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Socio-political aspects of RSI

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Abstract

We discuss three avenues for insight into the socio-political dimensions of work-related musculoskeletal problems or RSI, namely the social construction of medical knowledge, social problems as social movements and the politics of research. Each approach leads to a different set of characteristic insights and is primarily useful for a particular set of purposes and groups.

1. INTRODUCTION

Work-related musculoskeletal problems have most commonly been approached using standard ergonomic and epidemiological techniques. More recently there has been growing recognition that these disorders have an important socio-political dimension which determines the context in which other explorations take place. In this paper we offer three insights into socio-political issues and use the Australian experience of so-called 'repetition strain injuries' or 'RSI' as an illustration. The insights we discuss are the social construction of medical knowledge, the relationship between the recognition of a problem and a social movement, and the politics of research.

2. THE SOCIAL CONSTRUCTION OF MEDICAL KNOWLEDGE

Research into musculoskeletal problems faces the constant challenge of definition of what it is that is being examined. This reflects the uncertainties in diagnoses and underlying pathophysiology. It helps explain why there are important differences in, for example, the prevalence of symptoms and signs depending on whether they are measured by self-completion questionnaires, interviews or medical examinations. These uncertainties are not only intellectual challenges but are also important for the ability of affected individuals to understand and manage their condition. This ability can be significantly undermined by disagreements about pathophysiology. The same disagreements however are a delight for social scientists as they provide a direct window for observing the social construction of medical knowledge.

Disagreements allow first hand observation of the challenge to the conventional belief that the physical realities of health and disease are revealed unproblematically by clinical examinations, supplemented by biochemical and other scientific methods of assessment of evidence. With regard to RSI there are two basic contests. One is between the views that these disorders are primarily physically based and that they are psychogenic and/or hysterical (for more detail see Bammer and Martin, 1988). In this debate those critical of the view that these disorders are physically based have highlighted what might otherwise have been ignored, namely how diverse symptoms and the social phenomenon of RSI have been interpreted and organised into a traditional medical injury model, with inadequacies and loose ends being dropped along the way. The other debate is within the view that these disorders are primarily physically based and is a contest between which signs and symptoms are meaningful and how they can be best explained. This debate partly revolves around issues of reproducibility, specificity, sensitivity and validity. One of us (GB) is involved in co-ordinating a set of working papers which aim to promote discussion about and possible resolution of competing explanations (Quintner and Elvey, 1991; Cohen et al., 1992; Fry 1992).

The sociology of medical knowledge is founded on deconstructing, and thereby opening to social explanations, the origins, development and deployment of medical knowledge. By its very nature such analysis threatens the dominant position in a medical debate. In the case of RSI, understandings from the sociology of medical knowledge were brought into play when the dominant position was that RSI is an organic work-related condition and were thereby used to undermine that position. If the dominant position had been that RSI is a form of mass hysteria, a sociology of knowledge analysis would have undermined that claim (for more detail see Bammer & Martin, 1992).

3. SOCIAL PROBLEMS AS SOCIAL MOVEMENTS

This analysis addresses questions such as 'why is it that RSI has received so much attention in Australia?', 'why did the issue not come to the same widespread attention in the USA and the UK until many years later?', 'why is there an emphasis in the USA on carpal tunnel syndrome, which is unmatched elsewhere?', 'why is there a common perception that the problem in Australia has disappeared?'.

When relevant people in society define something as a social problem, it can be transformed into one. This analysis draws heavily on the work of Armand Mauss (1975, 1989), who sees social problems as inseparable from social movements, because the characteristics of social problems are typically those of social movements. Social movements undergo a natural history dependent on their interaction with the surrounding society. Typically this includes incipiency, coalescence, institutionalisation, fragmentation and demise. Particularly at the beginning of a social movement, there are several levels of participants, including principal leaders and organisations, an active membership and a sympathetic public. Changes in participation are

important in the natural history. Subjective definitions of reality and the mobilisation of public opinion are also central to understanding social movements.

We have described the value of a social movements explanation in understanding the rise in the RSI 'epidemic' in Australia in the early 1980s elsewhere (Bammer & Martin, 1992). Here we will examine the demise of the epidemic from that perspective.

Not only did the recognition of RSI as a social problem depend on the existence of an RSI movement, but as the movement fragmented and declined the 'problem' was also seen to recede. There are a number of reasons which help explain why social movements decline. Unless the movement is institutionalised, for example through jobs or laws, many participants will drop out or move on to other issues. Key activists, in particular, become burnt out after years of campaigning. The role of the media is also important. Media interest in issues is often short-lived and a movement must provide increasingly dramatic stories to maintain media coverage. Finally opposition to and accommodation of the movement are crucial. Overt opposition can thwart movement initiatives, reduce morale, and lead to disillusionment; accommodation or co-option involves addressing the problem, often in a limited fashion, and removing its urgency or saliency.

