THE MEANING OF EMPLOYEE HEALTH IN THE BUSINESS CONTEXT:

A NARRATIVE INQUIRY WITH HUMAN RESOURCES PROFESSIONALS

by

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ABSTRACT

Illness arising out of the course of employment is the cause of a great deal of human suffering world wide. It represents significant costs for individuals, organizations and society, yet is not the primary focus of business. Human resource professionals are traditionally charged with the responsibility of employee health risk management, however little is known about the meanings human resource professionals ascribe to employee health in the business context.

In this qualitative study, narrative inquiry was used to explore the meaning of employee health among human resource professionals in the business context. Nine human resources professionals, from a range of industry sectors, participated in in-depth interviews for this research. Data analysis of the interviews involved explorations of content themes and the structure of the human resource professionals' stories. The study findings provide important insight into human resource professionals' struggles with ensuring employee access to health services, accessing medical information and managing issues related to employee stress.

Two narratives emerged from this study: "Providing a Toolbox of Supports" and "Fulfilling the Prophesy". In the first narrative, human resource professionals detailed their efforts to draw from their "toolbox" to support employees who were perceived as good workers, trustworthy and well-liked in the organization. In the second narrative, the participants described employees who had performance problems, were not trustworthy and were not forthcoming with information related to their illness. The sub-narrative of "Responsibility" recurred throughout the stories; participants felt responsibility to help their employees while at the same time protecting the employer's bottom-line.

The findings of the study have implications for education, practice and research in both the health and business sectors, as well as for employees. Understanding the meanings human resource professionals give to employee health problems makes clear the need for collaboration between health and business in caring for patients who are also workers.

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CHAPTER FIVE: DISCUSSION AND IMPLICATIONS

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CHAPTER ONE: INTRODUCTION

This thesis describes a narrative inquiry intended to elucidate the meaning of employee health in the business context. This first chapter provides the background to the study.

Background to the Problem

Illness arising out of the course of employment is the cause of a great deal of human suffering world wide (World Health Organization, 1999a, 1999b, 2002). This situation is complicated because employee health is not a primary focus of business. While businesses need their human capital resources to function well and be productive, maintenance of the health of their human resources is most often viewed as peripheral to their profit mandate (Bates, 2001; Littman, 1998). Traditionally, health maintenance in the business world has been largely viewed as the individual worker's responsibility, based on the presumption that the worker is the source of the problem (Bliese & Jex, 1999; Gilbert, 1994; Trudeau, Deitz, & Cook, 2002).

Human resource professionals (HRPs) within the framework of traditional organizational culture are charged with the responsibility for employee health risk management (Baur, 1999). Employee health is perceived as peripheral to other roles within the organization. A review of business risk management association websites and educational programs reveal a primary focus on financial risk management. HRPs are responsible for managing the risks associated with employee health but are not educationally prepared to understand either the etiology or management of employee health issues (Tomlinson, 2002). The traditional approach to employee health by HRPs has been largely administrative, centering on compliance with legislation, performance-

based absenteeism management and administering agreements with health and psychological service providers, such as Employee Assistance Programs (EAPs). In Canada, provincial Workers' Compensation (WC) legislation is intended to safeguard the health and safety of Canadian workers. These regulations provide penalties and incentives designed to ensure that businesses attend to protecting workers safety. In practice, these health and safety regulations place the focus on safety rather than health.

Not surprisingly considering their unique administrative role in relation to health, HRPs express frustration with employee health issues that require extensive paperwork. One revealed her frustration with this aspect of her role when she explained that employee health issues are "just not sexy". She stated that she does not find the employee health component of her role enjoyable or intriguing. She further explained that the employee health mandate places HRPs at the periphery of business management culture, working at the fringes of the business' core purpose.

How HRPs understand and allocate meaning to employee is important to understand because research has clearly demonstrated that workplace and organizational factors are significant determinants of health in working populations (Bosma, Peter, Siegrist & Marmot, 1998; Bosma, Stansfield & Marmot, 1998; Pelletier, Rodenberg, Vinther, Chikamoto, King & Farquhar, 1999; Sparks, Faragher & Cooper, 2001; Stansfield, Fuhrer, Shipley & Marmot, 1999; Stansfield, Rael, Head, Shipley, & Marmot, 1997). HRPs are the main decision makers on issues of employee health within organizations (Baur, 1999). As such, their understanding of employee health will affect their decisions about employee health issues and these decisions have significant impact on the lives and health of workers.

Purpose and Research Question

The purpose of this thesis was to achieve a greater understanding of the business perspective on employee health. The research question that guided this research was:

What is the meaning of employee health for human resources professionals?

For the purposes of this study, "employee health" was whatever the participants defined it to be in their stories.

Significance of the Study

The issue of employee health has particular significance in the Canadian context. There are a significant number of injuries and illnesses that arise out of business decisions and organizational factors that are not covered under Workers Compensation programs. The health care costs that result are paid for by the publicly funded health care system in Canada and can represent a significant cost to Canada's already burdened health care system. When businesses fail to attend to the health of their employees, they also erode the human capital of Canadian society.

Health care professionals can contribute to efforts to empower businesses to be socially responsible by helping HRPs make decisions supportive of employee health. Health professionals can communicate this message to HRPs if they use language that is compatible with and reflects their understanding of the concept. By understanding employee health through the eyes of the organizational decision makers, health professionals working within business contexts will be better able to target interventions to fit the organizational structure and culture, thus promoting optimal benefit for the health of workers. The research described in this report will contribute to this aim by articulating the meaning of employee health by HRPs and by providing direction for

future collaboration between the health and business sectors to promote and protect workers' health.

Organization of Thesis

This chapter served as an introduction to the research study. I outlined the background, purpose and research question and described the significance of the research. Chapter Two will consist of a review of both health and business-based literature pertaining to employee health. In Chapter Three, I will outline the research design, including the research method, setting, and sample, as well as the procedures for both data collection and analysis. I will also explore issues of rigor, ethical considerations and limitations of the research. The plan for dissemination of the findings is provided at the conclusion of Chapter Three. In Chapter Four, I identify the central narratives provided by the HRPs about employee health. I will provide quotes and detailed findings to clarify and expand upon the meaning of these narratives. In Chapter Five, I will provide a brief overview of the research design and findings. I will also discuss how the research findings reflect and contradict relevant literature in the field. In the conclusion of the thesis, I will identify the implications of the research findings for nursing practice and research.

CHAPTER TWO: LITERATURE REVIEW

This chapter is organized into seven sections: 1) resources accessed for the review, 2) how work affects health, 3) the impact of employee health at the individual, organizational and societal levels, 4) current business approach to employee health, 5) human resources preparation to deal with employee health, 6) why this research is important, and 7) summary of the review. This review of the literature will provide further background to the study, as well as a critique of the current knowledge base related to employee health and human resources experience.

Resources Accessed For Literature Review

In my effort to identify literature relevant to this study, I accessed a broad range of health and business resources, including the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, Business and Industry, PsychInfo, and ABI/Inform databases. I also accessed the catalogue of the University of British Columbia library website for other relevant print media. The search terms "employee health", "workplace health", "human resources", "human capital", "wellness" "education", and "workplace stress" were used alone and in combination in the search of computerized databases. I also accessed websites of organizations related to health and safety, human resources, including educational institutions and regulatory agencies, for this review. Both research and non-research based information is included in this review because much that is written on this topic is anecdotal or theoretical, rather than empirical.

The literature review begins with research and theoretical literature that relate to the phenomenon of interest; i.e., what is known or believed about how work affects

health, the impact of employee health beyond the individual, HRPs' preparation to deal with employee health, and the current business approach to employee health. The review of this body of relevant literature will reveal that the effects of employee health extend beyond the individual employee to the organization and society at large. It will expose the field of human resources as lacking consistent standards in both the implementation of employee health practices by HRPs and educational preparation of HRPs to deal with employee health.

How Work Affects Health

According to several authors, work can affect an employee's health in a number of ways. Safety is perhaps the aspect of employee health that is the primary focus of this body of literature. Health issues that do not fall under the safety rubric, such as wellness, primary prevention and aspects or work-related stress, are a lesser focus in employee health literature.

Safety

The safety component of work health pertains to eliminating exposure to hazards in the workplace that can lead to injury, illness or death. In the occupational health field, workplace safety hazards are commonly classified into the following categories: biological/infectious, chemical, environmental/mechanical, physical, and psychosocial (Rogers, 1994). In Canada, regulatory frameworks protect the health of workers through requiring workplace safety standards. Provincial Workers Compensation (WC) legislation regulates employer responsibilities to ensure the safety of their employees and assesses penalties for lack of compliance with the legislation. In spite of these safety regulations, the Canadian Fitness and Lifestyle Research Institute (CFLRI, 1998) reports

that "as many as 86% of employees report being either somewhat or very concerned with the physical work environment" (p. 2). As is evident in the following sections, a subjective, perceived threat to health status is as important in determining health outcomes as any objectively measurable threat can be.

Stress

The World Health Organization (2002) expresses serious concerns about the health effects of precarious employment. When the health of employees is threatened by insufficient training, economic pressures and unsafe or stressful working conditions, illness and accidents are inevitable (Sparks et al., 2001). Probst and Brubaker (2001) note "the spectre of losing one's job as a result of corporate restructuring... or organizational downsizing" (p. 139) can foster employees' perception that their job is not secure, even in the absence of objective evidence confirming a risk. These researchers found increased absenteeism due to illness and higher levels of workplace among employees who reported high perceptions of job insecurity.

Overwork is another factor that can affect employee health. Marlowe (2002) notes that work can become hazardous to employee health when employers push worker productivity past the workers' limits. This push is often manifested in overtime hours and pressure to do more work in less time, creating the conditions for stress. Such psychological stress and overwork are strongly associated with employee health effects including sleep disturbance, depression and elevated risk for cardiovascular disease (World Health Organization, 1999a). Lynch (2001) indicates that men who did not take their annual vacations were more likely to die from coronary heart disease than men who were sedentary or men who smoked.

It is not only amount of work done or time spent at work that can create ill health. In Flower's (1997) interview with Dr. Fraser Mustard, Mustard explains that it is the structure of work and the degree of control a worker has over their work that are important determinants of health and longevity. Likewise, Stansfield and colleagues (1999) found that high job demands and imbalance in the effort-reward ratio resulted in increased worker risk for psychiatric disorders. They emphasize, however, that social support and job control (autonomy) may actually protect some workers from psychiatric illness (Stansfield et al., 1999: Stansfield et al., 1997). Marion, Hertzman and Ostrey (1996) reviewed 56 studies "on the relationship between (workplace) stressors and moderators and (coronary heart disease) morbidity and mortality and (coronary heart disease) risk factors" (p. 4). Their review indicated that psychosocial job strain was consistently associated with coronary heart disease. Low job control is strongly associated with new coronary heart disease, regardless of personal characteristics (Bosma, Peter, et al., 1998; Bosma, Stansfield and Marmot, 1998).

