Repetition Strain Injury in Australia: Medical Knowledge, Social Movement, and De Facto Partisanship*

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One of the most vehement debates over medical knowledge in Australia in the 1980s concerned "repetition strain injury" or RSI. This paper analyzes the Australian RSI experience using two contrasting approaches: the sociology of medical knowledge and social problems as social movements. Each approach tends to delegitimate the position that RSI is work-related and has an organic basis. A key factor leading to the de facto partisanship associated with each approach is the choice to analyze the Australian RSI experience in the first place. The de facto partisanship associated with the choice of a framework of analysis and issue to study is an important aspect of understanding social problems, an aspect which has been largely ignored until now.

In recent debates about the appropriate approach to studying social problems, three positions can be identified. First is the "objectivist" approach, in which the existence of social problems is viewed as a consequence of real, knowable social conditions. Objectivist analysts do not attempt to provide a social explanation of social reality, since this reality is thought to be known as objective fact. In a second approach, strict social constructionism, no assumptions are made about objective realities. Rather, the analyst studies the social activities of actors, especially those by which the actors define certain things as "social problems"—a process called claims-making. A third, intermediate approach, termed "contextual constructionism" (Best 1989b), acknowledges making some claims about social reality, and uses these as a framework for analyzing the social processes of claims-making.

This categorization of course simplifies the diversity of approaches found in the social problems field, but suffices for the purpose of informing our study. The important point is that proponents of each approach claim a methodological superiority linked to assumptions about the reality of what is being studied.

Whatever approach they adopt, social problems analysts typically present themselves as social *scientists,* not as partisans for a particular viewpoint. Our concern here is the process, which we term de facto partisanship, by which analysts may prejudge their conclusions by their choice of analytic framework. According to constructionists, objectivists prejudge their conclusions through their assumptions about social reality because they do not attempt a social explanation of this reality. Woolgar and Pawluch (1985a) extended this critique to many ostensibly constructionist analyses, pointing out that while analysts subjected some claims to scrutiny, others went unexamined and hence were essentially treated as objective; they called this process "ontological gerrymandering." In both objectivist and contextual constructionist analyses, greater credibility is imputed to the views treated as objective, thereby often providing de facto—and sometimes open—support for those views. This sort of partisanship is not

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overcome by a strict constructionist or relativist analysis. Such an analysis, by treating all claims as subject to social explanation, undermines the views backed by greater scientific authority much more than views critical of the orthodoxy, and thus is likely to serve the interests of the latter (Scott, Richards, and Martin 1990).

De facto partisanship does not depend on conscious intent and, indeed, can be contrary to the analyst's intent. An assessment of de facto partisanship must be made sociologically, by examining the use made of social problems accounts. An assumption in most approaches to studying social problems is that the analysis is independent of the struggles involved with the social problem. But this assumption is untenable, at least for controversial, contemporary issues. Whether it is intended or not, analysts and their work may be taken up by partisans. Indeed, a range of claims-makers may try to "capture" analysts to serve their own purposes. This process of attempted capture cannot be avoided by the analyst and undermines any claims to neutrality (Hess forthcoming; Scott, Richards, and Martin 1990).

Using a case study, we explore the de facto partisanship associated with the choice of a framework for social analysis. In order to probe more deeply into this process, we deploy two frameworks of analysis: the sociology of medical knowledge and social problems as social movements. Our chosen case study is "repetition strain injury" (RSI), which became a controversial social issue in Australia in the 1980s when there was a dramatic increase in the number of reported cases, making up a large fraction of payments for workers' compensation. Detailed examinations of the epidemic among government employees (Task Force Report 1985), national telephone company employees (Hocking 1987), and employees at one university (Bammer 1987b) have been conducted. The symptoms reported generally affect the neck, shoulders, and/or upper limbs, and include pain, tenderness, loss of strength, fatigue, and lack of coordination.

A major struggle between those who support and oppose recognizing the cases as real work-related injuries developed. In addition to some debate about the reported symptoms themselves, the major focus of contention has been the meaning given to the symptoms and their causes. As will be described later, the phenomenon of RSI has been explained at the individual level in terms of organic injury, malingering, compensation neurosis, conversion hysteria, normal fatigue, and "social iatrogenesis." Each of these explanations has been linked to more general explanations of the rise of RSI as a social problem in Australia in the 1980s. Proponents of organic injury causation prefer an explanation involving a hidden pattern of injuries, exacerbated by economic, social, and work changes (especially technological innovation), which has finally achieved social recognition. Critics prefer an explanation in terms of a social epidemic of cases triggered by reporting, availability of compensation, and faulty diagnosis which encouraged lying (malingering) or psychosomatic manifestations.

Building on the explanations of RSI partisans, social scientists have added further interpretations. For example, Helen Meekosha (1986; Meekosha and Jakubowicz 1986), a feminist, has focused on the role of patriarchy in RSI; Wayne Hall and Louise Morrow (1988), working in psychiatry and psychology, have drawn on causal attribution; Evan Willis (1986; see also 1983, 1989) and Andrew Hopkins (1989), sociologists, have used the sociology of medical knowledge framework; Merrelyn Emery (1988) and Trevor Williams (1985), supporters of industrial democracy, have focused on the role of work organization in RSI. There is no simple and automatic relation here, but an obvious tendency for analysts to use frameworks compatible with their professional field and personal commitments.

