Medicalising Work Behaviour: The Case of Repetition Strain Injury

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Summary

What can managers learn from the workplace phenomenon of the 1980s called Repetition Strain Injury (RSI) – now Occupational Overuse Syndrome? It is the thesis of this article that RSI represented an example of the progressive medicalisation of Australian work behaviour in which notions of “illness”, “treatment” and “patienthood” figure prominently. RSI provides a case study of the tendency in Australian management, trade unions and occupational health circles to emphasise medical (physical and psychiatric) rather than moral behaviour at work. This tendency, stimulated by professional interests, has retarded work reform strategies based on the principle of responsible autonomy.

KEYWORDS

Repetition Strain Injury
Medicalising Work Behaviour
Responsible Autonomy
Therapeutic Paternalism

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MEDICALISING WORK BEHAVIOUR: THE CASE OF REPETITION STRAIN INJURY

INTRODUCTION

The history of occupational medicine records many instances where the quality of working life has been compromised (Weindling, 1985). For example, the conflictual nature of employment relations and the ‘careless worker myth’ inhibit constructive work reform, whilst more conspiratorial accounts highlight the subservience of occupational medicine to broader corporate, and even national, interests. The same subservience has been noted among occupational psychologists in the U.S. who, it is claimed, have acted as ‘servants of power’ (Baritz, 1960).

One of the goals that has guided work reform strategies since the 1970s is responsible autonomy for all employees. Progress towards this goal was widely acknowledged to be a feature of the Scandinavian experiments of that era (Johnson and Johansson, 1991). But that goal is threatened by policies and practices which deprive employees of their autonomy by treating moral conflicts (behaviourally manifested) as if they are illnesses (physically or psychiatrically manifested) in need of therapeutic control. Medicalising moral conflicts can lead to therapeutic paternalism in which employees are regarded as potential victims in need of medical or psychological treatment rather than as responsible agents (Szasz, 1984).

In Australia, many cases have been brought before courts that point to the medicalising, or “demoralising”, of conflicts at work. For example in the case of Anderson Meat Packing Company vs. Giacomantonio (1973) a worker was
judged to be incapacitated for work whilst “demoralised” after “seeing” God in the cool room of the meatworks (Bennett and Hely, 1982). The use of the word ‘demoralised’ is significant because it suggests that workers who suffer distress at work may lose their capacity for rational, and thus moral thought, and so cannot be considered responsible agents. In this way a moral issue is medicalised. The considerable increase in the number of occupational stress claims in the last decade is further evidence of the ongoing tendency to view problems at the workplace (e.g. interpersonal relationships), in terms of (quasi) medical conditions (e.g. stress), rather than as moral conflicts in human relations.

In the case of Repetition Strain Injury (RSI) conflicting ideologies, clashes between experts and witnesses in litigation proceedings and unpalatable recommendations from government advisory bodies combined to challenge the principle of responsible agency in several ways: by standardising work practices, enforcing time breaks, demanding the use of ergonomically designed furniture, increasing supervisory controls, reporting suspected RSI cases to medical authorities (Bammer and Martin, 1992). In short, RSI was from the beginning defined as a medical (or psychiatric) problem.

RSI: PAIN, PRETENCE AND PATIENTHOOD

What is RSI? Or rather what was RSI since it is now called Occupational Overuse Syndrome?

Pain, discomfort and functioned disorders of a transient nature have long been recognised as occupational hazards. In Australia, such problems
attracted mild interest. Perrott (1961) and Peres (1961) independently noted the prevalence of simple muscle complaints among process workers. Medical intervention was rarely required and the problems were generally overcome by rest and prevented by uncomplicated changes to work practices (task modifications, training). In a small minority of cases the problems were diagnosed as tenosynovitis which had been associated with occupational behaviour and relieved by conservative medical treatment. For the majority of “ill-defined symptom complexes”, to use Ferguson’s (1971) term, the advice of researchers was to consider the influence of psychosocial factors both in and beyond the workplace, since these were important in the incidence, persistence and prevention of these complaints.

In 1976, an industrial health group established at the Liverpool Womens’ Health Centre (NSW) published a booklet Your Job: His Profit or Your Life? in which information on tenosynovitis was documented. In 1977 a Workers’ Health Centre was established at Lidcombe (NSW) and a Workers’ Health Action Group in Melbourne (Vic). These centres were influential in drawing attention to “repetitive injuries” as a serious occupational health issue. More than half of the workers treated at Workers’ Health Centres suffered from what was later called RSI and staff of the centres were particularly concerned about its prevalence among non-unionised, female labour (NOHSC, 1985). In an article entitled A Crippling New Epidemic in Industry published in New Doctor in 1979, these “injuries” were attributed, in part, to the inadequacies of the medical profession and legal/ compensation systems (Walker, 1979). Taylor, Gow and Corbett (1982) studied 89 complainants attending Workers’ Health Centres and attributed their “injuries” to high work rates associated with bonus systems and poor workplace design. The paper concluded with a response to
a letter which appeared in the Medical Journal of Australia in which
tenosynovitis was described as “migrants’ arm”. Interestingly, it was pointed
out that diagnosis (sic) without objectives signs is not an uncommon
phenomenon in medical practice.

