THE PERSON WITH EPILEPSY AT WORK

formulated by
the committee on psychiatry in industry

Group for the Advancement of Psychiatry

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I. INTRODUCTION

Estimates of the number of persons in the United States who suffer from convulsive seizures, commonly called “epilepsy” or “fits” range from 800,000 to 1,500,000. The President’s Committee on the Physically Handicapped states that “Treatment of epilepsy with anti-convulsants results in complete control of seizures in over 50% of cases, a reduction of seizures to the extent that patients may be rehabilitated socially and vocationally in an additional 30% of the cases.” Despite this indication that the majority of epileptics are employable, there is considerable resistance in industry to their employment.

This lag between medical progress and society’s rejection of a person with epilepsy is based on erroneous but long-standing attitudes about the person with seizures. There have always been fears, anxieties and misconceptions concerning individuals subject to sudden loss of consciousness and convulsions. A stigma has been attached to epilepsy for many centuries. Many people have believed the disease is inherited. This contributes to the social stigma of epilepsy. Laws in many states discriminate against the epileptic. It is because of such persistent misconceptions and anxieties that industry rejects many persons or discharges them.

In the light of modern medical advances these attitudes are unrealistic, actually wasteful of human resources, and specifically deprive industry of a sizable group of acceptable workers. In areas of labor shortage and in less popular occupations this potential of man-power supply cannot be profitably overlooked. Quite aside from these realistic gains in employee potential, industry cannot afford not to liberalize its policies toward epileptics. Faced with an applicant who reports having had seizures, the natural tendency of the employment officer is to refuse him. Uncertainty over a greater incidence of accidents, the possible disruption of the work group, and the stigma of the illness all combine to create a barrier against the epileptic. Confronted with a reported seizure of an employee, the most common reaction in industry is to dismiss him. This re-
sponse, too, is understandable when questions of possible injury and compensation problems arise.

For these reasons many individuals subject to any type of seizure feel they have to conceal this fact in order to secure employment. A reaction acquired through the experience of repeated rejections for employment. Certainly the epileptic who tells the truth should not be penalized for it, yet this is often the case. It is obviously better for the employee and for the company to be in possession of all the facts of his handicap. In this way safe placement plans can be carried out based upon the recommendations and treatment of the employee’s own physician and the judgment of the industrial physician. The result of refusing to employ or of indiscriminate firing of epileptics is to force the person who has seizures to conceal his problem. Many are therefore employed without industry’s knowledge and are unwittingly assigned to jobs which are dangerous to themselves and to others. As a result both management and the worker are in a far greater jeopardy than they might be if this problem were handled in keeping with modern medical understanding.

Merely eliminating people who have had seizures prior to the time of hiring, were this possible, would still not be a solution to the problem since seizures can develop after a period of seizure-free employment. Even when a person has not experienced seizures before employment, there are many factors within and without industry which influence the development of such attacks. Head injury, brain tumor, toxic conditions and arteriosclerosis are a few examples of these factors.

Before proceeding with a discussion of industry’s role in the problem it is necessary to define more precisely what is meant by epilepsy.*

II. DEFINITION OF TERMS

There is much confusion and misunderstanding concerning the word “epilepsy.”† This term is rather loosely used to cover a wide variety of sudden interruptions of consciousness with or without accompanying convulsions. These interruptions may be associated with convulsive movements and/or brief disturbances in thought, feeling or behavior. The severity and frequency of seizures varies from individual to individual. In some people seizures are frequent and associated with incidental self-injury. In others they are frequent but are accompanied only by very momentary lapses of consciousness. In some individuals seizures are infrequent and severe. In still others seizures are infrequent and very mild.

These seizures are indicative of a disturbance in the electrochemical activity of the central nervous system. Seizures occasionally occur as a complication of acute physical illness, are usually isolated events and are not expected to recur. The term “epileptic” is ordinarily reserved for people with both a history and future possibility of such interruptions in consciousness. This report is limited to a consideration of these individuals.

Information regarding the actual nature of a seizure does much to dispel the ancient anxiety associated with it. The most severe type of seizure is called a grand mal attack. In this the patient loses consciousness, his muscles become rigid, respiration is interrupted, and he falls if not supported. This is the first phase of the attack, the tonic one, and it is superseded by the second phase, the clonic one. In this the muscular rigidity gives way to a series of jerking movements, sometimes forceful. Breathing is resumed within a minute, and the movements cease of themselves in a period ranging from seconds to a minute. There may be a brief post-convulsive period of confusion, before the patient completely regains his bearings.