There is nothing very surprising in finding a link between analysts' expertise and interests and their choice of conceptual frameworks. A closer inspection, though, reveals some intriguing discrepancies. Some analysts who have chosen a constructionist approach—such as Willis (1986)—are quite clearly in sympathy with workers with RSI, yet their work has been cited by those who dispute that RSI is an organic, work-related injury. This raises the question of whether it is possible to undertake a constructionist analysis of RSI yet not provide

de facto support for the critics of RSI. Is the use of the analyst's work by RSI critics a result of the choice of analytic framework, or is it somehow linked to the study of RSI in the Australian context, or both?

The following analysis has three levels. The most basic is an account of RSI as a social problem.[1] The second level applies the frameworks of the sociology of medical knowledge and social problems as social movements to RSI. The third investigates these frameworks to determine where de facto partisanship arises and provides insights into the characteristics of de facto partisanship.

The Sociology of Medical Knowledge

The sociology of scientific knowledge attempts to analyze scientific knowledge in a manner similar to the study of other social phenomena (Barnes 1974; Bloor 1976; Mulkay 1979). The special status of scientific knowledge—namely an alleged correspondence with the realities of "nature"—is rejected. Instead, scientific knowledge is treated like other belief systems, such as religion. The influence of social structures, funding, professional vested interests, and laboratory micropolitics on the form and content of what is accepted as scientific knowledge are all topics for investigation.

In RSI, the focus is on a condition disputed within medicine. The sociology of scientific knowledge becomes the sociology of medical knowledge, which examines social factors' role in the creation and negotiation of knowledge claims, including beliefs about health and disease, the social organization of medical care, and the distribution of power in society (Figlio 1978, 1982; Gubrium 1987; Richards 1988, 1991; Wright 1980; for a critique see Bury 1986). This challenges the conventional belief that the physical realities of health and disease are unproblematically revealed by clinical examinations, supplemented by biochemical and other scientific methods for assessment of evidence. From the sociology of medical knowledge standpoint, the orthodox view is a convenient gloss on actual medical practice, providing a set of meanings which unify the medical profession and give it status.

Following Collins' (1981) prescription for the sociology of scientific knowledge, a program for the sociology of medical knowledge involves three stages: (1) demonstrating the "interpretive flexibility" of medical findings, (i.e., that they are open to more than one interpretation); (2) describing the social processes, known as closure mechanisms, that terminate medical controversies, (i.e., the processes that limit interpretive flexibility); (3) showing links between closure mechanisms and the wider social setting.

The following description of the claims and counterclaims about RSI demonstrates the interpretive flexibility involved. In fact, critics of the standard medical view have seen it as their task to demonstrate this flexibility. The second stage of describing closure mechanisms is more tentative, since the debate in Australia is not yet closed. The final stage, relating closure mechanisms to social structure, has only rarely been carried through in case studies. We offer some observations on the final stage as it relates to our analysis.

The Sociology of RSI Knowledge

Until about 1988, the dominant medical position in the Australian debate held that the term RSI covered a group of organic injuries caused by rapid repetitive movements, less frequent but more forceful movements, static load, or a combination of these. Some cases were

1. The account is not presented in the typical manner as a single unified view, but draws on the two separate perspectives of the sociology of medical knowledge and of social problems as social movements; these perspectives are partly competing and partly complementary.

diagnosed as relatively well-defined entities such as tenosynovitis and epicondylitis, whereas others were more diffuse syndromes. The underlying pathology for the injuries is a matter of some contention, but is thought to involve one or more of muscles, nerves, and tendons.

RSI is usually graded into several stages according to its severity. The earliest stages are characterized by no physical signs, with pain and tenderness going away at night or on days off work. At the most severe stages, physical signs are present and symptoms persist even during rest. It is commonly thought that individuals can progress through the stages if they persist in the causative activities. At the early stages, RSI is thought to be reversible through modification of work activities, rest breaks, and exercises. In the severe stages, no treatment seems to offer any real solution, except perhaps complete avoidance of any activity that causes pain (Browne, Nolan, and Faithfull 1984; Champion et al. 1986; Ferguson 1984; Fry 1986; McPhee 1982; Quintner 1989; Stone 1983; for a survey see Bammer and Martin 1988).

This view is very much tied to orthodox medical approaches to disease and injury. RSI is interpreted as an organic problem caused by activities that induce injury. It can be diagnosed through the regularity of symptoms and, in severe cases, through clinical signs. Although some practitioners suggest a role for psychosocial factors, these are interpreted in the context of the main focus, which is on the body and injury to it, consistent with standard diagnoses of related injuries such as muscle tears, as well as the wider array of diseases. We refer to an approach to disease or injury using orthodox medical concepts and techniques as following a medical model and to the view that RSI is a work-related organic injury as the "standard medical view."