Authors of work-related stress literature outline several models to explain how the psychological strain of work can negatively affect health. The early literature in this field in the 1970s focused on the individual worker's response to external job factors. Research in this field in the 1990s focused on subjective perception of job factors and then in later years, began to include the examination of the role of cultural and contextual factors in explaining work related stress. In 1974, French, Rogers and Cobb developed the Person-Environment Fit (P-E Fit) model that accounted for subjective factors in the experience of job strain. In this model, job strain is related to the relative fit or mismatch between the individual's perception of the psychosocial working conditions and their

own perception of their ability to deal with them. In 1979, Karasek postulated what has become known as the Job Demand-Control (JDC) model of occupational stress. According to Karasek, the work load (job demands) and the worker's ability to control aspects of their work (job control) combine to predict the amount of work related strain an employee will experience. When work conditions result in high strain (high demands-low control), psychological and physical illness are expected. He stated that jobs where employees have little input into decisions are problematic no matter what level of demand. Karasek found that those employees in passive jobs (low demand-low control) were largely dissatisfied. Those in active jobs (high demand-high control) had lower rates of depression and found satisfaction in their work. This pioneer work indicated that organizations could mitigate employee health problems by increasing employee influence in decisions that affect their work.

Johnson and Hall (1988) expanded this seminal work in their recognition of social support as an important factor in job related strain. They modified Karasek's JDC model, and developed the Job Demand-Control-Support (JDCS) model (van der Doef & Maes, 1999). Marion and colleagues (1996) note that the JDC and the JDCS models are the most well-validated in the epidemiological literature on psychosocial job strain. Other researchers have identified specific influences within the JDC and JDCS models and elaborated on contextual factors that impact employee response to job stress. Bliese and Castro (2000) contend that when employees clearly understand their role in their job (role clarity), the negative effects of high workload are ameliorated in groups with support from leadership.

It is clear from the relevant research that employee perception of job stressors is a critical factor in workplace stress. Marion and colleagues (1996) assert that "objective work conditions (are) much less relevant than... subjective perception of these" (p. 1). Ettner and Grzywacz (2001) asked workers to rate the impact of their work on their psychological and physical health. Their findings were that "workers who had higher levels of perceived constraints and neuroticism, worked nights or overtime, or reported serious ongoing stress at work or higher job pressure reported more negative effects" (p. 101) of their work on their health.

Recent literature, such as the Culture-Work-Health model of work stress presented by Peterson and Wilson (2002), conceptualizes the problem of the effects of work on health "as much a managerial and business concern as a health concern" (p. 16). These authors suggest that researchers should "focus on organizational culture as a primary preventive element in work stress" (p. 23). Peterson (1997) and Bliese and Jex (1999) recommend that the historical focus on analysis of individual responsibility and health behaviours be balanced with an examination of the workplace culture, and its effect on employee health. Peterson (1997) recommends that "research... be directed toward an understanding of management's influence on health" (p. 250).

The Impact of Employee Health beyond the Individual

The effects of employee health are more far-reaching than those that affect the individual employee. Researchers and other authors point to the effects of employee health on the organization, and on society at large.

Organization

Health problems of workers affect business organizations in a number of ways. The payments to be made for Workers Compensation (WC), short and long.term disability, and health care benefits are direct costs resulting from poor employee health. According to Tomlinson (2002), providing mental health support and intervention to employees cost nearly 14 percent of the net annual profits of companies... $14 billion (CDN) per year" (p. 7). Indirect costs, such as absenteeism and decreased productivity, are also significant.

There is a significant body of research in which researchers explicate how organizational factors, as determinants of employee health, affect business. In Dr. Fraser Mustard's interview with Flower (1997), Dr. Mustard illustrates this with a comparison of absence rates at two automobile manufacturing plants in Ontario. General Motors (GM) has a traditional top-down organizational structure and Honda has a co-operative model that gives employees input into the work processes. GM has 10% employee absenteeism rate due to sickness on any day, compared with an only 2% rate of sickness absenteeism at the Honda plant (Flower, 1997). Employee retention is a related problem for business. Thirteen percent of the participants in a study conducted by Harper, Mullin, Merz, and Tarazi (2001) cited health concerns related to work as the reason they changed jobs.

Society

Human capital is defined as "productive investments in humans, including their skills and health, which are the outcomes of education, health care, and on-the-job training" (Zidan, 2001, p. 437). Human capital is integral to the economic development

of a nation (Zidan, 2001). Measured internationally as the Human Development Index (HDI), national competitiveness depends on the knowledge and longevity of their population, as well as Gross Domestic Product (GDP). Society invests in the health and education of its people, expecting to reap a dividend that will support the economic viability of the nation (Zidan, 2001). Business practices that erode employee health not only erode the productivity, profitability and competitive advantage of the organization, but also that of the nation. Business practices that contribute to poor employee health, burden what politicians assert to be an already overburdened publicly funded health care system in Canada (British Columbia Ministry of Health Planning, 2002). In fact, according to the World Health Organization (1999), "health care expenditures are nearly 50% greater for workers who report high levels of stress at work" (p. 3).

Nursing is an example of a working group whose ill health can affect the public. Studies show that patients suffer when nurses experience work-related stress and poor working conditions. According to the Institute for Work and Health (2001) in conjunction with the Canadian Health Services Research Foundation, the Ontario Ministry of Health and Long-Term Care, and the Nursing Policy Office of the Policy and Consultation Branch of Health Canada, nurses have the highest absenteeism due to illness and injury among the major occupations in Canada. The authors of this report acknowledge that this situation could ultimately affect the quality of health care received by Canadians.

Preparation of HRPs for Employee Health

There is a lack of educational standards in the human resources industry. In Canada, there are no minimum standards required for an HRP to practice. HRPs have the

option to participate in a certification program resulting in a Certified Human Resources Professional (CHRP) designation through the Canadian Council of Human Resources Associations. Cohen (2001) indicates that certification in the HR field has experienced a "gradual building of interest and respect... (and has a) promising future" (p. 296). Some voluntary provincial and territorial associations exist in Canada to provide opportunities for networking, education and support within the HRP community. However, Simmonds, Dawdley, Ritchie and Anthony (2001) found that managers acquire knowledge "principally through experience" (p. 360), with direct education being the least common method of knowledge acquisition. Bates (2001) found that "the top HR executive at... one-fourth of large U.S. businesses started the job with no HR experience" (p. 34). One executive explained that putting a strong business person in the HR role, even without HR experience, was "recognition by companies of the critical importance of the HR function to the success of... organizations" (p. 37). This seems to indicate a lack of respect for the unique skills and abilities required to manage the human aspect of organizations. Bates (2001) notes that some business executives may see human resources as "not contributing to- or... standing in the way of- corporate financial goals" (p. 36).

The substantive knowledge underpinning HRPs' practice consists of theory and knowledge in the fields of Human Development derived from psychology and education and Human Capital from the disciplines of economics and management (Swanson, 1990). Health knowledge is noticeably absent. Several Canadian business schools offer programs in Human Resource Management. The Joseph L. Rotman School of Management at the University of Toronto is a typical example of this type of program.

The curricula of these programs are predicated on business theory and regulatory compliance. Any substantive content related to employee health is not clearly represented in these curricula. Several authors discuss the economic potential and business rationale for investing in employee training (Zidan, 2001), yet few mention the importance of including employee health in this education.

The concern about the effects of inadequate education about employee health for HRPs has been echoed by Sleezer and Kunneman (2001). They discuss the difficulties HRPs face in "differentiating between effective and ineffective (human resources) products" (p. 210). They call for increased utilization of research findings in assessing the effectiveness and suitability of a product or service. Health promotion and wellness programs are often sold to HRPs by service providers. HRPs may not understand the complex factors contributing to employee health problems and therefore purchase a product or service promised to 'solve' the problem for them without an understanding of the complexity of the issues that these are supposed to address.

As is evident from the preceding paragraphs, HRPs have difficulty identifying and managing workplace health issues. HRPs who focus on employee health issues may not always be accepted by their peers as true partners within the business culture (Green, 2002), since according to the World Health Organization (1999b), some employers would prefer "to deny or reduce their liability for" (p. 2) health issues related to work. In the following section, I will outline how, as a result of these conditions, the establishment of effective employee health practices can be difficult for business.

Current Business Approach to Employee Health

In efforts to manage employee health, employer based health promotion and wellness programs are becoming popular (Leonard, 2001). Wellness initiatives in workplaces promise the reduction of absenteeism and increased productivity through health promotion programs such as fitness and nutrition. The theory that supports these initiatives is that by increasing the overall health status of workers through health promotion programs, employers can control costs associated with employee ill health (Downey, 2001; Littman, 1998; Szalai, 1998). In Health Canada's Adult Health website (www.adulthealth.com), a Workplace Health page identifies resources for employers interested in influencing employee health. These resources focus on both wellness and organizational based information. Wellness programs, however, do not address the interaction between work and health and should not be the prime focus of corporate resource allocation.

Employee Assistance Programs (EAPs) are an example of employee health-related organizational initiatives. These programs are usually sponsored by employers and are "designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal problems" (Gilbert, 1994). The EAP provider intervenes in the individual employee's personal problems, presumed to be the seat of the performance problem. The success of the program is evaluated on the basis of the employee's job performance (Gilbert, 1994). A critical shortcoming of the EAP trend is that there is rarely feedback and assistance to the organization to clarify how the organization itself may be contributing to the employee health or performance problem.

Researchers have found significant correlation between utilization of worksite health promotion programs and decreased health care costs and absenteeism rates and increased productivity (Trudeau, Deitz and Cook, 2002). However, it is not clear if those who participate in health promotion activities would do so whether they were offered through work or not.

Johnson (2000) found that supervisors perceived aspects of organizational culture more positively than non-supervisory employees. Since employee perception of factors, such as work environment, plays a role in health status looking at the employee health issue from the point of view of the supervisory personnel is worthwhile.

Summary

In summary, businesses do not tend to focus on the aspects of employee health that are determined by their own workplace factors. Instead, safety and wellness are the primary foci. A lack of education and understanding related to workplace determinants of employee health (beyond safety) among HRPs likely plays a role in business decisions to invest in wellness programs rather than working on internal factors having a deleterious effect on the workforce. Factors such as job insecurity, work organization, work demand, job control, leadership support, and employee's subjective perception of factors play significant predictive roles in employee health outcomes. The findings summarized in this literature review have significant implications for HRPs' practice. The focus of HRP practice could be on positively influencing employee reactions to and perceptions of workplace factors, rather than on the administration of externally resourced services. By shifting the focus from the individual employee as the source of employee health

problems and moving beyond physical safety issues, organizational decision makers can play a key role in the complex employee health puzzle.