There is little for the observer to do but to keep the patient away from objects against which he might accidentally strike and injure himself and, if possible, to keep him from biting his tongue. Much of the superstition and revulsion toward the epileptic has grown up around these violent jerking movements. The patient is unconscious and is experiencing no pain or suffering at the time of seizure. About 50% of patients having grand mal attacks experience an “aura” or warning. This is a subjective experience that varies with each patient but which may give him a premonition of an oncoming attack, so that he may have time to move to a place of safety.

In a milder form of epilepsy, the petit mal attack, convulsions
do not occur, but the unique event is a loss of consciousness. This is temporary and may be so brief that it is unnoticed by people close to the epileptic. In some instances the only observable symptom may be a blinking of the eyes or a sudden facial pallor. In some instances the epileptic becomes slightly rigid but does not have a clonic phase.

Some persons, despite apparently good treatment and medical control, will have a rare third type of attack. This is characterized by an abrupt and radical personality change of brief duration. During these episodes, confusion, suspiciousness, irritability and impulsiveness appear suddenly. After the attack the individual returns to his normal personality. If the employer understands that this is a transient episode he may then deal with it as he might any other acute brief illness by arranging for medical care and allowing the necessary time for recovery. Thus, by being able to accept such an occurrence on rare occasions, an employer may retain the services of a worthwhile employee.

In recent years a variety of new drugs to prevent convulsions has been introduced. Used singly or in combination they are particularly effective in decreasing the frequency of occurrence of seizures. Some drugs are more effective in some individuals than in others and medical experience is necessary to determine which is most suitable in any particular patient.

III. PERSONALITY FACTORS IN EPILEPTICS

Probably the most frequent misconception concerning the epileptic is that he has an inferior intellect. This is a gross error. In point of fact, epileptics vary in their intellectual ratings in the same way as do people without this handicap. In the past many epileptics functioned as if they were of limited mentality. This was due to the fact that the medication then used to control the seizures made them drowsy. With the implementation of the newer drugs the seizures are not only decreased in number but in most instances the unfortunate sedative effects are markedly reduced.

In those cases where seizures arise from injury to or disorder of the brain, the individual may tend to become more rigid and concrete in his thinking. Since as a result of his injury he is less flexible and less able to think abstractly he may compensate by efforts to be overly precise and maintain his surroundings in a well-ordered fashion. He may have difficulty in adjusting to change and complexity. In job placement consideration must be given to these traits. Such individuals can frequently make a satisfactory adjustment in a situation which demands simple, meticulous order and a regular routine.

Many investigations have been conducted in an attempt to describe the personality characteristics of epileptics. Although these researches have been extensive they have not been satisfactory because so many were conducted on epileptics sufficiently handicapped to be institutionalized. As a result, the studies do not present the personality of the epileptic as industry would encounter it, but rather depict only the very seriously ill individuals. As a consequence much misinformation about the “epileptic personality” is prevalent. Review of the studies with a correction for the biased sample on which they were done indicates that the majority of epileptics shows no gross evidence of a peculiar personality or of unusual behavior.

The picture is not, however, always this simple since as with other handicaps, emotional reactions to the handicap may confuse the picture. There is perhaps an additional complicating factor in epilepsy that arises by virtue of its being a concealable condition in the interval between seizures. The epileptic’s handicap is not immediately apparent. Reactions to this existing, but for prolonged periods, hidden disability vary with the personality structure of the individual. For example, a person who is basically optimistic emphasizes in considering his seizure threat its relative infrequency and his normal physical appearance. He strives to assure himself and others that it is not a serious problem. Some of these individuals may not only reject the diagnosis of epilepsy and refuse to go along with a treatment program, but they may also ultimately refuse to have anything to do with the physician. People with this type of reaction are generally unemployable since it is a prerequisite in rehabilitation that the patient must accept his handicap realistically. In general, the epileptic is subject to all of the neurotic traits found in any other group and these traits, when present, must be handled in essentially the same way as in the non-epileptic.

All handicapped persons quite naturally have feelings about being handicapped. A sense of inadequacy and incompleteness often plagues them. Some are driven by these feelings to overcompensate for the loss. Others are left with feelings of resentment
and hostility. More than others who are handicapped, the epileptic suffers from rejection by community and family, discrimination in employment, legal barriers and social ostracism. These severe pressures are sometimes met by reactions on the part of the individual that color his whole personality. With patience and acceptance, such people can be helped to make a satisfactory adjustment to the job.