Critics of the standard medical view also criticize recognition of a unified entity called RSI. These critics have adopted a variety of interrelated positions, some of which are alternative medical (psychiatric) models whereas others are nonmedical models (Bammer and Martin 1988; somewhat different categorizations are found in Meekosha and Jakubowicz 1986; Spillane and Deves 1987). One explanation, subscribed to by some employers, workers, and doctors, is that many or most people claiming to suffer from RSI are faking their symptoms (malingering) in order to obtain time off work or compensation benefits. This highly derogatory interpretation seldom makes its way into print (but see Bloch 1984; Ireland 1986; Scarf and Wilcox 1984). Unlike malingerers, those said to be suffering from compensation neurosis are considered to genuinely experience pain and other symptoms. Their problems may begin with a real injury, but psychological mechanisms generate disproportionate disability and delayed recovery. The main mechanism cited is an unconscious desire for secondary gain, such as financial rewards, invalid status, or escape from work (Bloch 1984; Rush 1984). A similar explanation holds that RSI is a form of conversion disorder, in which there is no initial injury at all. Pain and disability, according to this explanation, result from emotional disturbance or unresolved psychological conflict converted into perceived symptoms, allowing an escape from the psychological problem (Black 1987; Cleland 1987; Ireland 1986; Lucire 1986a, 1986b). Another view is that the reported symptoms are normal aches and pains, usually due to simple fatigue, with no underlying injury. The RSI problem is considered to be a rash of reporting of common fatigue. The solution is rest and ergonomic changes at work (Brooks 1986; Hadler 1986). Closely related is the "pain-patient" explanation, in which workers who experience normal pain are encouraged by doctors and others (trade unionists, co-workers, etc.) to become patients with pain. Psychosocial or economic incentives help people to define themselves or to allow others to define them as patients. This pattern is described as "social iatrogenesis" (Bell 1989; Cleland 1987; Spillane and Deves 1987).

The critics of RSI have made a range of claims against the standard medical view, arguing that there are no clinical signs or identifiable underlying pathologies, no reliable patterns of symptoms, that this is an "Australian disease," no effective treatment exists, causal links to work are not clear, preventive strategies are not effective, and epidemics are usually caused by viruses or psychogenic factors (Brooks 1986; Cleland 1987; Hadler 1986; Ireland 1986). To

illustrate the debate, we briefly discuss the first three of these criticisms; for others see Bammer and Martin (1988).

It is important to recognize here the distinction, central to the medical model, between "signs," which are observable organic changes in the body, and "symptoms," which are sensations reported by the patient. Medical science normally expects to find signs indicative of underlying pathology if there is a "real" disease or injury. Symptoms are considered valuable for diagnosis and are supposed to be verified by assessment of signs. Supporters of the standard medical view acknowledge that there are usually no signs for RSI in the early stages; there is no unified position on signs in the later stages. Critics have repeatedly argued that without objective signs, the case for organic injury is insufficient. A few critics further suggest that some signs which do occur may be generated by psychological mechanisms (Lucire 1986a, 1986b).

The crucial role of signs and associated pathology in the debate over RSI depends on acceptance of a one-dimensional medical model. Since future advances in medical science may allow for detection of organic changes that are currently invisible or unrecognized, the absence of signs is not a definitive argument. In addition, claims of suffering from other conditions, such as migraine headaches, are usually accepted as genuine even though there are seldom clinical signs linked to the symptom of pain. The acceptance of symptoms without signs seems to depend on a range of social factors, such as the status of those reporting the symptoms.

The critics have also argued that RSI symptoms do not make clinical sense, in that they are diffuse; vary from patient to patient; and do not relate sensibly to conceivable sites of injury, fit with existing objective signs, or fit any recognizable pathological patterns (Brooks 1986; Cleland 1987; Hadler 1986; Ireland 1986). For example, some people with RSI who originally reported symptoms in one of their hands or arms due to repetitive motions at work, later reported symptoms developing in their other limb during time spent away from their jobs. (Whether or not this results from compensatory activity by the other limb used for housework and other tasks is a point of dispute.) Again, the critics appeal to an image of a standard injury or disease in which an underlying pathology results in regular and predictable symptoms.

Another criticism of RSI is that it is unknown or rare outside Australia or at least that there has been no "epidemic" of it elsewhere. Mentioned by only a few medical critics (Awerbuch 1985; Bell 1986; Brooks 1986; Morgan 1986; Sharrod 1985), this view is commonly raised among the media and general public. The assumption is that an organic disorder and reports of its symptoms would develop in a similar fashion in all countries with similar technologies and work organization. This view again follows the medical model, implying that organic injuries are reported and assessed more or less independently of social arrangements. Proponents of the standard medical view, however, can cite many studies over many decades and in many countries of pain and disability in workers' hands, arms, necks, and shoulders as a result of physical stresses on the job (Bammer 1987a, 1990c; McDermott 1986; Quintner 1989; Task Force 1985; Wallace and Buckle 1987). The few critics who do mention these studies either dismiss them or interpret them as supporting their own case (Bell 1986).

