traditionally been numerical. There is an impression that to be objective (and therefore 'real') everything must be quantifiable. Verbalised evidence is recognised as valid in the law and in the social sciences and we have to adjust our minds to its acceptance in the field of occupational mental health. The Birkbeck College survey[1] showed that the single most significant factor in determining the contribution of an occupational health department to the mental health aspects of work was not the size of the occupational health department (which had no relevance whatsoever) but the interests of the senior medical officer.

**Table 3. Positive components of successful change.**

| Component                          | Description                      |
|-----------------------------------|----------------------------------|
| Management competence             |                                  |
| Management commitment             |                                  |
| Trade union involvement           |                                  |
| Adequate funding                  |                                  |
| Enough general security—guaranteed earnings | —no compulsory redundancy |
|                                   | —employment security             |
| Shared economic motive            |                                  |
| Allayed initial fears             |                                  |
| Adequate training                 |                                  |
| Communication                     |                                  |
| Humanisation of work              |                                  |
| Time to build a climate of acceptability and fairness |                              |

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Occupational physicians have always used a number of different skills, but if they are to respond effectively to this new challenge they will need to learn new skills and to work with members of other disciplines such as sociologists and psychologists.

**Occupational Mental Health Programmes**

The mental health strategies, appropriate for use by occupational health departments, outlined below are appropriate at any time, but may be more easily introduced at times of change, when even the most insensitive managements may be prepared to allot some resources to this area.

**Prevention**

When confronted with a hazard to health the members of an occupational health team traditionally advise removal or enclosure of the hazard (in this case, the change process). It is unlikely, however, that the occupational physician will be able to influence this process. Where possible, managements should be encouraged to acknowledge organisational factors that will facilitate change (Table 3). Realistic intervention by the occupational health department will take place at the individual or group level, and will take the form of protective skills. Protection of individuals may be attempted in a number of ways.

**Recruitment Selection.** Exclusion of vulnerable individuals is not a task lightly undertaken; indeed, occupational physicians always endeavour to find suitable posts for the less than totally able. Routine pre-employment medicals to elicit physical disease are now generally regarded as a waste of time (except where there are special fitness requirements). Psychological testing to screen out vulnerable individuals or to select those with personality characteristics appropriate to the job have been used for many years in some organisations. There appears to be a gradual increase in the use of this sort of screening procedure, particularly for work where suitable and unsuitable personality characteristics are easily identifiable, for example, police work and salesmen. Such testing could be useful if properly validated and used as an adjunct to normal selection procedures. It does not yet seem advisable for occupational health staff to become involved in such procedures.

In the case of overt psychiatric disease, as long ago as the mid-1970s a study by the Sociology Department of Southampton University showed that rehabilitation to full employment of patients who had received in-patient psychiatric treatment was extremely poor.

**Increasing Personal Awareness.** The basis of this approach is that from self-knowledge comes strength. The statistically orientated physician may find such non-numerical theories difficult to accept. An excellent summary[7] explores these problems and may help such physicians to accept what they perceived, but not quantifiable, needs can be met by perceived and not quantifiable help-strategies.

The ability to cope with change depends on a number of individual characteristics, which include personality traits, perceived resources and options within the organisation, at home and within oneself. Some of the individual characteristics that have been identified [8,9] are shown in Table 4. Factors 1-7 make up the individual stress profile.

**Table 4. Individual characteristics affecting response to stressful events.**

| Physical and psychological state |
|----------------------------------|
| Personality factors              |
| Individual's behavioural skill repertoire |
| The extent to which the individual feels locked in |
| The extent and intensity of other acute or chronic stressful life events |
| The extent and outcome of past similar experiences |
| The extent of the advanced warning of the stressful event |
| The extent of the organisation's efforts to facilitate change |

In the Yorkshire Water Authority the training and medical departments designed a day-long small group seminar with the help of an experienced psychologist. Various questionnaires designed to elicit each individual's stress profile were used, and maximum participation was stimulated by a number of techniques of group dialogue. The didactic input was kept to a minimum. Participants found the seminars to be at least cathartic and at best a revelation. As a physician used to more didactic, paternalistic exchanges, I found these group workings particularly exciting.

**Enhancing the Ability to Cope.** Part of the input into the seminars was an elucidation of certain skills which seem of particular value in a situation of change, such as coping and transition skills (Table 5).

It became clear during discussions that, whereas certain strategies may be effective in one situation, a

**Table 5. Coping skills.**

| Being able to relax |
|---------------------|
| Being able to control the pace of a difficult situation |
| Being able to bring the amount of stress experienced under control |
| Being able to change aspects of one's own behaviour |
| Being able to cope with being disliked |
| Behaving as the situation requires, regardless of personal feelings |
| Having leisure activities which help relaxation |
| Being able to set realistic objectives independent of their appraisal by other people |
| Being able to turn one's mind from a difficult problem and focus on some other task |
changed organisational style may demand a different response for success.

**Explaining Transitional Behaviour.** Dr Barrie Hopson has contributed greatly to our understanding of transitions[10]. For an experience to be classed as transitional he suggests that there should be personal awareness of a break in the continuity of one’s life and a requirement for new behavioural responses.

One of the most effective ways of explaining the stages of transition (Fig. 1) is to take individuals step by step through a current transition or one that they have previously experienced. This exercise produces a remarkable degree of common experience and helps to identify the behavioural skills needed for such a process.