It is apparent in this review of related literature that little is known about the experience of HRPs in relation to employee health issues. Since HRPs are the organizational decision makers with respect to health, understanding their experience and understanding of employee health is important.

CHAPTER THREE: METHODS

In the preceding chapter, it became evident that there is a strong relationship between workplace factors and employee health effects. What is missing from the available literature is an understanding of HRPs' experiences with employee health. I have chosen to use narrative inquiry methods to explore this aspect of employee health. In this chapter, I will describe the research approach and the setting, providing rationale for these choices. I will explain my strategies for sampling, data collection and data analysis. Finally, I will discuss the ethical considerations and limitations of this research, ending with a summary of the chapter.

Research Approach

I used the narrative inquiry approach to explore the meanings HRPs give to their experiences with employee health situations. The narrative inquiry approach facilitates understanding of experiences from the insider or, emic point of view, central to qualitative research (Morse and Field, 1995). In order to gain insight into another's subjective experience, qualitative researchers focus on hearing the 'voice' of the participant. This involves hearing the implicit meanings they bring to the aspect of their life being explored. Participants in narrative inquiry express their social reality through their choice of words, expression and context. The careful analysis of linguistic and structural components of narratives can provide a window onto the world of the participant (Mishler, 1986).

It is important to note that the researcher in narrative inquiry cannot understand the true subjective experience of the participant. The language used in the telling of narratives holds clues to reality and meaning for the teller. The researcher does well to be

open to and attend to those clues. These hints are then pieced together through induction to make sense of the reality the participant intended to communicate.

Mishler (1986) argues that the discourse or narrative "is jointly constructed by interviewer and respondent" (p. 52). The interview is seen as a reciprocal process where both the researcher and participant contribute to the data or story through their reactions to each other. As a result of this interaction, the researchers may be able to identify aspects of themselves in the narrative.

Rocco (2001) views the study of stories as "an appropriate method to uncover norms, values and other elements of an organizational culture" (p. 241). The narrative inquiry method is well-suited to the HRP population since features of organizational culture are often perpetuated through the telling of stories (Meyer, 1995). The research entailed an "interpretive approach, seeking to identify the meanings and symbolism of stories" (Gabriel, 1998, p. 138) for HRPs as members of cultural organizations. Narratives can reveal how HRPs perceive their professional identity (Lieblich, Tuval-Mashiach and Zilber, 1998).

Sampling and Recruitment

The participants were nine HRPs who had decision-making authority in their organization with respect to employee health. The following demographic information was collected from study participants before beginning their initial interview. Seven of the nine participants were HRPs. One was a human resources generalist, one was a senior benefits analyst, one was the Vice President of human resources for the firm, two were human resource co-ordinators, and the other two were managers. Two participants had earned human resource certification in a voluntary national certification program. Two

participants were comptrollers who had been charged with the human resource duties in the absence of dedicated HRPs in their organization. Participants had from 3-15 years experience working in a human resource role. They worked in retail, high tech, food service, recreation, financial, energy, and design industries. The employing organizations had from 30 to 10,000 employees. Three of these companies employed less than 200 workers and the other six employed over 800 workers. All but three of the HRPs' companies had variability in their workforces, meaning that some of their employees were seasonal, contract workers or spread over international or inter-provincial sites. The participants worked in British Columbia (5), Ontario (2), Alberta (1), and Quebec (1). All but one of the participants was female. None of the participants had ever performed work related to health care or worked in the health care industry.

The sample size was guided by the data collected. As the interviews were conducted, the stories from each interview were reviewed in relation to those already collected. Once interviews revealed no new storylines, the sample was considered to have reached the point of saturation and no more participant interviews were conducted. In the narrative inquiry approach, the emergence of common storylines indicates an adequate sample size (Leiblich et al. 1998).

The titles and roles of each participant varied as a reflection of their unique position within their particular organization. For example, in one company the HRP responsible for employee health decision-making was a Vice-President. In another company, there was only one person responsible for human resources and that person assumed additional areas of responsibility. I chose to interview HRPs working in the private, for-profit sector; HRPs employed by businesses engaged in profit are likely to

have a particular set of values and motives that may not be shared by the non-profit sector. Along the same lines, Rocco (2001) argues "that non-profit executives represent a managerial culture" (p. 242) that is unique.

The HRPs who participated in the study worked for a company employing more than 20 employees. This excluded HRPs working in firms that the British Columbia WCB defines as "small businesses". The management dynamic and the resources available to manage employee health issues are different in small and big business. On a practical level, many small businesses are unlikely to employ a dedicated HRP with decision making authority with respect to employee health. My intention was to explore the experiences of business professionals who are not professionally familiar with health issues. For this reason, I also excluded any HRPs employed in businesses within the health sector; that is, any business providing a health-related product or service. Similarly, the study participants worked in settings that did not employ an in-house health professional to help with employee health issues.

Recruitment of participants began following ethical approval from the University Behavioural Research Ethics Board. I purposively sampled the HRP community in the Vancouver area. As new storylines emerged from the data, I recruited participants who could provide data that expanded the understanding of those storylines. An effort was made to attract participants from diverse industry sectors and from other provinces, in an effort to ensure that I captured the breadth of HRP experience with employee health. Their stories brought subtleties to the stories I had already collected; presenting them through another window. The initial participants were recruited through a notice distributed through various HRP associations (see Appendix A). When participants were

selected for the study, I asked each participant to refer other HRPs they knew who had had significant experiences with employee health and who met the selections criteria; i.e., the snowball technique of sampling. This sampling method allowed me to use the expert knowledge within the HRP community to add richness to the data I collected.

Description of the Setting

The interviews were conducted at the time and location chosen by the participants. This was most often in their workplace and the interview space was quiet and free from interruptions. When possible, the interview was scheduled when the HRP was assured of a free block of time of at least one hour to ensure that we did not run out of time or feel rushed.

Data Collection

I explored HRPs' understanding and subjective experience regarding employee health through the stories they told (Lieblich et al, 1998). The tape-recorded interviews were conducted with individual HRPs and lasted from forty-five minutes to one hour. Five participants lived or worked in the Greater Vancouver area and their interviews were conducted in-person. Two of these in-person interviews took place in local restaurants, two in the participant's office and one in the participant's home. The remaining interviews took place over the telephone because the HRP did not live or work in British Columbia. The nonverbal aspects of telephone interviews were obviously not accessible. In one case, it became apparent to me by shuffling noises in the background and the change in the participants' manner of speech (from open and conversational to business-like and confined to factual details) that another person had joined the participant in her office just as we were ending the telephone interview. The pace and

tone of her answers changed to indicate that we should be "wrapping up". As she hung up the phone, she was saying "that was that UBC…". She was presumably explaining to another that she had just been participating in an interview with a UBC graduate student. I provided a brief introduction to the study and two copies of the consent form (Appendix B) for participants to read and sign before the interview began. During the interview, the participants shared stories of significant employee health situations that they had encountered in their role as HRP.

In keeping with the tenets of qualitative research, the initial interview 'question' was open-ended in an attempt to put the participant at ease and to minimize the influence I had on the types of information they chose to share. I began by asking them to tell me about an experience they had had with an employee health situation. I chose not to construct in advance a list of concepts to cover in interviews with each participant. Instead, I allowed meaningful aspects of the HRPs' experience to emerge through their choice of words and stories. As necessary, I used prompts and probes to keep the story flowing (See Appendix C).

I provided ongoing nonverbal encouragement as appropriate in a conversation, such as nodding and smiling. I also created the space Mishler (1986) asserts is necessary to allow stories to be told in interviews. I did this by establishing a relaxed tone for the conversation, being open and flexible to the flow of the participants' story, and ensuring my verbal and non-verbal language communicated acceptance of their story. I remained sensitive to the emotions of the participant by observing for cues of distress but no participant exhibited emotional distress during the interviews.

The primary source of data in the research was participants' stories and statements in interviews with myself as researcher. The interpersonal factors traditionally found in stories usually involve "a hierarchical relationship between interviewee and interviewer" (Mishler, p. 104). Features of this relationship can find expression in the content and structure of the narrative being shared. In this way, researchers are co-participants, in part determining the data that will be provided, both by how and what they ask but also by the reaction they evoke in the participant. At the beginning of one interview, the participant had been providing general information about the organizational approach to employee health. When the researcher asked her if she could think of a concrete example of a specific case to illustrate what she was describing, the participant replied; "Okay, so I'm trying to work out what you're getting at. You've got a hypothesis here somewhere." On the other hand, the researcher's identity as a nurse and an outsider opened the lines of communication on issues that may not have been openly discussed with others in the same workplace. One participant disclosed personal experience with panic attacks in the course of speaking about an employee dealing with depression. The narrative that results from an interview is shaped by the interpersonal context in which it was told. Where the story is told, to whom and under what circumstances or for what purpose can affect the story that results. For example, Lieblich et al. (1998) found that some of their interviewers were more directive, asking more questions and sticking to pre-set topics, while others let the storyteller "carry (them) away" (p. 26). The resulting data were dialogical, consisting of "question-answer transitions" (p. 26), and monological, providing "an undisturbed narrative" (p. 26) respectively. Five of the participants launched into detailed accounts of the stories they

had selected to share after the opening question. The remaining three storytellers required more guiding and probing questions to draw out the story.

The interviews were tape-recorded and transcribed verbatim by myself. Data collection and analysis took place concurrently. I made notes of emerging themes during the transcription of interviews, before I interviewed my next participant. In this way I was aware of the influence my interview structure had on the information participants shared and I could adapt my questions. I returned to several participants following the initial interview to review and verify common themes and storylines as they emerged during data analysis. I asked permission from participants to return to them to clarify content of previous interviews if questions arose during data analysis while conducting interviews with other participants. The participants who expressed an interest in hearing about the findings of this research were the ones I returned to with the storylines. I contacted them by phone and email and read both main narrative storylines and discussed the sub-narrative with them. Their response was supportive and encouraging. They responded with "Oh, yeah, I definitely recognize that one" and "yeah totally" to indicate they could see aspects of their own stories in the storylines. They empathized with the tension between their responsibilities to employees and the organization. When discussing the "Providing a Toolbox of Supports" narrative HRPs expressed interest in "resources for knowing places to send people and how to put people in touch with people (practitioners) in the community".