This short survey illustrates the methods used by the critics of the standard medical view. These critics explain how the diverse symptoms and social phenomenon of RSI have been interpreted and organized into a traditional medical injury model, with inadequacies and loose ends dropped along the way. The critics' arguments are quite vulnerable, however, if their demands for objective signs and predictability of treatment are applied to their own explanations (Bammer and Martin 1988; Foster and Fry 1988; Mullaly and Grigg 1988). For example, what are the clinical signs of compensation neurosis? Although the critics have written many articles and letters to journals, for the most part these have not been answered

or refuted by supporters of the standard view, who have largely rested on their medical credentials and studies of RSI in their attempt to close the debate. By contrast, the critics initially tried to open the debate by demonstrating interpretive flexibility, as discussed above. They also argued that all discussion of the problem had to cease in order to stop recognition of what they saw as a "nonproblem." This strategy succeeded in 1988 when the *Medical Journal of Australia*—the main forum for technical discussion and debate—terminated publication of articles and letters on RSI for over a year.

Thus far we have analyzed the disputes over the nature of RSI by implicitly treating evidence and arguments as resources used by the various actors to promote their favored explanations. From this basis, there are various ways to begin dealing with the wider social dynamics associated with RSI.

One method uses the concept of interest. The connection of arguments to social interests is straightforward at one level. Those promoting the standard medical view have legitimated the claims of people with symptoms of pain and disability as organic, work-related and hence compensable. Their arguments have been taken up by people with RSI, trade unions, and various support groups to press for improved workers' compensation and ergonomic changes, including improving furniture, equipment, and the organization of work. The arguments of those criticizing the standard medical view have been taken up by employers and insurance companies seeking to deny compensation claims. Some proponents of the alternative explanations have been prominent in testifying for employers and insurance companies against RSI claims by employees (Campbell 1988). While the concept of interest has been widely used in the sociology of knowledge, the method for attributing interests is not inherent in the analysis of knowledge claims, but rather relies on some theoretical assessment, explicit or implicit, of the dynamics of society (Barnes 1981; MacKenzie 1981, 1984; Woolgar 1981; Yearley 1982).

A different way to proceed is to build up an understanding of society from observations of behavior at the micro level (e.g., Latour 1987). Yet another approach is to draw on already existing concepts, such as social class, patriarchy, and professions, from various bodies of theory (Russell 1986).

This diversity of options for undertaking Collins' (1981) third stage of linking closure mechanisms with the wider social setting suggests that while the sociology of medical knowledge as a theoretical framework is well-equipped to deal with micro-struggles over knowledge, it is poorly defined when it comes to making links with the wider dynamics of society. For this reason we have kept our analysis using the sociology of medical knowledge mainly at the level of knowledge claims, a restriction that does not hinder an assessment of de facto partisanship.

De Facto Partisanship I: Sociology of RSI Knowledge

The sociology of medical knowledge is founded on deconstructing, and thereby opening to social explanations, the origins, development, and deployment of medical knowledge. This program of analysis involves no overt assessment or moral judgement of patients, physicians, or others. Yet, applying the sociology of medical knowledge leads to a de facto intervention into medical debates, which is very apparent in the case of RSI. The first task of critics of RSI is deconstructing claims that RSI is an organic condition. Appropriately, RSI critics occasionally refer to the literature on the social construction of reality. For example, Lucire (1986a) cites the classic social constructionist book by Berger and Luckmann (1966); Bell (1989) cites Willis (1986), who is sympathetic to the cause of workers, and also cites two leading critics of conventional medicine, Illich (1977) and Zola (1977), to support his case.

What exactly is it about the sociology of medical knowledge that provides de facto support to the critics of the standard medical view? The relativist sociology of medical knowledge—when deployed in a social environment dominated by objectivist assumptions—serves to undermine medical orthodoxy because most observers consider that a social explanation gives a phenomenon less credibility than one grounded in alleged physical or biological reality. The de facto partisanship of the sociology of medical knowledge thus rests on the relation of its symmetrical method to the asymmetry of credibility of knowledge claims (and power) in the medical community and the wider society. If the medical orthodoxy were toppled and replaced by one of its challengers, the sociology of medical knowledge would threaten the new orthodoxy. The de facto support provided by the sociology of medical knowledge therefore depends on what issue it is applied to, and at what time and place. Applying it to RSI in Australia in the 1980s means undermining the standard medical view that RSI is organic and work-related.

Consider, by contrast, applying the sociology of medical knowledge to RSI in the United States, where RSI has been almost invisible until recently. The issue gained increasing attention in the late 1980s, but there has been no debate in U.S. medical journals like the one in the *Medical Journal of Australia*. Because there has been relatively little debate in medical circles and the general public in the United States, social scientists have not been drawn to analyze the issue as they have in Australia. The sociology of medical knowledge is much less likely to be applied when there is no publicly visible debate. This points to an application bias: when there is a dominant position backed by medical authorities, the deconstructionist sociology of medical knowledge provides de facto support for challengers. But when there is no debate at all, such a relativist social analysis is less likely to be made in the first place.

Social Problems as Social Movements

The approach to the study of social problems that is closest to the sociology of scientific knowledge is the definitional or social constructionist approach (Spector and Kitsuse 1977; see also Best 1989a; Gusfield 1981; Hilgartner and Bosk 1988; Schneider 1985; Schneider and Kitsuse 1984). When relevant actors define something as a social problem, it can then be transformed into one. This process can involve a range of activities, including categorizations by doctors, reports by journalists, policy statements by governments, public meetings by citizen groups, and studies by social scientists.

