CHAPTER 9

OCCUPATIONAL HEALTH NURSING AND OCCUPATIONAL STRESS

Edna May Klutas

According to the earliest accounts, occupational health nurses in this country and in England were concerned with all aspects of the health of the employee, and of his family. By providing nursing care in the home, as well as in the factory,they "linked the factory and the home, thus keeping continuity of nursing care and by following the patient...could provide for many of his needs" (Charley, 1954). In addition, they were involved with employee welfare programs, with English nurses being part of company welfare units. This early concern of the occupational health nurse for the "whole man" has continued with varying degrees of emphasis.

During the war years, with their demand for high productivity, nurses became alert to the fatigue of moonlighters, the pressures and/or the monotony of the assembly line, the worry about family members in the armed services. She (or he) took what steps she (or he) could to help workers cope with these matters, encouraging sound health practices, assisting with identification and use of resources, providing emotional support through listening and counseling.

The depression years presented many challenges to the occupational health nurse. They kept employers informed regarding workers' needs for assistance and were influential in the development of mutual aid societies. They noted that sick workers concerned about loss of income would return to work tired and discouraged about unpaid bills, or come back to work too soon. As one nurse reported of her welfare activities "many problems deal with personal problems (which)...grow out of illness...which created problems that (the low income) employee cannot meet..." so the nurse assisted workers to find the necessary resources whereby the worker could help himself and keep his self-respect (McGrath, 1946).

Nursing is caring, and occupational health nursing is caring in relation to the effects of occupational stressors (of all kinds) on the worker. The extent to which nurses put this caring into specific action, to assist with reduction of the adverse effects of stress, varies with the nurse. As in any profession or work group, we have the good and the bad. Usually, the deciding factors can be traced to such influences as the level of the nurse's preparation, individual interests and values, the type of industry, the company policy regarding the health program, and the availability and attitude of the occupational health physician.

The opinions or assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of the Army or Department of Defense.

There are nurses, because of the nature of the industry, who are limited to caring for the stresses of injury or illness, which may include some "emotional first aid." But, generally, there is not time in their day for handling more than the volume of injuries that come to the health clinic. Other nurses have been restricted because the occupational health physician (or the nurse supervisor) takes over all the mental health support activities of the occupational health service. And then, there are nurses who--because of their own lack of preparation, or because of their attitudes toward nursing and people--are afraid or insecure and choose not to be involved in emotional support activities.

At the opposite end of the spectrum are the nurses who become over-involved in providing emotional support. They care too much, to the end that they interfere with the worker's development of his own self support system. However, in one way or another, the majority of occupational health nurses have been involved in assisting employees to cope with occupational stress. This may not always be a clearly defined part of the occupational health nursing program, but it has been an element of occupational health nursing from the beginning.

In 1943, a Public Health Service survey of Nursing Practices in Industry (McGrath, 1946) revealed that in addition to their primary function of nursing treatment and care of occupational and nonoccupational illnesses, in 72% of surveyed plants, occupational health nurses were sought out by workers for counseling and assistance concerning personal or family problems. In 42% of the plants, nurses were concerned with accident control and safety education, including work-site visits to observe workers at their jobs, to followup on health or other problems of workers, and to better understand the causes, symptoms, and prevention of occupational health hazards.

Increasingly, occupational health nurses have become more deeply involved in prevention and control of harmful effects of occupational stressors. They are assuming more independent roles in case finding, in program planning and implementation, and in assisting workers to cope with an ever-widening scope of health problems that affect health and productivity. For example, instead of serving merely as assistant to the physician in the physical examination program, the nurse is taking the health and work history and relating it in a meaningful way to her knowledge of the assignment, its hazards and its physical requirements. She listens and looks for possible problems and alerts the physician to them. Together with the physician, she uses the findings of the examination to counsel and guide the employee to correction of problems and improved health maintenance. Where examinations by a physician are not required, the nurse--in accordance with protocols developed with the physician--conducts the entire health appraisal, both for preplacement or periodic evaluations. Thus, nurses are identifying and taking action to control the effects of both physical and psychosocial stresses to which workers are subjected.