Data Analysis

In keeping with the tradition of narrative inquiry, data analysis was not based on a theoretical framework. It was grounded in participants' stories, taking analytical direction

from the narrative itself, rather than using a framework to "control the data" (Morse & Field, 1995). I used Mishler's (1986) approach to explore the structural, content and interpersonal aspects of analysis. Accordingly, in analyzing the structure of each narrative, the transcript account is summarized into a "core narrative" (Mishler, 1986, p. 103). The core constituents, abstract, orientation, complicating action, and resolution, are then specified. The setting is presented, a problem is introduced, alternative plans of action may be introduced, circumstances may intervene, and an action is chosen, and there is an outcome (Mishler, 1986, p. 90). Structural analysis features abstracting the linguistic and textual components of the narrative. The elements as they are presented are linked to each other in ways that provide local or global coherence. Such coherence provides a link between structural form and content (Mishler, 1986, p. 91). Often the structural elements of the story did not appear in temporal order and needed to be re-ordered to make sense of the events. For example, some participants began their stories with descriptions of the complicating factors and provided the characterization of the employee later in the story.

Content analysis of narratives included analysis of themes. The theme of responsibility was so prevalent in each story that it became the sub-narrative in this research. Other themes such as fiscal concerns and employee credibility contributed to shaping the main narratives. Cultural values and personal identities are often expressed through themes (Mishler, 1986). Themes can add to the coherence of the story by providing structural linkages. This level of analysis explores the ideas expressed in the narrative and how they relate to each other and the broader cultural context.

The five stage process of data analysis described by Lieblich et al. (1998) was used to provide structure to the process of data analysis. First, I read each transcript and reviewed the taped material to allow patterns to emerge. I made ongoing notes of my impressions and the contradictions I identified in the data. I summarized the stories to allow for comparison. The themes and sub-narratives identified in participants' stories were underlined in the interview transcripts and colour coded. I identified patterns, transitions and contexts of themes in a research journal. These stages of analysis were not undertaken in a stepwise manner but occurred concurrently.

The objective of narrative inquiry data analysis is to achieve understanding that can "articulate and resolve" (Mishler, 1986, p. 151) complex human issues: in this case, those related to employee health in the workplace context. Narratives function to "rearticulate opposing values and goals in meaningful structure, the plot of which makes cultural sense" (Turner, 1980, p. 168). The storylines that result from the analysis, in as much as they reflected the values and cultural meanings among HRPs, provided a vehicle to develop shared understandings of employee health.

Ethical Considerations

Written, informed consent was obtained from each participant before the initial interview. Volunteers who did not meet the research selection criteria were excluded from participation in the study. Confidentiality was a priority in this project as the study pertained to business practices and stories involving the health problems of third parties. Consequently all identifying information of people, locations, and organizations were removed from the interview transcripts. In addition, each participant was assigned a code number known only to myself; the participants' names were not used in the interview

transcripts. The research tapes, computer discs, and transcripts will be kept in a locked cabinet to which only I have the key for 10 years.

Issues of Rigor

Morse and Field (1995) identify four aspects of rigor or trustworthiness of qualitative research; truth value, applicability, consistency, and neutrality. To preserve the truth value of the data, it is important to report participants' experiences as clearly as possible (Morse & Field). Accordingly, I reviewed the narrative summaries with the participants and asked for feedback to ensure I captured their experience accurately. The criterion of applicability refers to the whether these "findings can be applied in other contexts or settings or with other groups" (Morse & Field, p. 143). As is characteristic of qualitative research, this study was not designed to be applicable to other contexts or settings. The data and findings that arise from the interviews are grounded in the stories of these participants in particular and cannot be construed or presented as broadly applicable. Similarly, consistency, which is "whether the findings would be consistent if the inquiry were replicated" (Morse & Field, p. 144), should not be anticipated in this research. The nature of qualitative research is that it attempts to capture a unique reality. The results are not intended to be replicable. Contextual and individual factors because they are captured in the data and yet at the same time dynamic make replicability impossible. However, I maintained records of my methodological and analytical decisions throughout the research so that my work may be auditable (Sandelowski, 1986). I maintained a journal about the data analysis according to the components of Paterson's (1994) framework to identify reactivity, including emotional valence, distribution of power, goal and importance of the interaction, and normative or cultural

criteria, to raise my awareness of personal bias and to reflect on possible reactive effects in this research.

Limitations

As I am a nurse as well as a researcher, participants may have believed the need to slant their stories to appear sensitive to health issues in a way acceptable to a health professional. In order to mitigate this effect, I downplayed my professional role as an occupational health nurse by not referring to it unless asked specifically and emphasized instead my role as a researcher, genuinely interested in their unique and varied experiences. I consciously avoided using medical jargon in the interviews. A second limitation of this research is that the participants were volunteers who were likely to perceive the issue of employee health as important. Those who believe employee health is not significant or who were indifferent to the topic most likely did not agree to participate in the study.

Summary

Narrative inquiry was the method used in this study to explore the meanings HRPs give to employee health in the business context. This method of inquiry was particularly appropriate for this population since "storytelling is an important organizational phenomenon" (p. 135, Gabriel, 1998). The narrative inquiry method effectively facilitated participants' sharing of stories which could "open valuable windows into the emotional and symbolic lives of (their) organizations" (p. 135, Gabriel, 1998).

The process of narrative inquiry research, including sampling, data collection and analysis, as well as considerations related to ethics and rigor are outlined in this chapter.

Data was collected using semi structured interviews and analyzed according to Mishler's (1986) framework. The measures employed to preserve the ethical integrity and rigor of the study are detailed. Finally, the limitations of this research are discussed, recognizing that this research was not intended to be definitive but does represent a venture towards a better understanding of the meanings HRPs give to their experiences with employee health situations in the business context.

CHAPTER FOUR: FINDINGS

The purpose of this study was to elucidate the meaning of employee health in the business context as was conveyed via participants' narratives. The chapter begins with an overview of the general characteristics of the interviews for this study. The subsequent sections are structured according to Mishler's (1986) three components of narrative analysis: specifically, interpersonal factors, structure and content. The main focus of the chapter is a detailed account of each of the two main narratives, "Providing a Toolbox of Supports" and "Fulfilling the Prophecy", and the sub-narrative, "Responsibility".

General Characteristics of the Interviews

The interviews represented a wide range both in the quality and focus of the participants' stories about an employee health situation. Each HRP interviewed shared two stories reflecting at least one of the narratives, as well as elements of the sub-narrative. Some participants told stories about experiences they had inherited from their predecessors in the organization or others they worked with. These stories had attained the status of legend within the organization. These were tales that they stated had changed their practice as HRPs and their approach to similar cases in the future. These stories will be discussed further in this chapter under the narrative of "HRP as Protector."

The participants' narratives reflected the unique structure and culture of their workplaces and their role within that cultural context. For example, two participants had little direct contact with employee health situations in their work. The roles they held were those of Claims Analyst and Human Resources Coordinator. Employees in those organizations had more contact with supervisors and the insurance company than with the HRPs. During one interview, one participant left the room to try to locate another

person who had had more contact with employees; however, when she returned to the room, she advised me that no one else in the Human Resources department could contribute employees' stories related to health. These two participants shared stories about employee health from the perspective of the organization, rather than from a personal perspective, such as exploring organization-wide trends rather than individual cases.

Most participants expressed some reluctance to share stories that were seen to represent either "confidential employee information" or "company secrets", even after my having discussed the provisions that I would take to maintain confidentiality and providing assurance that they did not need to provide the names or identifiers for the employee situations they shared. Although I had anticipated the potential for participants to be reticent, this was a more significant concern than I had expected. The first indication of the degree to which HRPs would be reluctant to participate in the research came during the recruitment process. Several business organizations distributed the Call for Participants in their e-mail distribution on my behalf, while others either did not reply to my requests or expressed concern over the issues of confidentiality noted above. One member of one of the organizations that chose to distribute my Call for Participants responded by indicating that I "must be running into a wall" in my recruitment efforts as "health issues are personal". Other indications of the delicate nature of this topic were revealed in the context of the interviews. For example, one participant arrived 30 minutes late for her scheduled interview, saying she "forgot about the appointment". She then expressed concern about confidentiality and asked for repeated reassurance that any employee she discussed would not be identifiable.

Structure of the Narratives

The way a story is constructed can reveal aspects of the narrator's identity, perceptions and values (Lieblich, Tuval-Mashiach & Zilber, 1998). The following analysis of the structure of the narratives begins with a comparison of the participants' narratives in relation to classics narrative typologies. Next, I will analyze the structural elements of the narratives. Finally, I will consider the literary devices used to express meaning in the narratives.

The central narratives revealed in the analysis of participants' stories fit into certain classic typologies. "Providing a Toolbox of Supports" portrays the HRP as a hero in a "romance" storyline structure. This hero "faces a series of challenges en route to his goal and eventual victory, and the essence of the journey is the struggle itself" (Lieblich, Tuval-Mashiach & Zilber, 1998, p. 88). The heroic struggle of the HRP in this narrative is aimed at supporting the employee while preserving both the HRP's identity as a caring individual and the employer's interests. Interestingly, participants did not articulate the organizational goal of the struggle overtly in the course of the telling of their narratives. However, when the researcher asked the participants what was significant about the story they had chosen to share, their answers revealed an organizationally-focussed fiscal or "bottom line" goal, as well as concern for the "attention" such situations attracted to the HRP's handling of the employee's situation.

> I think it is the strongest and the worst situation we had. Okay. So it was really, really particular and it retained lots of attention and it cost a lot also. So I think it's the worst situation. So that was the best example I can give you.

The narrative "Fulfilling the Prophecy" fits the structure of a "comedy" where the goal is "the restoration of social order and the hero must have the requisite… skills to

overcome the hazards that threaten that order" (p. 88, Lieblich, Tuval-Mashiach & Zilber, 1998). The HRP as "hero" perceives the employee with questionable work habits as possibly "milking the system" and as a threat to the social order of the organization. The HRP's skills are used to protect the organization from the hazard the employee presents.

Participants' narratives about employee health situations were clearly presented in the interviews. The stories included an abstract, an orientation, a complicating action, and a resolution (Mishler, 1986). While they clearly had a beginning, a middle and an end, these were often presented out of usual sequential order. All participants told more than one story.

Some HRPs' stories provided an abstract; that is, a section which presented the storyline in brief and served as an introduction to the story. One participant presented a "common scenario" where "women who were in secretarial roles, weren't highly paid and something happened in their life and they went off on stress leave". Another abstract of a story indicates "the person fell sick, and after that what happened, how we treated the person, how she was covered by insurance and how she came back (to work)". "I had to deal with that from an HR standpoint and what he was entitled to. He was somebody who thought that he should get the world and he was just a (blue collar worker)". The abstract, or miniature story summary, prepared the listener for the story to follow.

The participants' stories included an orientation to the employee and the nature of their health problem. The introduction of the employee often involved a description of the "type" of person they were perceived to be, the job they had and how long they had been with the company. "She is very well liked and gets along very well with everybody.