Both the sociology of scientific knowledge and the definitional approach to social problems deal with the processes by which categorizations of reality are made. The former usually concentrates on the social construction of knowledge claims among specialists, whereas the latter typically emphasizes the wider processes by which something is defined as a social problem. Much of the work done under the aegis of the definitional approach retains an overt or covert commitment to the reality of social conditions. Hence, the work is not totally constructionist, but rather applies constructionist analysis selectively, what Woolgar and Pawluch (1985a) call "ontological gerrymandering." Best (1989b) defends this approach, which he terms "contextual constructionism." By contrast, Ibarra and Kitsuse (forthcoming) argue for a "strict" constructionism. (See also Hazelrigg 1986; Pfohl 1985; Woolgar and Pawluch 1985b.)

The strict constructionist and sociology of scientific knowledge approaches share a commitment to analyzing all sides to the struggle using the same tools. As a result, the comments about de facto partisanship made earlier about the sociology of medical knowledge also apply to the strict constructionist approach. Therefore, in order to explore a contrasting theoretical perspective, we have chosen the perspective of social problems as social movements. Mauss (1975, 1989), who champions this approach, sees social problems as inseparable from social

movements because of their shared characteristics, including subjective definitions of reality, the formation of interest groups and their respective definitions of reality, and efforts to mobilize public opinion. In a social movement, there are several levels of participants, including the sympathetic public, the active membership, and the principal leaders and organizations. The movement undergoes a natural history, dependent on its interaction with the surrounding society, which typically includes incipiency, coalescence, institutionalization, fragmentation, and demise. Its legacy may include residues and redefinitions at the levels of popular culture, norms, and laws.

Troyer (1989) points out similarities and differences between constructionist and social movements approaches, and argues that it is not useful to say that social movements and social problems are the same thing. However, our main purpose here is not this debate but rather an examination of de facto partisanship and RSI. Hence, setting aside the theoretical limitations of the social-problems-as-social-movements perspective, we apply it to the RSI issue. To extend the contrast with the sociology of medical knowledge, we find it useful to adopt the objectivist assumption that RSI is an organic, work-related injury. Afterwards, we use this application to probe the sources of de facto partisanship in the approach.

RSI as a Social Movement[2]

In industrialized countries, the pain and disability long associated with work has received little public attention. Manual workers, who often carry out monotonous physical motions with little respite, face imposed conditions which reflect their weak occupational position vis-à-vis employers. This same weakness is associated with their difficulty in effectively presenting claims about occupational injuries. Relatively few manual workers—especially those from ethnic minorities—have the skills, confidence, and personal connections required to contest medical evaluations, undertake legal actions, lobby politicians, or organize media coverage. Ethnic and class differences are compounded by gender differences in the work force. Occupations which put male manual workers at high risk of developing RSI include welding, meat processing, and car assembly; for female manual workers, high risk areas include assembly line electronics, food processing and packaging, and the garment industry. Although the gender division of labor is central to the social geography of occupational health, the special health problems related to gender have received relatively little attention.

Several conditions provided the basis for an Australian RSI movement in the 1980s. Until the 1970s, Australia experienced low unemployment and stable economic growth. Thus, many of those experiencing pain or injury, or suspecting incipient physical problems, found it easier to change jobs than to apply for workers' compensation. Increases in unemployment and inflation in the 1970s led many workers to stay in jobs and put up with conditions they would have left in previous years. In the rapid industrial restructuring of the 1970s, new technologies were introduced ostensibly to maintain international competitiveness, while unemployment weakened the capacity of trade unions to defend traditional work practices. For many workers, the changes meant intensification of work rates, which appears to place greater physical stress on the body and to lead to an increased number of people experiencing pain and disability. The introduction of visual display units (VDUs) has had a dramatic impact on clerical workers, increasing two of the risk factors for RSI, namely rapid repetitive

2. Quite a number of factors and groups have been nominated as important or possibly important in the rise of RSI in Australia. These include changing work organization (especially increased productivity), inability to change jobs, migrant workers, white middle-class female workers, Australian trade unions, laws on workers' compensation, the medical profession, and the media. Here we consider these factors and a wide range of sources, including Bartlett (1984), Davis and Lansbury (1986), Meekosha and Jakubowicz (1986), Reid and Reynolds (1990), Stone (1984), and Willis (1986).

movements and static load (often combined with awkward postures). In addition to bringing changes in work organization, including increased workload and reductions in task diversity, autonomy, control, and peer cohesion (all of which are associated with RSI), VDUs pose a real threat of increased unemployment (Bammer 1987a).

While clerical workers are nominally "white collar," their low wages and limited control over work conditions are very similar to those of manual workers. Women's health problems commonly receive less attention than those of men (Lewin and Olesen 1985; Scully 1980). In addition, the low status of clerical work makes it difficult to generate concern about its associated health problems. But several factors counterbalance these weaknesses. As well as being white and English-speaking, many Australian clerical workers have moderate to high family incomes. In addition, a major focus of the "second wave" of the feminist movement has been women's health issues, and the movement gave women confidence, individually and collectively, to pursue their interests. Both an organizational network, including contacts with health practitioners, and a willingness to take women's concerns about their health seriously helped lay the basis for an RSI movement.