More and more occupational health nurses are getting out into the work environment. For example, some have become skilled in taking certain environmental hazard measurements, such as noise levels and air samples. Primarily, though, they use these visits to keep acquainted with hazards and work situations (including problems of crowding or lighting in offices), to establish and maintain working relationships with supervisors and with employees, to provide on-the-

spot safety education, including education about the prevention and control of health hazards at work, and to respond to requests for counsel or assistance with personal health problems.

In health service support of the sickness absence control program, occupational health nurses are frequently the key health care figure. Through health education and counseling, the nurse encourages employees to obtain indicated medical care or take other health protection actions. She coordinates with personal physicians by providing information about work demands and stresses and the available occupational health service resources, and by providing follow-up care or observation when the individual returns to work. Some industries continue to provide home nursing visits. In others the nurse may coordinate with the physician and the community visiting nurse service to provide this assistance to workers. And, the nurse continues to be a resource to the employee in alleviating his concern about cost and other worries of illness, by advising him about or referring him to available health care benefits and resources.

In the area of mental health, occupational health nurses are becoming more knowledgeable and are providing counseling and referral for alcohol and drug abuse control and other mental health problems. Because the occupational nurse is usually the most visible and the best known health care person, employees will frequently go to the nurse first when they are troubled. Or, because she has come to know them, she will sense that they may be having a problem and will offer her assistance. For example, the wife who calls to ask the nurse to "get after Bill, he won't stick with his ulcer treatment. Maybe he'll listen to you." Because she knows Bill, the occupational health nurse may be able to find out why he's gone off his regimen (or she may know that the workload in his department has peaked) and can encourage him to take the proper actions.

For employees under treatment for mental illness, the nurse may coordinate with the psychiatrist and occupational health physician to provide support to both the patient and the supervisor, when indicated. Or, the nurse may become aware of potential employee relations problems in a department, because of the actions of a supervisor. This presents a different type problem and nursing action will depend on company policy and organization, her relationships with the supervisor and other factors. As a nurse she can counsel with the supervisor and attempt to determine the reasons for the changed behavior, providing assistance as indicated. As a management advisor, she may need to alert the physician or management to the problem so they may take action. In any event, the occupational health nurse must know the extent and limits of her capabilities, company and medical policies, and available resources in determining and implementing nursing interventions.

These are some examples of the expanded role of the occupational health nurse. A glance through the journals, and a review of the rapidly expanding lists of a varied range of short courses being offered occupational health nurses will provide further evidence of their widening interests and concerns. There are various reasons for this. These include changes in nursing practice, per se, evidenced by the revised definition of nursing in state nursing practice acts which provide for the expanded role of the nurse (AJN, 1977); the establishment

of Nurse Practitioners (or Clinicians), and the credentialing of nurses to perform health assessment and manage the care of patients; the increased emphasis in nursing schools on patient evaluation, teaching, interpersonal relationships, and prevention (as well as treatment) of illness and injury; the increasing availability of educational programs relative to occupational health nursing at the undergraduate, graduate, and continuing education levels, and the resultant increased numbers of prepared occupational health nurse leaders and practitioners; the establishment of standards of nursing practice; the potential demands of and for mandatory continuing education related to certification and/or licensure; the pressures of peers, professional organizations, and consumers (labor and management) for high quality nursing care; and the increasing needs of workers for care related to the proliferation of more and previously undreamed of occupational stressors of all types.

The occupational health nurse who considers herself to be a professional has no choice but to become better prepared in order to fulfill the expanded role. This role is well defined in the American Nurses' Association Model Nurse Practice Act. "...Nursing...is a process in which substantial specialized knowledge derived from the biological, physical, and behavioral sciences is applied to the care, treatment, counsel, and health teaching of persons who are experiencing changes in the normal health processes; or who require assistance in the maintenance of health or the management of illness, injury, or infirmity, or the achievement of a dignified death; and such additional acts as are recognized by the nursing profession as proper to be performed by a registered nurse"(AJN, January, 1977).