So everyone was shocked to hear, 'cause she's always at work, she never misses a day." This set the scene for the listener to place the problem in context.

> This woman had been unemployed for quite a few years (before coming to this company), and she was a good employee ... and she was well-liked by her group and her husband was dying... and her dog died and her husband died and there was a series of events in her life that were just pretty heavy for anyone to handle.

Another participant described an employee as having "at that time lots of experience with (the company) but she was kind of a depressive woman".

The participants' stories involved detailed descriptions of the complicating factors in the employee health situations. Some of these related to the employee's disease, including the manner and circumstances of the onset of illness, the duration and nature of the pre-diagnosis period, the certainty of the eventual diagnosis and prognosis, and treatment and care interventions. For example, an HRP described the uncertain prognosis which comes with an incurable degenerative disease as complicating Human Resource decisions regarding how long and how often the employee would be away from work. Other complicating factors identified by the participants included the nature of the workplace and the employee's work, the length of time the employee had been off work to date, the efficacy of previous attempts made by the employee to return to work, and the breakdown of personal relationships between employee and their spouse, the HRP, work colleagues or the employer.

The criteria which determined the HRP's response to employee health issues related to the HRP's personal perception of the employee's character and status within the company.

> After she went off (work), while she was here (in the company), it was so conflictual between her and the person (department head), that it was really awful

> for us. So when she asked to be terminated, we didn't really push to have her back. So we said, 'Yeah'. We agreed.

The participants provided commentary on the story they had provided. "When she came back? That's a kind of huge, not huge story, but a strange story". These commentaries provide insight into their expectations and evaluation of the situations they described and were particularly prominent in the "Fulfilling the Prophecy" storylines.

Several narrators shared a "Providing a Tool Box of Supports" story, followed by a "Fulfilling the Prophecy" story, creating a contrast between these storylines. In the excerpt below, the narrator discusses two cases as indicative of the contrast between both employees as justification for the different human resource approaches afforded each employee.

> They are two completely different situations. One is just -- it could not be avoided. It's just a horrible situation to be in and you know you want to help a person like that (an employee with an incurable degenerative disease). And the other one, as far as I'm concerned he deserves what he gets out of the whole situation because he's just a money grabber and looking for a way, I mean it is a horrible way for him to try and get money. And what he's had to go through with a (major orthopaedic injury) and everything. But, on the other hand, I think he is just out to screw whoever he can basically. And that to me is just, it's unethical. I don't agree with it at all. It just put me in a horrible situation. And not having any education on how to deal with this kind of stuff it hasn't made it easy either.

Narrators often returned to previously-related details in their stories to modify the characterization of the employee or information provided and to make their human resource intervention consistent with the body of the story. In the following excerpt, the narrator, who had previously indicated the employee was a "good worker", revised her perception of the employee to one who lets things "snowball". When exploring the employee's health issues, the narrator hints that the employee's own work habits are the source of her stress while underestimating the potential for organizational factors to have

played a role in her illness. This characterization of the employee's work habits is presented following the litany of organizational changes that took place immediately before the employee became ill and the many efforts the organization has made to accommodate the needs of workers and to streamline their jobs. This information is included to make sense of the source of stress that may have contributed to the onset of what the HRP referred to as a "stress related disease".

> It can certainly be a stressful place to be here.... We've got five thousand (customers) and we've got 800 and some odd employees and we're open day and night and stuff. There's a lot to be done. And however, having said all of that, we've got a lot of good people in place. And we're working for a good company and we've been making strides every year improving little things, whether they're computer systems. A year ago we implemented a time management system for employees that interfaces with our payroll. So that's a part of her position that has become easier to deal with. It was a challenge to implement but it's working really well. And we're changing our accounting system this summer and we're also changing all of our point of sales systems, yeah.... However (names employee) can get, she can let everything snowball a bit. But when you really sit down and analyze it and set guidelines and deadlines, it's (the work that the employee is required to do) not that bad. And certainly, this certainly worked out best for both of us, both for her and obviously for us that this happened when it did.

Participants regularly portrayed physical injury, such as a broken leg as a straightforward situation, whereas they described stress or mental problems as "far more complex" and "impossible to handle". However, their narratives revealed that the actual nature of the employee's health issue is far less significant in determining HRPs' involvement than what type of person and worker the employee is perceived to be. One participant told of an employee whom she deemed as a significant problem for her because of his reputation as a manipulative and lazy employee; this man had broken his leg.

The narratives revealed subtle cues about HRPs' perceptions of power and domination in the organization, particularly in the words they selected to describe their experiences. They used phrases such as, "We made her go through a program," "We really had to force her" and "We allowed her to choose," when "we" most often referred to the HRP in consultation with the employer. Another use of language was in terms of what was considered valuable as work and what was not. Recovery was generally phrased in terms of "doing nothing." Part-time work was described as an unfortunate option for employees who were unable to handle a full time workload.

> I guess in a best case scenario, she's back to work full time and everything is behind her and she's just learned a valuable lesson about nutrition and stress and then hopefully she never has any more symptoms. A worst case scenario I guess is she can't work anymore and she goes on Long Term Disability. And I guess an in-between would be she finds she can only work part-time or she has to work from home or she has to work at something else. Either way we would work that out, you know it wouldn't be a big deal. She's capable of doing anything. We're more than happy to make sure that she's in a position that is good for her. So whether she has to move into a different building because we need wheelchair access that is not a big deal and that could be arranged, same with carpools or you know.

The narrators used devices such as word repetition and linking words to emphasize points and to create a picture for the listener. Many narrators used the phrase "you know" frequently throughout their stories. Two narrators inserted "and blah, blah, blah" at the end of their descriptions of the complicating factors in their stories. Several participants indicated they had reached the end of their stories by saying "So". Some narrators re-enacted the dialogue that had ensued in their story, speaking as if they were talking directly to the employee. Several storytellers referred to employees as "they" and "the person," instead of "he", "she" or by name as others had. One participant stated she did this because of a concern for confidentiality.

Content of the Narratives

The content of the narratives was interpreted through thematic analysis to reveal "general cultural values and particular personal identity" (p. 104, Mishler, 1986). Through exploration of the ideas expressed in the narrative and how they relate to each other insight into the HRPs conceptions of themselves and the broader cultural context in which they work was accessed. The storylines associated with the main narratives are detailed below with examples from the text of the interview to illustrate the content of the narratives.

Providing a Toolbox of Supports

The storyline of "Providing a Toolbox of Supports" is: **We had an employee who was a good worker, trustworthy and everyone liked him/her. He/she developed a serious health problem. It was tragic. I did what I could to provide him/her with resources and help him/her manage his/her health problem. He/she was very co-operative. We were a very caring group and did what we could to make his/her return to work a success. Sometimes my toolbox was not sufficient and we failed him/her.** The essence of "Providing a Toolbox of Supports " is summed up in this quote: "I felt that it was my role to really give support and be there and give her references, things like that."

The storyline of "Providing a Toolbox of Supports" began with a depiction of the employee as well-liked and competent.

> We had one employee, nice girl, but had some drug issues. And we had actually agreed to pay for a rehab program twice for her. The second time she found a free program. But we counselled her through that whole thing. We gave her options and said "This is what we're willing to do for you", being a good employee, obviously. And it hadn't really been affecting her work but it had started to be and so we said "Look, your mental health is important to us and this is what we're

> willing to do for you and we'll loan you money during that time and we'll pay for a program". And so we did that twice with her.

Another feature of the characterization of employees in this storyline is that the employee is perceived as enjoying his or her work; work is a focus of the employee's life. One participant remarked that she discussed the possibility of long term disability with an employee but was aware that the employee "really likes to work" and that being on disability would be perceived as an unfavourable option by the employee. Well-liked and competent employees were also perceived as being co-operative and willing to accept the advice that HRPs gave.

> She had reached a point...that she was open to receiving assistance. So it was actually not a confrontational situation or anything like that. So it was good. It was just a matter of trying to find the right program and trying to assist her in that and she needed to find the right fit for herself as well.

If the employee had originally been perceived as "a good worker" and was well-liked, contrary information was unlikely to change the HRP's involvement with the employee. When an employee returned to work after extensive absence due to illness, the HRP stated, "Well, he got a new boss, then he got a performance issue, then they fired him." She perceived the performance problem to be "more about the boss" than the employee.

The narrative of "Providing a Toolbox of Supports" is oriented toward action by the HRP; i.e., providing information to the employee. The majority of the participants referred to the "tools" they had to offer employees who experienced health issues as their major contribution to the recovery of these employees. The HRPs described providing extensive written and verbal lists of websites, phone numbers, institutions, and specialists to help employees recover and return to work healthy. One participant volunteered an

employee with an incurable degenerative disease the information she had found on the internet about the various complications of the disease. Participants concurred that obtaining these lists of services and supports required a great deal of time and energy in research and networking. Another tool that the HRPs provided was their sharing of related previous experiences, namely those they had with other employees with related conditions and their personal experiences with similar health conditions.

> We have a few people that we refer to, yeah. We can just say, and also (provincial) psychiatric or psychologists association. They have a referral service....Now we've got a few names and contacts just from asking around to people and I have gone myself --- so I have somebody I can actually vouch for and friends that have gone to different people and you get them to tell you about that person --- so then and about how it was with the person.

The HRPs stated that they perceived employees who were well-liked and competent as trustworthy; therefore, they accepted as credible the information provided by the employee about the nature of the illness/injury and the duration of required absence. They did not investigate these claims or refer the employee for independent medical examinations (IME)[1] to verify the information. The participants agreed that they were willing to extend themselves beyond what was generally expected in their role as HRPs for such employees.

> So I had to take him and bring him back to my office and talk to him. I got a hold of this doctor and then sent him, we brought him home and then he got medical attention. And so it has been like that. I mean he (employee) calls every week, we talk, you know, and ask him how it's going.... I pretty much got his doctor's number now, his psychiatrist that he sees, so if I have any concerns I give him (doctor) a call and just tell him how I'm feeling and so that they can check up on him.... It's not to a point where I think he needs to go to the hospital....he just needs to get away from the situation that's causing him stress. And the best thing for him to do is to go home and just calm himself down, is usually what happens. And then he calls me as soon as he gets home and by the time he's home, he's fine. But you know just to make sure that he's okay. I just want to make sure that

[1] An IME is a medical-legal examination performed by a physician hired by the employer.

> his psychiatrist at least knows what's going on.... You know, I'm not a professional, so I'm not quite sure, yeah.
>
> He used to talk to me for hours. And he would talk to me and he told me about the (treatment) and what was going to happen and all these, putting his finances in order. And then I had to find out how to get his body home to (his home country) if he died. So I'm phoning funeral homes and caskets and, you know, it has to be a metal casket and how much it would cost to get him home. I did all this work for it..... Yeah, well we were talking about it and he said "Well, what would happen if, you know?" He was lost. He didn't have much family here so he didn't know how to get his body home. It's kind of hard to talk to a friend, I consider him a friend-ish, friendish guy, how to get his body home. So I think I'll pound all that stuff out for him and straighten all his finances in order.