Although intensification of work rates, introduction of VDUs, and the strength of the women's movement are hardly unique to Australia, one key difference in the Australian situation may have been the trade union movement. Australian trade unions have long played a prominent role in society; many have a history of activism on social issues, of which the green bans (bans on construction or other work in environmentally sensitive areas) are the most well known (Roddewig 1978). In recent years, some of the white collar unions, most of whose members are government employees, have become increasingly militant. Trade unions developed increased interest in occupational health and safety in the 1980s and publicized the problem of RSI through their internal journals, by organizing industrial actions, and by backing some workers in legal test cases (Bammer 1990b).

Specific Australian institutions reflecting the strength of trade unions were crucial in the rise of an RSI movement. One important factor is the Australian system of compensation for worker injury or death which is considered relatively generous (Hopkins 1990). Access to workers' compensation laid the basis for an expansion of claims around a new pattern of injury, or increased reporting of a pre-existing pattern of injury.

Another Australian institution behind the rise of an RSI movement was workers' health centers, established by trade unions in the 1970s to deal with health problems of special concern to workers. In the late 1970s, doctors at some of these centers began to publicize pain and disability among manual workers due to repetitive work and static load. Early in the 1980s, a small number of Australian medical practitioners also began to write about similar problems among white collar workers which they attributed to repetition strain and static load especially associated with VDU work (Walker 1979; see also Browne, Noland, and Faithfull 1984; Stone 1983; Taylor, Gow, and Gorbett 1982; Taylor and Pitcher 1984). Adopting the common term RSI to include a broad range of symptoms and conditions facilitated recognition of similar problems by different practitioners and others. The medical interpretation of RSI was crucial for those seeking to legitimate it as a social problem. The stamp of medical approval certifies complaints as having a real basis, backed by a highly credible profession. A number of doctors subscribing to the standard medical view, especially those who have done research and written about RSI, have been prominent in testifying in court on behalf of RSI complainants (Campbell 1988). Doctors' interpretation of the potential for serious injury progressing through identifiable stages was taken up by several groups: trade unions, the media, women's health groups, and workers themselves. The link with VDUs was important because concerns about the rapid spread of this technology made the issue very topical.

Reporters picked up and maintained a sustained interest in the story, and this interest

expanded over a period of years until RSI became a household word.[3] Women's health groups provided support and encouragement, interacting with trade unions, media, and those with RSI. In addition, as workers saw their workmates acknowledge and report RSI, and learned firsthand about the symptoms and contributing factors, they were much more likely to take note of the same problems in their own bodies.

The net result of this symbiotic process was a rapid increase in reported cases of what was dubbed RSI. Throughout the RSI expansion, countervailing forces were also at work. Employers, including the government, perceived that they had much to lose from RSI. Privately, many considered "victims" to be malingerers who were abusing the system to illegitimately claim workers' compensation; this view was supported by some doctors and workers. Another interpretation was that the problems were minor and the symptoms were exaggerated.[4]

As the number of RSI claims expanded during the mid-1980s, a variety of responses emerged. "Ergonomic" furniture, rest breaks, and exercise routines were instituted in many work places (for example, Australian Apparel Manufacturer 1985; Dunstone 1985; Kemp 1984; Rowe 1987; Tasker and Westerly 1985). On a different front, employers (often through their insurers) attempted to minimize payments. In several instances they went to court to challenge employee claims, relying on a number of doctors who questioned the validity of occupational injury claims.

Thus the rise of RSI in Australia, rather than in some other country, arguably depended on the generation of a movement which included core activists (such as advocates at workers' health centers and organizers of support groups), active supporters (trade union officials, journalists), and passive supporters. It used a variety of resources to mobilize concern, including personal communication, the efforts of various organizations, and media coverage. In addition, it included an interpretation of the world which justified social action. The initial rapid expansion, the plateau, and the counteraction by opponents are typical of social movement dynamics.

If recognition of RSI as a social problem depended on the existence of an RSI movement, the "problem" of RSI could be expected to recede as the movement fragmented and declined. Social movements decline for a number of reasons. Internally, key activists become burnt out after years of campaigning. Unless the movement is institutionalized in the form of jobs, laws, clients, and income, many participants will drop out or move on to other issues. Failures can lead to disillusionment, whereas successes can lead to a perception that the problem is being adequately handled. Outside the movement, the role of the media is 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 block success; accommodation or co-option involves addressing the problem, often in a limited fashion, and reducing 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 stabilized and then declined, the opponents of RSI mobilized, effectively capturing and silencing the debate. Statistics on the number of cases are no longer routinely published. 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. In a major court case, the federal government argued that RSI was not an organic injury (Campbell 1988). On the other hand, as outlined earlier, a variety of measures, including "ergonomic"

3. In our literature search, we encountered a wide range of business and occupational group newsletters and journals containing articles about RSI. Usually, there was only a single article subscribing to the standard medical view in the mid-1980s (also see Bammer 1990b).