Each of these factors played a role in the decline of the RSI movement in Australia. As the number of RSI claims stabilised and declined, the opponents of RSI mobilised. They were effective in capturing and silencing the debate. For example, in line with the view of opponents that the 'epidemic' was being fuelled by discussion about it, *The Medical Journal of Australia*, which was the main forum for the debate, decided not to publish papers about RSI for an 18 month period beginning in September 1987. The federal government ceased routinely publishing statistics about the number of cases amongst its employees at about the same time. Although new cases continue to be reported, there is little media attention to the problem and hence a perception in many quarters that it has gone away. Workers' compensation entitlements have been and continue to be reduced. A landmark court case by a worker with RSI against the federal government was lost, partly because the federal government argued that RSI was not an organic injury (Campbell, 1988). On the other hand, a number of measures were also introduced to mitigate the problem. There was widespread introduction of so called 'ergonomic' furniture and equipment. Moves towards industrial democracy were enhanced and, in the office environment in particular, job redesign to increase task variety was common. Worker awareness of RSI and likely risk factors was greatly increased, leading to earlier reporting and intervention. There was an increased emphasis on rehabilitation. While many people previously sympathetic to the problem have 'burnt out' and moved on, there is a residual network of sympathetic doctors, researchers and support groups (see also Bammer 1990a & b).

The social problems as social movements perspective is useful in understanding the widespread public attention given to RSI in Australia in the

mid-1980s and its subsequent decline. This situation was unique. More recently there has been public recognition of these disorders in the UK and the USA but it has not replicated the intensity of the Australian situation. Despite its value, a social movement explanation tends to delegitimate RSI because it is commonly assumed—except by analysts of social problems—that a real, organic condition will be recognised as a social problem without the entrepreneurial activities of a social movement. In principle, the description of RSI as a social movement should not legitimate or delegitimate the reality or importance of RSI.

4. THE POLITICS OF RESEARCH

Research, intentionally or not, may influence political debates. The choice of what is studied and how leads to partisanship, which can be intentional or de facto (Scott et al., 1990). As illustrated above, bringing the sociology-of-medical-knowledge and the social-problems-as-social-movements perspectives to bear on RSI tends to delegitimate the claims that it is a 'real' problem. Given that partisanship is built into the choice of theoretical framework and the choice of where and when to apply it, it is futile to try to eliminate partisanship, de facto or otherwise. Instead partisanship needs to be recognised and accepted, along with the understanding that there is no single road to 'truth'.

This highlights the limitations of research based on positivism and reductionism and the need for new approaches. Participatory action research is one model which may be useful. This begins with the premise that no social enquiry is possible unless it is effectively value driven. Participatory action research emphasises investigation which is driven by the interests of those whose problems or situations give rise to the research questions. This connection between researcher and researched (where the researched often become the researchers) allows social realities to be better understood and explained (Wadsworth, 1984; see also pamphlets of the Action Research Issues Centre, Melbourne).

Another model of research which may be useful is being developed by one of us (GB) and has two elements. One is that it is problem centred and brings a range of disciplinary perspectives to bear on the problem. The second is that is consultative and collaborative with all relevant interest groups.

5. CONCLUSIONS

We have illustrated several approaches to the social analysis of RSI. Each approach leads to a different set of characteristic insights and is primarily useful for a particular set of purposes and groups. One implication of this is that anyone undertaking a social analysis of RSI should carefully choose the approach which is most useful for their own purposes. A second implication is that it is important to scrutinise approaches used by others, taking note of the groups to which they are most useful. There are no neutral methods in this enterprise.

6. REFERENCES

Bammer G 1990a The epidemic is over ... or is it? *Australian Society 9(April)*: 22-24.

Bammer G 1990b Occupational disease and social struggle: the case of work-related neck and upper limb disorders. NCEPH Working Paper Number 20. Canberra: National Centre for Epidemiology and Population Health.

Bammer G & B Martin 1988 The arguments about RSI: an examination. *Community Health Studies 12*: 348-358.

Bammer G & B Martin 1992 Repetition strain injury in Australia: medical knowledge, social movement and de facto partisanship. *Social Problems 39*: 219-237.

Campbell, SA 1988 Taxing work: Susan Cooper's RSI case. Paper presented at the National Conference of Social Science Research on Occupational Health and Safety: Past Present and Future, Adelaide, August.

Cohen ML, Arroyo JF & GD Champion 1992 The relevance of concepts of hyperalgesia to 'RSI'. In Bammer G (ed) *Discussion papers on the pathology of work-related neck and upper limb disorders and the implications for diagnosis and treatment.* NCEPH Working Paper Number 31. Canberra: National Centre for Epidemiology and Population Health.

Fry HJH 1992 Overuse syndrome and the overuse concept. In Bammer G (ed) *Discussion papers on the pathology of work-related neck and upper limb disorders and the implications for diagnosis and treatment.* NCEPH Working Paper Number 32. Canberra: National Centre for Epidemiology and Population Health.

Mauss AL 1975 *Social problems as social movements.* Philadelphia: JP Lippincott.

Mauss AL 1989 Beyond the illusion of social problems theory. In Holstein JA & G Miller (eds) Perspectives on social problems Volume 1. Greenwich, Connecticut: JAI Press, 19-39.

Quintner J & R Elvey 1991 The neurogenic hypothesis of RSI. In Bammer G. (ed) *Discussion papers on the pathology of work-related neck and upper limb disorders and the implications for diagnosis and treatment.* NCEPH Working Paper Number 24. Canberra: National Centre for Epidemiology and Population Health.

Scott P, Richards E & B Martin 1990 Captives of controversy: the myth of the neutral social researcher in contemporary scientific controversies. *Science, Technology, and Human Values 15*: 474-494.

Wadsworth Y 1984 *Do it yourself social research.* Collingwood, Victoria: Victorian Council of Social Service & Melbourne Family Care Organisation; in association with Sydney: Allen & Unwin.

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