The report of the Secretary of the Department of Health, Education,and Welfare's Committee on extending the scope of nursing practice further defines the broader functions of nurses (HEW, 1972). The qualified nurse will:

- "Secure and record a health and development history and make a critical evaluation of such records;

- Perform basic physical and psychological assessments and translate the findings into appropriate nursing action;

- Discriminate between normal and abnormal findings on physical and psychosocial assessments;

- Make prospective decisions about treatment in collaboration with physicians;

- Initiate actions and treatments within protocols developed jointly by medical and nursing personnel - such as adjusting medication, ordering and interpreting laboratory tests, and prescribing certain rehabilitative and restorative measures."

What does the occupational health nurse need to meet the demands for quality health care of the workers, to be ready to help them cope with the myriad of occupational stressors they face? She needs "substantial specialized knowledge" in such areas as toxicology; industrial hygiene; occupational diseases; epidemiology: health evaluation/assessment; emergency care; health teaching; safety; business and personnel management; interpersonal relations and communi-

cation skills; labor principles and practices; legal and regulatory aspects of occupational health; program planning, evaluation, and reporting; and nursing administration. The occupational health nurse needs knowledge and competency in these and other areas whether she works in a large or small industry, and whether it is an office or a chemical industry.

Although the depth of knowledge needed may vary, each nurse should be well acquainted with the basic principles and practices of occupational health and adapt them to the company where she works. This, in turn, requires that the nurse be well-informed about the company, its policies, the hazards and their controls, the workers, the resources in the company and in the community, and other essential factors that determine the needs, scope, and capabilities of the occupational health service. Further, she must keep her knowledge and competency current with changing practices and problems.

Equally important is the need for the occupational health nurse to establish collaborative relationships with the occupational health physician (where each respects the capabilities and responsibilities of the other) and to coordinate with management, workers, and others concerned with the health of the employee. Occupational health nursing can never be a static entity unto itself. The nurse is a vital member of a team in a world of ever changing health care needs. As such, she must be ready, willing, and able to contribute fully to the team effort.

To keep this discussion on balance, however, we must keep in mind that this "paragon of virtue" is also faced with her/his own occupational stressors. In fact, the very idea that the occupational health nurse is supposed to be such a paragon is a significant stressor. There is no way that any nurse can have all the skills, all the right answers, all the intuition, all the self control, or all of any of the attributes that would be required for the nurse to function at the 100% level. Yet, for many nurses (and the people they serve) it is not easy to acknowledge that perfection is for machines, not people, and to be realistic about the nurse's strengths and weaknesses. Because most nurses have been trained to be the strong helper, it is not easy for them to seek help when they need it. This may include help in knowing how to do a job, or it may be help in maintaining their own emotional and professional stability. As with anyone else, the nurse needs to feel free to ask for help, to take time not to be so busy with tasks so she can sort things out and get support or feedback on what she is doing or planning.

There are other stressors. The occupational health nurse repeatedly must define for others the role of the occupational nurse. This includes the employee (Why can't you give me a diet for my ulcer?), management (Why do we need a doctor, you know what our employees need?), the physician (Why do you want an otoscope?), the personnel officer (Why are all those goldbricks in your office all the time?), and other nurses and professionals (What a "cushy" job. Eight to five and just waiting for people to come in for a band-aid). One gets weary of trying to answer these questions so the consumer and the co-worker will know and understand the particular aspects of occupational health nursing that make it different from other nursing roles and an important segment of the health care system.

Closely allied with this is the stressor of demands for quality assurance and accountability for nursing care given. The occupational health nurse is accountable to more than one agent and there are conflicts regarding which has priority. My own belief is that the nurse is accountable professionally and personally: first, to herself; second, to her patient (the worker); third, to the profession; and fourth, to the employer. This could put the nurse in a double bind situation that is not easy to resolve, although it might be prevented by clear job definitions and medical-nursing service policies.

Briefly, let me review some of the other,more common, stressors of the occupational health nurse: the isolation of working alone and being separated from peers, sometimes feeling abandoned or ignored; conversely, the anonymity of being on a large staff, just another cog on the wheel with no opportunity or enticement to develop ideas or special skills; the peonage of being the hand maiden of the physician, without any freedom to exercise independent professional judgment; the frustration of inadequate preparation for the job to be done and difficulties in acquiring such preparation; the conflicts of concern for employees and their problems and the limits of the scope and responsibilities of the occupational health service; the frustration of inadequate pay and/or status in the health unit and in the company; restricted career patterns, even on larger staffs; problems related to personal values and trying to avoid being judgmental regarding other peoples' life styles or values; the threat of malpractice; the need to control "helping" instincts so as not to take over the initiative that is the patients or co-worker's; the demand of non-nursing duties and their effect on nursing responsibilities; and, for women nurses, the conflicting demands on time and energy of being a professional working woman and also a homemaker, mother, and spouse.