4. Ironically, Reid and Reynolds (1990) suggest that this denial of RSI as a real problem has been a major factor in making symptoms chronic. Doctors who do not believe the disorders are real, fail to provide appropriate care and constantly put their patients on the defensive by requiring them to prove they are in pain.

furniture and routine breaks were introduced to mitigate the problem. Thus, the movement has left some residues, including a popular awareness of RSI and likely risk factors; a network of sympathetic doctors, researchers, and support groups; and some changed work practices (Bammer 1990a, 1990b).

De Facto Partisanship II: RSI as a Social Movement

In principle, this description of RSI as a social movement does not necessarily legitimate or delegitimate the reality or importance of RSI. In practice, the social movement characteristics of RSI have been used as a basis for attacking its legitimacy. Most notably, the "pain-patient" or "social iatrogenesis" explanation of RSI focuses on the many activities characteristic of social movements. Bell (1989) refers to actions by trade unions, media, sympathetic doctors, and governments, all of which he cites as a contrast with, rather than as a response to, real clinical signs of injury. Spillane and Deves (1987:48) simply state that "RSI is a social movement and not a medical epidemic." Others also cite activities characteristic of social movements to delegitimate the standard medical view. For example, Bloch (1984:685) suggests that RSI is "a figment of vested interests and politics," citing the role of trade union literature, media presentations, and traveling theater groups.

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 recognized as a social problem *without* the entrepreneurial activities of a social movement. Of course, it is precisely this assumption that the social movement interpretation challenges. The contrast between the standard assumption and the view that a social movement is necessary to create a social problem builds a de facto partisanship into the latter.

Exactly how does the social movement perspective give de facto support to the critics of RSI? Before the social movement developed, there was no debate over RSI and the issue remained invisible, both socially and sociologically. In other words, the status quo was silence and the social context of nonrecognition of RSI problems was not examined sociologically. The de facto partisanship of studying a social movement thus arises from examining the social activities of only one side in the RSI struggle.

One way to change this emphasis is to focus on countermovements. A number of insurance companies and employers (including the government) have mobilized against the standard medical interpretation of RSI. They have not only contested the awarding of workers' compensation, but have promoted a climate of skepticism about the validity of complaints. This may have contributed to efforts to change several Australian states' and territories' laws to limit opportunities to seek compensation through common law (CCH Occupational Health and Safety Editors 1987; Journal of Occupational Health and Safety—Australia and New Zealand 1987).

The RSI countermovement's characteristics are different from the RSI movement itself, in that it tries to deny the presence of a "real" social problem, and has strong links to powerful economic groups. Nevertheless, the countermovement is a form of social mobilization; focusing on its mobilization in Australia could yield insight into activities of employers in other countries who attempt to prevent the emergence of an RSI movement. Comparative studies of countermovement activities would be especially beneficial. The struggle over RSI in Australia can sensitize analysts to social conditions and arrangements of social forces in other countries which have precluded the emergence of RSI as a social problem. Unfortunately, there are relatively few comparative studies even of recognized risks in dominant societies, much less of those which are unrecognized.[5]

5. Among the few comparative studies of risk are Gillespie, Eva, and Johnston (1979), Irwin (1985), and Jasanoff (1986). Bammer (1988) has carried out a pilot study comparing seven countries and showing that although the diagnoses

The de facto partisanship of the social movement explanation of RSI thus stems primarily from its application to Australia in the 1980s, where the issue has been most prominent, rather than to other countries or other times, where a real—or potential—anti-RSI "countermovement" has been powerful enough to keep the issue off most public agendas. To speak of a "potential" countermovement is to highlight the de facto partisanship associated with studying social movements.

Conclusion

The Australian RSI phenomenon is a useful case study for assessing social problems perspectives. The standard medical view has been central to RSI, but its deficiencies have been exposed by critics' alternative explanations. The dispute's prominence in the *Medical Journal of Australia* has made public negotiations and disagreements over medical knowledge claims; claims which in most cases are not easily examined. Open involvement of a wide range of groups, including doctors, trade unions, employers, women's groups, and journalists, in the vociferous public discussion means that a wealth of material is available for examining the social dynamics of the rise and fall of RSI as a prominent social problem in Australia.

An initial motivation for this study was the question of why diverse approaches to the social examination of RSI all seem to be more useful to the critics than the proponents of RSI. The sociology of medical knowledge, with its symmetrical analysis of negotiations over knowledge claims, selectively aids the critics of RSI. This is because under the circumstances of the debate, deconstructing knowledge claims undermines to a greater extent the position that RSI is a real, organic condition. The social problems as social movements approach, with its concentration on social movement activities, also selectively aids the critics of RSI because outside sociological circles it is commonly thought that recognition of a social problem does not require a social movement. Therefore, pointing out movement activities, even in the context of objectivist assumptions about RSI's existence, tends to undermine the position of RSI proponents and to provide de facto support for the critics of RSI. This is shown by the fact that partisans—only a few of whom are social scientists—who have attacked the standard medical view have undertaken a social deconstruction of medical knowledge characteristic of the sociology of medical knowledge, and have cited social movement-like activities. This is congruent with theoretical expectations that any social explanation of a problem will undermine the viewpoint that more successfully claims to be founded on physical reality. Accordingly, proponents of the standard medical view do not refer to social explanations for RSI, but rest their case on medical evidence.