Observations on the effect of these traits and reactions, on the job performance of epileptics have indicated that they do not provide serious blocks to constructive work. Two leading investigators point out that "the assumption that persons who are subject to sudden loss of consciousness experience more accidents than persons who never lose consciousness is not supported by actuarial experience. On the contrary, the general observation of certain competent persons is that 'the accident rate of epileptics working in all lines of industry does not suggest that they are injured any oftener than anyone else.'" 2

Similar results were found in a study by the United States Department of Labor on the performance of physically impaired workers in manufacturing industries. This investigation compared the work performance of epileptics with the performance of matched unimpaired workers and revealed no significant differences between the two groups. 3

It may well be that the epileptic because of his being handicapped, is actually a more conscientious and steady worker. In this regard a statement made to the British Epileptic Association points out that "it is the universal experience in the industrial rehabilitation unit that, handled with understanding, the epileptic readily settles down to work and can acquit himself as well as the best. Once he realizes that a seizure is not going to cause consternation to anyone, a steady improvement sets in, and the frequency and duration of the seizures diminish. With many, the seizures disappear immediately." 4

IV. EMPLOYMENT PROCEDURES

It is important in interviewing applicants for employment to determine which ones have had seizures, not with a view to their exclusion from the company, but to their adequate placement and care. For this reason, the details of seizure patterns will not be adequately elicited by a straightforward question in the medical history such as "Have you had a seizure?" More accurate information may be obtained by a question such as "Give the approximate age at which you have had any of the following: convulsions, fits, dizzy spells, blackouts, seizures or fainting spells?" There are probably other expressions used in particular localities but with similar meaning. It must be kept in mind that sometimes these terms are used to describe symptoms other than epilepsy. It is essential, of course, that further investigation of such symptoms be processed through or undertaken by the medical consultant. In order to facilitate placement and treatment, it is desirable for the plant physician to have a report from the applicant's own physician giving such data as date of onset, cause if known, type of attacks, frequency, severity, treatment used, response to treatment and date of last seizure.

Decisions concerning the employment and placement of individuals with convulsive disorders involve medical matters and should be made with the full appraisal of all the facts in each individual case. When medical examination is a standard practice, all cases of this nature should be referred to the company medical consultant who can then assume the responsibility for the decisions taken.

It is inevitable that a certain number of employees will develop seizures for the first time after they have been hired. Since the cause in such instances can be related to a number of factors, both personal and job-related, it is of vital importance to refer such an individual for a complete medical examination. This is particularly true of older individuals who have no previous history of seizures, where the first convulsion may be the signal of such organic conditions as brain tumor or other nervous system illness. Seizures may also develop following a head injury. In all such situations it is essential that there be complete co-operation between employee, employer, plant physician and the private physician.

V. EPILEPSY AND COMPENSATION LAWS

Some employers feel that they should not hire epileptics because this would inevitably result in an increase in the workmen's compensation costs. This, as we have seen, is based upon the view that the epileptics in industry have more accidents. Studies to date do not confirm this. In fact they contend that there are no significant
differences between the accident rates for epileptics, if properly placed, and others. There is need, however, for some modification of the workmen’s compensation laws which would render the employer exempt from liability for an injury involving the epileptic or others as a result of seizures.

The compensation problems involved in hiring handicapped people have been met by what is known as “Second Injury Funds”. An injury resulting in the loss of one part of the body such as an arm or a leg results in permanent and partial disability. A second such loss to the same person results in permanent and total disability. Clearly, the workmen’s compensation settlement in the latter is considerably greater than in the former. The “Second Injury Fund” pays the employer the difference between these two amounts and thus encourages him to employ handicapped people because the costs are shared. That is, the handicapped individual who reports for work initially is already presumed to be permanently, partially disabled. The difficulty is that in all states except New York, the Second Injury Fund is inapplicable to epileptics. In their recently published book on this subject, Fabing and Barrow point out that “Second Injury Funds are inapplicable to epileptics because in 25 states the first injury must have been the loss of a member, as an eye, hand, or foot; in 35 states the combined effect of the first and the second injuries must meet the test of total and permanent disability; and in several states the pre-existing disability must have been compensable under a Workmen’s Compensation Law in order for the second injury to be covered by the Second Injury Fund”.

It is recommended, then, that workmen’s compensation laws be amended so that the Second Injury Fund would serve to protect employers from injuries to or by epileptics resulting from the epileptic condition. It is not suggested that this would result in solving all the problems epileptics now encounter in obtaining employment, but it would remove the grounds for refusing to hire them because of the costs of possible injuries.