In some narratives, HRPs revealed that they felt ill-equipped to deal with the health situations encountered by well-liked employees and did not know where to turn for support. They expressed personal angst and responsibility for not being able to offer the employee more.

> ---- there was alcohol bottles everywhere and she wasn't taking care of herself. And then we tried every way we could to try to kind of get her into a... we were phoning alcohol counsellors and we phoned up the EAP and basically and we phoned her doctor and obviously he couldn't talk to us because who were we? And we spent hours trying to figure out what to do with her. And there was nothing I could do- the only thing was we had to cut her loose. And that was really discouraging and really disheartening to watch that kind of degeneration of someone's life. Because six months earlier, she'd been happily married with a husband and a dog and a good job and as far as I know no alcohol problem. And in a year, six months to a year later she's out of work. Completely a wreck. I don't know what ever happened to her. It's just like we weren't equipped to deal with that.

Fulfilling the Prophecy

In the second narrative "Fulfilling the Prophecy", the storyline is: **We had this employee who had personal and performance issues; he/she couldn't be trusted. He/she got sick/had an accident. I tried to get information to be sure that the illness/injury claim was legitimate. Everything I did to try to help didn't work out.**

He/she was uncooperative. Due to circumstances in no way related to the accident/illness, he/she's no longer with the company. In retrospect, we should have done something about him/her before.

Similar to the storyline of "Providing a Toolbox of Supports", it begins with a characterization of the employee but in this situation, the characterization is essentially negative. Such employees were described by participants as "very vague" or as being unwilling to provide confirmatory medical information. HRPs felt that what "tended to be the problem" was that employees often "didn't want to help (him)/herself to get better".

> I just thought he was just a person who, a money grabber, who was taking advantage of the situation. And I found actually I asked for him not to work for me at that point. He actually works for somebody else now. I just had a tough time dealing with somebody who wasn't fair. I just thought that what he was doing was wrong and I don't believe in that. The problem was, we did talk about whether or not we would keep him on but, when you've got somebody who's been on disability you cannot just let them go. And it becomes a very sticky situation. So. But he seems to have straightened around now but he's, it's been very difficult. He's quite a demanding employee from thinking he deserves this and deserves that. I guess we probably should have dealt with the situation before the accident even happened.

Narrators referred to situations within the storyline of "Fulfilling the Prophecy" as ones that became "really weird", "very odd", "strange", "just a disaster", or "a really bizarre case". They used this phrasing to convey that the employee's behaviour was incongruent with HRPs' expectations of employees. The implication was that such behaviour was abnormal, perhaps even pathological.

> It wasn't logical the answers that I received (from the employee) and in the other cases I've dealt with I've found the same problems. There's a depression that sets in and so you don't get that logical "Well, I need to go to the doctor on a regular basis and get myself back out there".

In contrast to the previous storyline of "Providing a Toolbox of Supports", the participants discussed these narratives in terms of distance from the employees and the events. They spoke largely in passive terms, as if something was "done to the employee" that was not related to themselves. When such employees were terminated, HRPs portrayed themselves as not involved in the decision.

> They had been disciplined, written up a few times before the incident had ever happened, so that they're two separate things. Because the letting the person go had nothing to do with the injury in any kind of way. It just had to do with like not being able to.... there was a lot of sort of attitude, and difficulties with other staff members and not adhering to policies and procedures, that kind of thing. So those were the types of things that were happening with that particular person.

In contrast to the previous storyline of "Providing a Toolbox of Supports", communication with employees perceived as problematic and/or incompetent was largely by means of letters. In addition, the employee's health issue was presented by participants in definite and concrete terms; for example, employees were described as being disabled one day and not disabled the next, by virtue of medical information that would affect the duration of insurance or sick-time coverage. In several such cases, the HRP did not consult the employee before making a decision directly affecting the employee's employment or insurance coverage; other sources of information, such as the employee's physician, were perceived as more credible. HRPs at times talked about discovering information that might invalidate the employee's medical claims, as if the employee had been deliberately concealing this information.

> We typically don't talk to employee directly a ton throughout, when they're on disability. We'll talk to the doctors, get information, request, it's a lot of letter writing. Not a ton of verbal over the phone conversation. And so yes, there was, I did correspond to the employee via letters to let them know that once we had found out the information, that they were not longer disabled. Let them know that this is what we have therefore we're taking them off of disability.

Participants described their expectations for employees within the storyline of "Fulfilling the Prophecy" as pessimistic, based on their evaluations of the employee's ability and personality.

> So that was hard to deal with. Just something that went on for two and a half years that just was paperwork. There was nothing more to it. Like she will never come back to work. Not here anyway. Even if she goes to another position or if she comes back to work I don't believe that it'll be at (names employer), I think it's just too long. You almost need to start fresh. But I don't know....I don't know what that one was. .... I think she had mentally retired."

> So ultimately I think what will happen is she'll continue not to communicate and they will terminate her employment, for non-culpable reasons. Meaning, no one's right or wrong, its just she's never coming back. Yeah. So, eventually you kinda have to end the relationship rather than spending a lot of time and energy writing letters and trying to help someone who really doesn't want to be helped. It's very odd. Very odd.

Responsibility

There was a thematic undercurrent, or sub-narrative of responsibility in each of the two main storylines in this research. In the sub-narrative "Responsibility", the HRPs describe themselves as having social, moral and legal responsibility for employees and the organization.

HRPs described feeling responsibility to control threats to the company related to employee health problems. As employee health issues emerged, HRPs assumed responsibility for finding out why they happened, what should be done about them and how to fix them. They often changed practices within the organization to protect the company's interests.

The participants understand their function to be a protector of the organization's well-being and functioning. Employee health problems are viewed as potential threats to the organization because they disrupt the organizational workforce's functioning and

morale, as well as the organization's reputation and economic well-being. Consequently, what HRPs learn from dealing with employee health problems are organizational learning experiences, part of a process of adaptation to threats to the organization.

Information about the validity of an employee's health problem is key, because it provided templates for HRPs to use in the future to detect cases that may threaten organizational integrity. Participants concurred that obtaining such information is particularly difficult in employee stress claims because stress is so difficult to prove or disprove. In this excerpt, the participant describes using an independent medical examination (IME), as the gold standard in determining the validity of stress related claims.

> For every single stress claim that we have, we'll do an IME because it just gives everyone the sense to say that "yes this is a valid claim" or "no this is not a valid claim". We've had it go both ways. We've had it say "yes this person definitely needs to be off", and it allows us, if there's work issues it tends to pull them out. Because if there's work issues and that's why the person's on stress leave, well if we don't know and we don't change it there's no way that person's going to come back. And so we, I mean we're trying to, it's always challenging right, because you know, you've got access to some information, not all of the information and you're trying to deal with this problem. But the problem's already clearly too far gone if the person's on stress leave because of it. And so it's a challenge to try and fix things. Because you don't want to be a stagnant company, you want to be able to always be improving, and if there's a situation that has led to someone being off work we want to be able to fix it. But it just you know a one line note for a doctor doesn't really enable us to do that. But doing an IME yeah then we've got the information, then we can start working on it.

HRPs focused on individuals as representing particular "cases" or patterns of behaviour they recognized as calling for particular human resource responses. For example, they described "suspicious" cases in which the employee was suspected of not really being ill or staying away longer from work than was necessary. Cases were also

described in terms of particular categories of workers. One participant explained the "challenge" she had with older workers that had been off work.

Participants had learned to rely heavily on professionals, particularly the employee's physician, to validate the employee's claims and to determine what was realistic in terms of the employee's return to work. Many participants asserted "I'm not a professional" or "We're not doctors", implying that they did not know what should happen with such health situations, in spite of assertions that they needed access to employee health information. Central to this information-seeking with professionals was the consideration of how the employee's absenteeism and return to work would affect the organization.

> The managers don't want them back....We are having to implement a retirement policy. To try and manage the demographics of the staff that we have... they don't realize how old these guys are. We're having to try and take a stronger stance that at age sixty-three the managers sit down and give them two years working notice so they're just more on top of it. 'Cause we're starting to see past the age of sixty-five a lot of health issues are coming up.... If someone leaves this company their spot will be filled within a matter of a month. People don't wait to keep the business running....It's always a challenge for us to work with the managers to let them know that we've got a duty to accommodate these (workers) coming back. And if we can not provide them with work then we need to sever the employment agreement which means that we're having to pay out severance. So, you know they don't want to do that, cause its costing money, yet they're really hedging on, you know they'll find so many excuses to try not to bring this guy back, you know "well he's been out he doesn't know, you know the workplace has changed" and it is right. I mean we change quite quickly here but you know we need to give these guys the opportunity to catch up and get back on track....They want to make the most cost effective decision. And to pay out thousands of dollars of severance when this person could work for us for another year doesn't really make a lot of sense. And they know that. They'll say "Well, you know, he's a danger, he's a risk. He'll have another heart attack soon as he goes out". And so we have to go back again and talk to the doctors and get a good understanding of what the risks really are. 'Cause that's something that I always find is, will be a first gut reflex, is "No, 'cause you know we put him back out and he'll, he'll have a another heart attack on us"....They're concerned about the health of that person coming back. They don't want to see that person get injured. They don't wanna have anyone be injured. So it's the concern that the

> person will be able to do a good job... if they're having to take care of an injury or illness that they have. And it's that things have changed. There's new rules, there's a new program. The managers get judged as to how their, their managers do. So you got your senior level manager that has other managers reporting in, well the performance of those managers reflects on that senior level manager. And so if they don't have good performers, that's going to impact their own compensation. And so it's just kind of, you know fear of the unknown, "Alright, I've got my guys, they're working well, I don't have to bring back this other person that's been gone for a year and a half. I don't want to have to re-train them...". Because then they have to spend so much more time with that one (employee) that they can't effectively manage everyone else.

Another means by which HRPs protected the organization from the effects of employee ill health was to track employee health trends. These were used to evaluate current human resource practices and to determine if revisions were necessary.

> The number one inquiry I get is about psychologists. Mental health seems to be a very, or even relationships and that outside of work, you know with husband/wife, that's my number one asked question. You know like how much coverage it is. That type of thing. And it's quite surprising to me. I never expected that that would have been so prevalent but it's definitely the number one asked question regarding benefits. Not dental not anything – it's about psychologists' fees. So. Obviously it's being put to good use. People are definitely using it. So.

One HRP described a level of responsibility to society, a social mandate for her organization. She conceived of her role as extending beyond the individual to the company's interests, to playing a role in the socialization of young workers entering into the workforce.