More fundamentally, the de facto partisanship in each case is linked to a contrast between sociological explanations and prevalent views about medical knowledge and reality. Hence, a plausible generalization is that any sociological explanation of RSI in Australia is likely to serve the cause of the critics. Even an objectivist analysis provides little help for the standard medical view, because the issue of the medical status of RSI has been opened up by the critics. Any discussion of the *debate* tends to give added attention to the critics, as long as they have less credibility in the medical profession.

Our assessment of de facto partisanship depends on recognizing the artificiality of the distinction between analyst and actor. Approaches to studying RSI may appear nonpartisan in the abstract, but cannot remain so in practice because sociological concepts and studies are taken up in the debate. Realistically, many of the social analysts have seen themselves as making a contribution to the debate rather than just commenting on it to a hypothetically

given by doctors varied greatly from country to country, RSI is common among office workers. There is some evidence that it is more common in Australia.

separate social science community.[6] The problem from this viewpoint is that is so difficult to analyze the Australian RSI issue without providing de facto support for the critics of RSI.

Identifying de facto partisanship in the 1980s Australian RSI debate is aided by a well-established orthodoxy and by the case study approach used in sociological studies of the issue. Both these conditions apply to many social problems, but not all. In some cases, the debate is sufficiently balanced or so fluid that there is no clear orthodoxy and determining de facto partisanship becomes more complex. The case study approach provides a ready resource to actors who want to use sociological findings for partisan purposes.

The case of RSI highlights a common feature in standard approaches to the study of social problems: the absence of a way to select for analysis either social conditions which are not social problems or scientific evaluations which are not subject to challenge. Social scientists began studying RSI only after the issue became prominent, and only in Australia where there has been a vehement debate. In many other countries, where pain and disability associated with repetitive work have been widely documented but no social movements or suitable scientific definitional activities have arisen, the issue has been seemingly invisible to social scientists.[7] Thus, a key factor in creating de facto partisanship on the RSI issue is the choice to examine the Australian debate in the 1980s, in which the standard medical view that RSI is an organic, work-related injury came under attack.

This sort of de facto partisanship could be reversed by dealing with issues generating little or no public debate. This would mean switching from studying what has come to be defined as a social problem (in a particular time and place) to studying what the analyst believes *should* be a social problem (perhaps in another time and place). Such an approach would not eliminate partisanship; indeed it would make it much more obvious. Considering that such partisanship is inescapable, we believe it is preferable to be open about it.

It is certainly possible for social scientists to analyze the social structures inhibiting the emergence of a social problem as well as the activities which signal the recognition of one. One way to do this is to use the concept of "nondecisionmaking" (Bachrach and Baratz 1962; Crenson 1971; Lukes 1974) to examine the nonexistence (or "unpolitics") of particular social problems. If a problem exists in one country but not in another, there is reason to study either its dynamics in the first country or its failure to emerge in the second. Similarly, a debate restricted to one medium (scientific journals, mass media, "fringe" publications, particular organizations, personal accounts) could trigger study of either the existing debate or the lack of discussion elsewhere. Clearly, the analyst must choose what to study; this choice entails partisanship, whether open or de facto.

This conclusion has implications for the sociological justification, or warrant, for studying a social issue. For objectivists, the warrant is real social conditions. For constructionists, denied the methodological resource of objective reality, the warrant is social debate and struggle. The inevitability of de facto partisanship suggests that the range of acceptable warrants should be expanded. Sufficient reason for studying topics which are not (yet) defined as social problems exists when there is either scientific evidence (not necessarily widely accepted) that there is debate, or there are critics (even if there is no public debate). Since a sociologist can be a critic, in principle, no further warrant is needed than the analyst's own judgment.

Of course, this prescription does nothing more than describe the actual practices of some sociologists, who on occasion analyze what they alone consider to be issues of significance. The concept of de facto partisanship provides a theoretical context for such initiatives. Given that partisanship is built into the choice of theoretical framework and its application, it is futile to try to eliminate partisanship, de facto or otherwise. Instead, a plurality of partisanships should be encouraged, in the spirit of the maxim that "there is no single road to truth."

6. This comment is based on our interactions with most of the analysts cited.

7. U.S. authors Keisler and Finholt (1988) looked at the Australian problem with little comment on the United States except to provide a baseline comparison of "facts."

In summary, we propose the following generalizations on the basis of our examination of accounts of RSI in Australia. To begin, there is a de facto partisanship associated with the choice of a framework for analysis. For example, symmetrical constructionist analyses tend to more severely undermine those views with greater cognitive authority. But de facto partisanship at this level is only a tendency, which can be either accentuated or counteracted by the choice of issue to study. Sociological accounts undertaken where and when a social problem is receiving its greatest attention tend to delegitimate the dominant view of what is a social problem. Similarly, sociological accounts of why an issue is not considered a social problem tend to legitimate that issue as a social problem. But this second facet of de facto partisanship is also only a tendency. In order to assess de facto partisanship in practice, a sociological examination of the uses of sociological accounts and perspectives in ongoing social problems activities is essential. Finally, these generalizations require sociological study, namely, further examination of de facto partisanship and, especially, the uses of sociological accounts in the activities studied.

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