**Discouraging High-Risk Behaviour.** Certain forms of behaviour are recognised as being detrimental to health. The presence of some of these will have been identified, if not acknowledged, in the programme for increasing personal awareness. The Employee Assistance Programmes which were developed in the USA during the 1970s reflected such areas of behaviour. The Litton Industries Employee Assistance programme, for example, included the programmes listed in Table 6.

It is obvious that an occupational health initiative would be appropriate in some of these areas and could have long- as well as short-term benefits. Only a few occupational health departments in the UK have an overall health education policy.

There are three areas which I would like to highlight in this context.

1. Individuals with Type A personality (broadly, more confrontational and striving) have been shown to be at risk from coronary heart disease.

The characteristics of the Type A personality[11] are often thought to be those of successful management—a full desk, hurrying all the time, doing more than one thing at a time. Individuals are often surprised to know that such behaviour is associated with at least a 25 per cent increase in the incidence of coronary heart disease. This self-knowledge may be salutary and persuade individuals to modify their behaviour.

2. The area of substance abuse (including nicotine) should be consistently reviewed within industry. Some industries have formulated alcoholism programmes but there has been little recorded response to these.

3. It is now common knowledge that regular exercise has beneficial effects. Physical fitness contributes considerably to the armoury of anyone experiencing potentially stressful processes. It has been shown that individuals who rapidly decrease the level of blood adrenaline following stress have a better psychological balance. There is a positive association between this ability and physical fitness[12].

**Treatment**

All the above strategies are preventive. They will enhance an employee’s ability to adjust and at best they will decrease morbidity.

As the process of change continues the need for individual counselling inevitably rises. This is an area in which occupational health nursing staff have developed some expertise. Few companies in the UK have arranged a counselling training programme for occupational health staff—the development of these skills being left to individual initiative. If counselling fails, individuals may benefit from training programmes organised by consultant organisations. Exercises such as life-planning workshops are of particular interest in such cases.

**Summary**

Those practising occupational medicine have responded slowly to the changing hazards of the work environment. As physical and chemical hazards are brought under control, new technology and streamlining of organisations are increasing psychological problems. At the same time there are radical changes in the working day, the working week, the working life. People are unprepared for these changes. If occupational physicians do not address the mental health aspects of work, they will reduce their positive impact on the health of the workforce.

This article is based on a paper read at the joint meeting of the Faculty of Occupational Medicine and the Faculty of Community Medicine held at the Royal College of Physicians in February 1984.
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Book Review

Advanced Medicine 19. Edited by K. B. Saunders. Pitman Publishing, London, 1983. Price £20.

I look forward each year to the publication of the proceedings of the annual Advanced Medicine Conference at the Royal College of Physicians of London and this year has proved to be no exception. As usual, the book is multi-authored, each chapter representing the various papers given at the conference. The topics covered include those of daily use to the practising clinician, such as the sections on renal medicine and respiratory medicine, while others, such as the section on molecular genetics, are more scientific and help one keep up to date in areas in which the original papers are difficult to follow and which are not always, regrettably, covered in my general reading.

The book does not aim to cover all the advances in a given field but tends to highlight certain areas. Professor Chantler’s chapter on renal failure in children and Dr Gokal’s chapter on continuous ambulatory peritoneal dialysis demonstrate the advances in treatment of renal failure, especially in the young and elderly. Professor Chantler’s paper ends on the optimistic note that 80 per cent of children with end stage renal failure can now expect to be alive as adults. Dr Ward’s paper on aluminium toxicity in renal failure demonstrates how a new disease entity can be created by new technology, and how, once recognised, it can be prevented—a cautionary tale for us all. The section on endocrinology includes a very useful review by Dr Clayton of the clinical results of abnormal hormone receptor interactions. There is also a fascinating paper on the development of methods for the detection of endocrine tumours by the use of labelled antibodies.

One of the most enjoyable sessions of the whole conference was the morning devoted to medicine in the Third World and this is reflected in the excellent section in this book. Dr Warrell’s paper is particularly fascinating. It is an account of cerebral malaria and louse-borne relapsing fever, two diseases seldom met by the average clinician practising in the UK. Dr Yudkin’s paper on the use and misuse of drugs in the Third World is disturbing and should give drug companies a guilty conscience. An important cause of disease in the Third World is malnutrition and Dr Waterlow highlights this problem and demonstrates that even now more research is needed in this area.

One of the best chapters is that of Dr Marsden on paroxysmal movement disorders. He succeeds in turning a subject which usually consists of long lists into something interesting. He manages this by giving case histories of patients with these disorders, a ploy which could be used more often when describing clinical conditions.

The two lectures at the end of the book were both most enjoyable when initially listened to, and both also make excellent reading. Dr Batten’s Croonian lecture on cystic fibrosis demonstrates another area where advances in medical care have improved dramatically both the quality and expectancy of living. Professor Kerr’s Lumleian lecture on uraemia is an excellent summary of the advances in the understanding of this difficult clinical syndrome, yet also demonstrates that many aspects are still poorly understood.

As with all multi-author books, some chapters are less good than others and there is no overall style. This problem, however, is unavoidable with a book which is a conference report. Attending the Advanced Medicine Conference is one of the most enjoyable ways of keeping up to date in areas other than one’s own and for those who have been unfortunate enough not to be able to attend the conference, this book is an excellent second best and at £20 is very good value.

Edwina Brown

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