> It's important to be dealing with your employees not just on a business level. You have to take that time to try and get to know people. And we have responsibility I think too. A lot of our employees are you know young people and probably we get a lot of people, who are between the ages of 18 and 24, and for a lot of people this is their first job. I think we have a certain responsibility to help them know how to be a good employee and know what to do about it and how to work in a safe environment and that kind of thing.

Responsibility was interpreted by the participants as both doing something to control the effects of employee health issues for the organization's sake and for the

employee's sake. These were not always compatible aims. Participants stated they were often torn between their human response to the employee's health problem and their professional responsibility to the company.

> So it was kind of between the two, you know feeling really bad for her and kind of thinking of the business as well. I need to really be by the book because if I do something wrong it could mean constructive dismissal from the company or human rights actions. When none of those things are intended but you never know how people understand or interpret things that go on.

Participants agreed that this conflict between the two allegiances was most evident whenever they were required to "walk the tightrope" to balance both employee and employer needs in working with employee health issues. For example, although they recognized employees' rights to confidentiality in regard to health issues, they also identified the company's need to be able to accurately determine what the employee could and could not be expected to do upon return to work.

> A stress related claim can have impact in a different way as to "I broke a leg". It can have a stigma attached to it, that sort of thing, and hence why we don't know any of those details as well. It goes under "stress claim" that's it. That's what we're told. We don't share all the ins and outs of it unless there is a personal relationship that goes on, unless there is a need to discuss with the medical practitioner and all that sort of stuff, so. And down the track, if they're not coming back to work, yes it kicks up, but initially it's like "okay, the doctor has said, 'can't be at work'".

Participants stated that at times, their personal relationships within the company and organizational requirements for more information to require the person to return to work would override what is "initially" a non-negotiable responsibility. They agreed that although confidentiality is a general standard in relation to employee health issues, HRPs exercise their own opinions in deciding what types of health issues require confidentiality.

> I just have something about if it's a stress related claim as opposed to "I broke a leg". I see those as quite different types of examples as well. Yeah, "I broke a leg" everyone knows that, that's fine. "I've got some stress related issue" well that's a different sort of issue.

Although it is part of their professional role, some HRPs expressed regret and a sense of being misunderstood because of having to take some of the actions they do to protect the company. They stated that such situations often created tension in their relationship with employees.

> No one likes to get a big formal letter saying "Here's a form you need to fill out, otherwise we can't consider, reconsider your employment with us". It's not a nice thing to do.... You want to try and be a nice person and be understanding. But like I said you always have to think about the company you're working for and reduce liabilities and risks and keep the books clean. I want to keep employees out there, there's lots of implications, vacation, bonus implications there's all kinds of implications of just keeping someone on the books whereas for them they didn't understand.

The sub-narrative of responsibility included the HRPs' expectations of responsibility for employees. Employees were expected to demonstrate cooperation with the HRP and a willingness to do everything possible to return to work. When employees were not forthcoming with information and did not make efforts to maintain regular contact with the HRP, participants perceived that the employee was disinterested in recovery or was avoiding work by feigning illness. One participant stated she had "valid evidence that did show that the person was fit for duty....but the individual clearly believes that they're not fit for work". Such discrepancies between the HRP's opinion and the employee's experience were construed by HRPs as arising from the employee's irresponsibility.

A significant aspect of the HRPs' sense of responsibility was the need to protect the company from legal or union action caused by a dissatisfied employee. The

participants concurred that the threat of legal or union reprisal gave rise to additional workload for themselves, particularly in regard to documentation and studying union contracts.

> I mean if you don't document information correctly it can create problems in the long run. Especially if you decided you want to let somebody go. I mean we never let go for cause but for any situations like that, where it can get sticky, if it's not documented properly you can get in big trouble as a company.

> "You're unable to return to work"... It wasn't a huge deal operationally because to be totally honest we didn't really need her, but legally we were required to recall her to work and so we would have been forced to kind of find work for her.

Summary

The participants' narratives of "Providing a Toolbox of Supports" and "Fulfilling the Prophecy" and the sub-narrative "Responsibility" provide insight into the complexity of HRPs' work with employee health issues. The stories enhance our understanding of their personal and professional orientation to their work, their perceptions of employee health issues in the context of the business and how their actions are influenced by the meanings they give to employee health situations. Although the stories came from diverse sectors of the business world, there are conspicuous parallels across the stories, particularly in regard to how their characterization of the employee in terms of their value as an employee dictates many of their decisions.

The general characteristics, structure, and content of the narratives were explored in this chapter. The HRPs' narratives revealed the tensions they experience in effecting their role as supporters of employees and protectors of the organization. In the following and final chapter, I will discuss the implications arising from this analysis of the participants' narratives.

CHAPTER FIVE: DISCUSSION AND IMPLICATIONS

In this chapter, I will provide a brief overview of the research. I will discuss the most relevant aspects of the research findings in relation to the meaning of employee health in the business context. I will locate this discussion as it applies to and contrasts with the relevant literature. In addition, I will identify the implications of the research findings to education, research and practice. Two main narratives emerged from the interview data in this research, "Providing a Toolbox of Supports" and "Fulfilling the Prophecy". The theme of "Responsibility" was threaded throughout the narratives, and played out on different levels as social, individual and organizational responsibility.

Overview of Research

The research study was an inquiry of narratives provided by HRPs in small business organizations about their experiences with employee health issues. The participants provided narratives that revealed their understanding of their role in relation to employee health. In the narrative "Providing a Toolbox of Supports," participants detailed their efforts to support employees they understood to be trustworthy and whose illnesses they highlighted as "tragic". When their efforts to assist the sick or injured employee were not successful, they felt they had failed the employee and, in some cases, concluded that they were perhaps "not equipped" to do the job.

In the second narrative, "Fulfilling the Prophecy," HRPs described employees who they perceived as incompetent and/or problematic as untrustworthy. Often, the HRPs questioned the veracity or severity of these employees illnesses or the duration of their recovery period. Narratives within this storyline revealed HRPs' difficulties in

working with employees who did not freely disclose information and who may be extending the situation to their advantage.

The participants expressed "Providing a Toolbox of Supports" as troubling, and "Fulfilling a Prophecy" as infuriating because of how each narrative fostered their sense of responsibility; in the first narrative, there was an enhanced awareness of her responsibility to employees and in the second, to the organization. In the first situation, HRPs perceived that they were unable to fulfill their responsibility to the deserving employee. By contrast, the second narrative created angst because the HRPs saw themselves as having failed to protect the organization's interests.

Discussion

In the following section, I will draw upon the relevant published literature to support or contrast the research findings according to the Utility Model of Health as Human Capital, the need for medical information, and employee stress.

The Utility Model of Health as Human Capital

The research findings are consistent with the Utility Model Of Health as Human Capital. Bolin, Jacobson & Lindgren (2002) present this econometric model of employer incentives for investing in the health of their employees. Health is conceptualized as human capital with a value to the employee and his/her family as well as to the employer. Employee health problems devalue the human capital of the employee. This model operates on the assumption that there is a connection between health risks and productivity. Employees with health risks will be less productive. Bartel & Taubman (1979) found employers paid substantially lower wage rates to employees who had one of the eight incurable diseases studied.

The HRPs in this study tailored their response to the employee health situation according to their perception of the work performance, a theme consistent with the Utility Model. HRPs in the research assessed the value of their human capital in determining their response to employee health problems. Since the employer cannot assess the health risk of the employee when they are hired (health information is confidential), HRPs used work performance and personal factors to determine the value of the individual employee's human capital. For employees who are perceived to be below par, as with those in "Fulfilling the Prophecy" narrative, the return on investment is perceived to be low so they do not attract employer investment of time and attention. Since the return on the investment is not perceived to be in the employer's interest, it does not make good business sense to invest in that individual. When the employee's work product is of poor or less-than-expected quality, the illness reduces return and tips the balance. The employer presumes the employee's risk outweighs the value of that employee to the employer, and since employers strive to employ workers of the greatest utility, letting the worker go is an econometrically reasonable response.

The perspective on employee health presented by the Utility Model does not, however, capture the individuality of the employee, nor does it account for variability in HRP practice. The HRPs in the study described personal connections with employees as a rewarding and important part of their work in the area of employee health. While the econometric model may be testable, it does not fully describe the meanings HRPs' ascribe to employee health. The Utility Model does provide a mechanism for framing some of the study findings in terms familiar to business, and thus may be useful in translating this research for presentation to business audiences.

Health Services Utilization

Implicit in how HRPs described employee health problems are implications for the use of health services for employee health. First, there was an emphasis in the HRPs' narratives on the importance of the employee having lists of services and specialists, implying that a variety of sources of information and health services are requisite for recovery. This is consistent with Roos & Roos' (1994) contention that in Western industrial nations, the ethos is that "more (health care) is better". They identify several arguments against such a view, such as that quality health care outcomes are not related to quantity, but to quality and appropriateness of care, the risks of iatrogenic illness increases with increasing use of health care services; and the cost of more services are not always justified.

A variation of the emphasis on multiple services and information was HRPs' belief that physicians are capable of determining "the validity of a claim". The occupational health community clearly struggles with many employee health problems that are difficult to validate and offer little objective evidence to support the employee's claim. Low back pain is perhaps the most common example so such a health issue. Kaufman (1996) is but one example of publications indicating very little correlation between symptoms, objective findings and validated diagnosis. At best, physicians can provide a professional opinion about the employee's situation and the prognosis; however, this provides limited assurance of the objective "validity" presumed by the HRP making the referral.

The role of HRPs as drivers of use of the health care system clearly could have implications for how we currently conceptualize health care utilization. A pervasive

theme among the HRPs' narratives was the role of medical information in decision making about employee health issues. Medical information was the currency HRPs used to drive their actions and decision making. Although HRPs who promote medical information may encourage employees to seek medical attention when they would not otherwise have sought such services, this practice could also contribute to health care system costs. In addition, making or encouraging referrals and "instructing" employees to seek medical attention may not effect desired health outcomes if information is not what the employee needs; for example, an overweight employee may know a great deal about diet but still not maintain appropriate eating habits. Individual employees' freedom to manage their own health may be distorted by HRP intervention with respect to health services utilization. Employees may base health care decisions on preferences supported in the workplace by HRPs. This may erode employees' rights to informed choices in health care and illness management.

Traditionally, the determination of health services has been thought to be that of the employee. The research findings, however, point to another determiner of these services; i.e., the HRP. This research has raised the possibility that models of health care utilization ought to consider the role HRPs may play in determining patterns of use by workers.