VI. PLACEMENT

Epileptics, like other people, vary and therefore a “blanket policy” is ineffective. The type of epilepsy, the seizure pattern, the presence or absence of an “aura”, the time of day at which the attacks may occur, all these and many more factors vary greatly from one individual to another so that it is impossible to generalize freely concerning the rules of placement of the epileptic.

However, there are some relevant general considerations. The aim is to protect the epileptic from hazardous situations where he may injure himself or others or damage equipment. Common types of environmental hazards are moving machinery, open electrical circuits, working at heights, and driving. Seizures may be precipitated by a wide variety of noxious substances. The most common protective policy has been the assigning of employees to jobs that are relatively free from hazard.

Usually, the work assignment is made on the basis of the employee’s condition. It would be inadvisable for a person whose seizures have not been brought under control, to engage in such activities as climbing or driving. The placement of an epileptic who has only occasional seizures, all of them during his sleep, would generally present no particular difficulty. He could work at heights and under hazardous conditions.

In arriving at decisions regarding individual placement the period of trial employment becomes more important for the epileptic than for other handicapped employees. When considering the employment of a person with seizures such a probationary period offers opportunity for realistically evaluating the potential contributions the epileptic may be able to make to the company.

One occasional problem is the effect that a seizure has on other workers. Many find this a disturbing experience with a resultant loss of an indeterminate amount of time and effective attention to the job at hand.

It is important to realize that the epileptic has the same assets and abilities as others and that his awareness of the fact that he is handicapped may result in his being a conscientious, careful and meticulous worker. In placing the epileptic, the thinking of those responsible should not be negatively expressed in terms entirely of the epileptic’s liabilities; these may be overstressed, especially if many restrictions are considered on the basis of rather sweeping generalizations.

VII. THE FUNCTION OF THE PLANT PHYSICIAN

The industrial physician has the responsibility first of diagnosing the limitations and assets of each patient. This is facilitated by
the maintenance of close liaison with the family physician and consultants. The next task of the industrial physician is the acquisition of thorough knowledge of the working conditions for each job. He then has the responsibility of suggesting to the Personnel Department the restrictions which may be required in the hiring, placement and transfer of these employees. Personnel workers then have the responsibility of the specific steps in the placement and transfer of these employees.

In addition to these functions the plant physician must also be responsible for the instruction of personnel who may come in contact with the epileptic. This group includes supervisors, the epileptic’s co-workers and first-aid personnel. Emphasis in this instruction should be on the care of the worker during a convulsion and on appropriate, healthy behavior of those witnessing a convulsion. It is hoped that the latter task has been accomplished by educational, preventive measures. The care of a worker during a convulsion is, as noted above, largely one of injury prevention. It can be delegated to an emotionally mature person after a brief amount of instruction.

These tasks are those that ordinarily fall within the scope of activity of industrial physicians and are not, in general, any more demanding than their numerous other duties. The chief difficulty that industry encounters in this connection arises in small plants in which there is no resident physician. In such situations industry has as an alternative, the employing or maintaining in immediate accessibility someone trained in the handling of a post-seizure patient. This need not be a physician but can be a first-aid worker or nurse whose knowledge is sufficiently extensive to recognize a condition which is serious enough to warrant calling a physician. In the vast majority of seizures no such step is necessary.

There is very great need for a significant change in the general attitude toward the epileptic and his problems. This arises not only from a humane orientation toward the epileptic but from society’s need to utilize the contributions that these people can make. Longstanding prejudices and beliefs must give way to a fresh, more realistic outlook compatible with the increased skill and knowledge in managing epilepsy. In these matters, the industrial physician can play a decisive role in working out methods of achieving a change of attitude that can benefit both industry and the epileptic.

VIII. CONCLUSIONS

1. The degree of handicap involved in the epileptic has been overrated by industry and society in general, in that this attitude has not kept pace with the newer advances in medical treatment of epilepsy.

2. The psychological and social problems of the epileptic do not present a major barrier to his profitable employment by industry.

3. The medically controlled epileptic can be an able, conscientious worker.

4. The Workmen’s Compensation laws should be revised so that the second injury clause is applicable to epileptics.

5. The people who work with the epileptic should be given the salient points about epilepsy by the plant physician.

6. It should be re-emphasized that the employment and placement must be governed by the facts in each individual case; not by blind prejudices, unscientific sentiments, or sweeping generalizations.

REFERENCES

1. Performance (April 1954, p.9) published by The President’s Committee on Employment of the Physically Handicapped.

2. The Employment of Epileptics, by Lennox, W. G. and Cobb, S. p.17. Published by The National League of Epilepsy, Chicago.


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