However, most nurses do manage to cope with their own occupational and personal stressors. In so doing, they become better able to help others learn to cope.

Exciting challenges face the nurse who wants to grow. Some nurses are already experiencing them. Others, who so choose, can be expected to join them in the forseeable future. Increasingly, the occupational health nurse will function as an independent practitioner. When definitive medical (or psychiatric) judgment is required, the nurse will coordinate with the physician. The nurse's emphasis will be on health promotion and maintenance, helping the worker reduce or control the effects of stressors that affect his health and productivity. As stated earlier, the Expanded Nurse Practice Act definition of nursing provides for more autonomous functioning of the nurse. But it also bases this independence on a requirement for specific knowledge. They go hand in hand. With them the caring occupational health nurse can go as far as her initiative and imagination will take her. She will become ever more important as an instrument of change, in accordance with the theme of the 1977 International Council on Nursing.

Bethel McGrath's words of 30 years ago still hold true: "There is nothing easy about industrial nursing...The work is never monotonous. There is endless variety in the daily problems that challenge one's ingenuity. The pace is rapid, stimulating, and most satisfying to nurses who...feel a close relationship to the workers...People are never so alive as when they struggle to earn their

bread and to make their mark in the world. It is good to be able to make one's contribution as a nurse where people live (and work)" (McGrath, 1946).

REFERENCES

Charley, Irene H. The Birth of Industrial Nursing. London: Bailliere, Tindall & Cox, 1954.

McGrath, Bethel J. Nursing in Commerce and Industry. New York: The Commonwealth Fund, New York, 1946.

Whitlock, Olive M., Trasko, J.M., & Kahl, F. Ruth. Nursing Practices in Industry. Washington, D.C.: US Public Health Service, 1944.

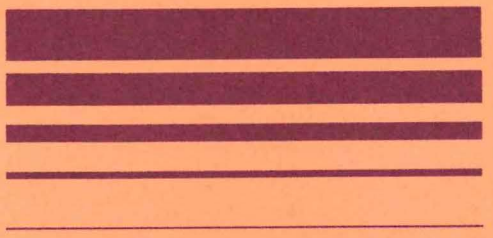
"New ANA Model Practice Act Expands RN, LPN Definitions", American Journal of Nursing, January 1977.

Department of Health, Education, and Welfare. "Extending the Scope of Nursing Practice", A Report of the Secretary's Committee to Study Extended Roles of Nurses. Washington, D.C. 1972.

NIOSH

PROCEEDINGS

Reducing Occupational Stress



U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Center for Disease Control
National Institute for Occupational Safety and Health

REDUCING OCCUPATIONAL STRESS

Proceedings of a Conference
May 10-12, 1977
Westchester Division, New York Hospital-Cornell Medical Center

Sponsored by
Center for Occupational Mental Health, Cornell Medical College
and the
National Institute for Occupational Safety and Health
with the cooperation of
International Committee on Occupational Mental Health
Permanent Commission and International Association on
Occupational Health
World Health Organization
Work In America Institute

Alan McLean, Editor-in-Chief
Gilbert Black and Michael Colligan, Co-Editors

Contract No. 210-77-0041

U.S. DEPARTMENT OF HEALTH, EDUCATION,AND WELFARE
Public Health Service
Center for Disease Control
National Institute for Occupational Safety and Health
Division of Biomedical and Behavioral Science

April, 1978

DISCLAIMER

The contents of this report are reproduced herein as received from the contractor.

The opinions, findings, and conclusions expressed herein are not necessarily those of the National Institute for Occupational Safety and Health, nor does mention of company names or products constitute endorsement by the National Institute for Occupational Safety and Health.

NIOSH Project Officers: Michael Smith
Alexander Cohen

DHEW (NIOSH) Publication No. 78-140