The Need for Medical Information

Participants discussed difficulties accessing employee information as a complicating factor in their experiences with employee health. Bolin, Jacobson & Lindgren (2002) discuss the "information advantages" that come with employer paid basic health care insurance. That is, if employers pay for health care services, they have a

right to access employee health information. In Canada health care services are paid by government and employee health information is kept confidential by health care providers. The HRPs in this research indicated a sense that employers do not have sufficient health information about their employees. Bolin et al (2002) propose that this lack of health related information "limits the extent and types of health investment activities, which the employer finds profitable". That is, the employer has to have enough information about the health of the workforce before health related investments are perceived to be justified. The HRPs efforts to put measures in place to prevent health problems were made once they had information that the condition was a health problem for their employees. In this study, a single case pointing to a threat to the health capital of the work force initiated workplace efforts to mitigate the threat. This phenomenon provides a window of opportunity for health professionals. By strategically providing information on the health of the workforce, the resources available through employer investment in health could be harnessed. This sort of co-ordinated, prioritized effort has potential to contribute to the protection of human capital in society.

Employee Stress

The concern HRPs expressed in this research in regard to the need for confidentiality around employee stress and mental health issues, as opposed to physical issues, may be reflective of the stereotypical assumption that mental illness is a sign of a weakness in the individual, and that employees should be able to control their emotions. On the other hand, HRPs may have felt a moral responsibility to protect the vulnerable; i.e., the emotionally fragile employee. Therefore, HRPs' distinction between physical and psychological health problems and their willingness to treat them differently in managing

information may be both an indication of and response to the discrimination individuals with mental illness experience in the workplace. In addition, the HRPs' description of stress-related issues as "impossible to handle" may be reflective of the dissonance they experienced between their sense of responsibility to the employee and the employer.

The societal infrastructure Canada has in place to handle stress-related employee health issues is minimal. Workplace health and safety legislation is based on the premise that work that is more physically demanding or dangerous, is more "capital intense". Since such work has greater capacity to compromise health capital via injuries, legislation is required to prevent injuries and protect employees should they lose their income as a result of the injury. In recent years, it is becoming clear that industries previously perceived to be of low capital intensity, such as white collar work, may be more capital intensive than previously understood. Stress is capital intense in its ability to erode health and productivity. The assumption that white collar workers face less risk to their health capital than those workers in more physically dangerous industries may no longer hold true. In fact, because the marginal product is often higher with white collar work, society has invested more human capital in white collar workers by virtue of their generally higher educational requirements (Bolin et al, 2002)] and therefore stress-related illnesses may be more costly to human capital. White collar wages are generally higher and the cost to replace those workers will be higher for the employer. Understanding how stress presents an emerging threat to health capital should provide an incentive to employers to adopt measures protective of their human capital.

Implications for the Future

In this section, I will discuss the implications of the research findings to HRP education, practice, and support, as well as to the role of health professionals in employee health and to employees. Directions for future research will be integrated throughout this discussion.

Education and Preparation of HRPs

This research has implications for the education and support of HRPs. For example, it is apparent that HRPs experience a sense of responsibility to intervene in employee health problems, yet are often unclear as to what intervention is appropriate. The research findings point to the need for HRPs to distinguish between management of organizational factors that may affect employee health and the medical management of employee health issues; education of HRPs could include such content.

Much of the HRPs' role in relation to employee health was described by the participants of this study as locating appropriate information and making complex decisions that accounted for both employees' and the organization's needs. Preparation for the HRP role must include an in-depth description of how these activities are enacted. Further study on HRPs' data mining strategies and decision making around employee health service utilization may be beneficial to a deeper understanding of this phenomenon.

HRPs' Practice

Participants in this research discussed difficulties accessing employee information as a complicating factor in their experiences with employee health. Bolin, Jacobson & Lindgren (2002) discuss the "information advantages" that come with employer paid

basic health care insurance as an incentive for employers. They suggest that it is profitable for employers to understand employee health issues and how to manage them because not to have this information might threaten the organization's human capital. Thus it is not surprising that the HRPs made efforts to put measures in place to prevent recurrences, once they had information, even if only from a single case, about a threat to the health capital of the work force. Their assumption was that this would be a good investment to preserve health capital.

HRPs described searching the internet and checking with contacts for information about health conditions and providing guidance to employees based on that information. Therefore, workplace health decision makers such as HRPs may represent a conduit for disseminating quality health care information via web based programs. Health Canada has started a workplace health page on their website; perhaps this website could be expanded to address HRP issues around employee health. Health professionals may benefit from this information because it would provide an understanding of the role of other actors, such as HRPs, who have an influence on the health behaviour of their patients.

It would be interesting to explore what employees do with the health related information or recommendations that HRPs provide. In light of the power relationship between employers and employees, HRPs may have significant influence on the health behaviour of employees. Professionals working with employees ought to be aware of this source of influence and be open to discussing the role that work is playing in their recovery.

HRP Support

The issue of employee health could have implications for the well being of HRPs. Some participants shared a desire to minimize their involvement in employee health issues. HRPs require the ability to protect the company's fiscal interests and corporate image while balancing the often competing interests of compassion for employees. Managing an altruistic orientation while demonstrating responsibility for the employer's bottom line is a matter of professional self-preservation. However, the dissonance created by this inevitable incompatibility can create feelings of stress for HRPs.

This research may provide direction for support of HRPs. Many HRPs characterized employee health issues as "dangerous" and "weird" indicating that they may feel alienated by it. Unfamiliar conditions or circumstances and psychological problems posed a particular problem. Buffett (2002) found that "less than one-third (29%) of Canadian HR managers regard wellness as an important priority" (p. 26). It may be that HRPs underestimate the effects of organizational factors on employee stress and health, or it may be that they do not have the tools to address the situations. According to Buffett (2002), HRPs are "ill-equipped to deal with worksite health promotion" (p. 27). This echoes one participant's assertion that she was "not equipped" to handle the employee health situations she faced. There is pressure on HRPs to be the "in-house expert" on health issues, but by all indications, they are not adequately prepared to shoulder the responsibility.

HRP may benefit from assistance in positioning themselves within the organizations to be effective in addressing organizational health issues. Helping HRPs broaden their perspective from a reactive position towards actions based on best practices

in employee health. Health professionals can assist HRPs in providing easily accessible information about key workplace factors. By finding ways to translate and communicate the workplace health knowledge available in a form that is accessible and useable by employers, health professionals could support HRPs. Such a best practice approach to employee health through prevention, promotion and management would see health professionals working to tailor what we know about health phenomena to the workplace context. In considering the organizational context that supports or reinforces employee health, the solution need not be complex. For example, one could consider the Hawthorne effect. A change in working conditions effected by research, as basic as an investigation of lighting, produced an increase in productivity. Regardless of the direction or magnitude of the change, the employees' productivity increased (Polit & Hungler, 1999). The changing light settings indicated that management was concerned about the employees' working conditions, indicating a climate of genuine consideration for employee well being can have a positive effect on workers.

The Role of Health Professionals

This research has implications for all health professionals who work with patients who are employed. Since HRPs and health professionals share a concern with the health issues of employees, it is logical to open a dialogue between the sectors for the benefit of workers. The HRPs in this study demonstrated a degree of reluctance to discuss health related issues, citing confidentiality as a concern. Further investigation into the dynamic behind the distance between HRP and health professional communities may provide direction for establishing a degree of communication and trust. In addition to the possible employee health benefits which may accrue from co-operation between the corporate and

health sectors; in the context of Canada's publicly funded health care system, collaboration resulting in increased efficiency and effectiveness is socially responsible.

Health professional education that considers the particular workplace context of their patients' lives could serve to foster more meaningful connections between professionals and patients. Health practitioners who understand the workplace dynamics such as the influence the HRP may have in the patient's health care decision making may be more effective in teasing out patient health concerns from concerns originating in the workplace. In some cases, it may be reasonable to include the HRP as stakeholder in decision making around the peripheral aspects of employee health related issues. By understanding that workplace "agents...have incentives for investing in the health" (Bolin et al, 2002, p. 564) of employees, health professionals can consider workplace resources that may be available to support employees in their recovery. Considering the workplace a site and source for health promotion will expand the health resources in our community. Health practitioners could engage with HRPs as the health care decision makers in the workplace as resources or mentors. Health practitioners could support confidentiality and freedom in health decision making among HRPs if collaborative approaches to employee health situations. This research indicates that helping employees determine the communication expectations of the employer and encouraging employees to maintain appropriate contact with their HRP may help employees preserve their human capital within their employing organization, thereby increasing the likelihood they will have a job to return to.

Implications for Employees

Bolin et al (2002) refer to "good-health-risk" and "bad-health-risk" groups of employees. "Good-health-risk" groups have fewer sick days, and represent more stable capital for employers. "Bad-health-risk" employees represent less stable forms of capital, as such they are a threat to the employer; these employees are liabilities. These two categories can be seen in parallel to the employee characterizations that emerged in the two main narratives in this study. The "good-health-risk" group is the one which HRPs are willing to support, as in "Providing a Toolbox of Supports". They are more valuable to the employer. The "bad-health-risk" employees figured prominently in the "Fulfilling the Prophecy" narrative. This research extended beyond health to indicate that work-performance and personal factors may figure into the employer's assessment of an employee's risk compared to his/her worth to the organization.

The dichotomy that seems to be present in employer perception of employees does not represent stable employment conditions for employees faced with health problems. It becomes apparent that organizations are social and economic systems and an employee's place in it determines the outcome, independent of such factors as the nature of the illness or the availability of work.

Conclusion

In this chapter, significant findings were summarized and the implications they have for practice, education and research in the health and business communities were discussed.

This study used the narrative inquiry strategy to capitalize on the role storytelling plays in organizational culture. By analyzing the structure and content of the stories

shared by HRPs about their experiences with employee health situations that were significant for them, a beginning understanding of the attitudes and practices within the HRP population surfaced. Employees were characterized in one of two ways, according to the two main narratives. Either they warranted the HRP "Providing a Toolbox of Supports" to help them in their recovery and return to work or they fell into "Fulfilling the Prophecy" and minimal support was extended to secure their return to health and productivity. Tensions between HRPs' sense of responsibility to their employers and employees emerged as significant. This improved understanding of HRPs perception and role in employee health situations suggests that developing supports for HRPs involved with employee health issues would be an appropriate goal for health professionals.

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Appendix C

Interview Questions

1. Tell me about a significant employee health situation that you have encountered in your work as a Human Resources Professional.

Additional probes will be asked to clarify the details of the story and to encourage the participant in their storytelling. For example:

2. What factors contributed to the situation?
3. Who were the significant players involved? What role did they have to play?
4. What was it about this story that made you choose to share it with me today?
5. What lead up to the situation/how did it arise?
6. How did you come to be involved?
7. What was the central issue/moral of the story for you? For others?
8. What about this situation made it significant?
9. What happened next?
10. Who else was involved?
11. What was the resolution? How was it left?