Prior to the late 1970’s RSI was unknown in occupational medicine.
Compensation statistics show that the number of musculoskeletal disorders
had been relatively static for many years. Statistically the “epidemic”
commenced around 1979 and continued well into the 1980s. The increases
could not be explained by changes in the size or composition of the workforce,
the nature of work processes or the compilation of official statistics. In NSW,
for example, the number of “musculoskeletal” cases increased from 670
(1976-77) to 980 (1978-79) to 4550 (1983-84), an unparalleled increase. By
1983-84 these cases represented 28.5% of total cases in NSW compensation
statistics. Females accounted for around 55% of 1976-77 claims and 65% of
1983-84 claims which probably reflects, in part, the proportion of women in
jobs that involve repetitive tasks.

Large organisations, particularly in the public sector, recorded similar
increases. Unofficial estimates placed the national total in excess of 20,000
and almost 4,000 cases were recorded in Australian Government
organisations in the December 1985 quarter alone. However, the incidence
pattern was inconsistent with exposure to repetitive tasks. Some organisations
remained ‘unscathed’ whereas others with similar work patterns reported
outbreaks of “epidemic” proportions, e.g. Telecom (Hocking, 1987);
government employees (NOHSC, 1985). Of those organisations affected by
the “RSI epidemic” some revealed a pattern which suggests a contagion effect in that workers were affected in quick succession (Deves and Spillane, 1989).

Clearly, Australians in the 1980s were involved in an epidemic of compensation claims. But what were individuals seeking compensation for? Did the extraordinarily rapid rise in claims correspond to an underlying incidence of musculoskeletal injuries? Or was the epidemic one of mental illness? Or of malingering?

Historically, workers’ compensation cases recorded under the classification ‘Synovitis, Bursitis, Tenosynovitis’ affected, in the main, blue-collar, factory workers. But by the early 1980s a new incidence pattern emerged. No longer were these injuries exclusively associated with semi-skilled, blue-collar workers on production lines. Keyboard operators and clerical workers in traditionally ‘safe’ white-collar jobs began reporting these injuries in increasingly large numbers. As claims for compensation mounted and ‘test cases’ were decided in favour of complainants, insurance premiums skyrocketed. A notable feature of litigation proceedings was conflicting expert medical evidence.

In the early 1980s researchers at the Australian Council of Trade Unions (ACTU) were collecting data on tenosynovitis, cervico-brachial injury and what the Workers’ Health Centre in NSW called repetitive movement injuries. The ACTU issued guidelines in August 1982 in which the author, John Mathews, coined the term “repetitive strain injury” to widen the scope from ‘movement’ to ‘strain’ incurred at, say, a poorly designed keyboard (Mathews 2002). He was influenced in his thinking by white-collar work with new computer-based
word-processing systems in the Australian Tax Office and in the Victorian Railways, where word processing targets of 12,000 or more keystrokes per hour, without rest breaks, were common. The purpose of the ACTU recommendations was to encourage unions to negotiate improved working conditions with respect to the new high-speed equipment, calling for limits on repetitive activity and for regular breaks. The unions were spectacularly successful in having these demands met. The front line in this endeavour was to be the unions’ elected workplace safety representatives. It was Mathews’ intention to have Australian workplaces peopled by worker representatives who would monitor conditions and ensure that employers were meeting their ‘duty of care’. The ACTU guidelines were conceived, therefore, as guides for these workplace negotiations. Importantly, Mathews’ document is critical of endeavours medically to screen individuals to determine susceptibility to RSI. It was also noted that the degree of success attained by medical treatment of the various types of repetition strain injury was unimpressive and in some cases depressingly poor (ACTU, 1982).

Stone (1983) published a paper in the Medical Journal of Australia which helped legitimise RSI as a medical condition. In the following year another paper suggested guidelines for the diagnosis and management of RSI (Brown, Nolan and Faithful, 1984). National concern resulted in the Australian Government establishing two independent enquiries into RSI which recommended substantial changes to the design of work as the major preventive strategy (NOHSC, 1985, 1986).
Whereas earlier approaches to the prevention of RSI concentrated on biomechanical factors (e.g., posture, speed etc) the RSI Committee report makes the following important observation:

‘...preventive strategies based solely on the biomechanical approach and in particular on a disease model have limitations. In Australia, some organisations have spent large sums of money on work-stations and equipment only to find that the problem remains. On the other hand, broader strategies which focus on the way systems of work are organised are more likely to succeed’ (NOHSC, 1985:42)

By 1986, RSI had been called ‘Repetition Strain Injury’, ‘Retrospective Supplementary Income’, ‘Runaway Social Invention’, ‘Golden Wrist’, ‘Kangaroo Paw’, occupational neurosis and conversion hysteria. What, then, is meant when an individual is said to have RSI?

The RSI debate produced four competing perspectives (Spillane and Deves, 1987).

1. **Medical perspective.** RSI is a medical condition that can be diagnosed since workers are physically injured. The injury is attributed to biomechanical factors, (such as inadequate work practices) which must be rectified to prevent further injury. Injured workers are subjected to a range of conservative (e.g., rest) and active (e.g., physiotherapy, surgery) treatments. This model was endorsed by the National Occupational Health and Safety Commission but it slighted the influence of psychosocial factors and gave RSI a medical legitimacy that was unwarranted because of the absence, in the majority of cases, of the necessary clinical signs.
2. Psychiatric perspective. RSI is not a physical condition but a psychiatric problem (occupational neurosis, conversion hysteria). Such psychogenic illnesses closely mimic physical illness and have been known to occur en masse in industrial settings. Attribution is independent of the physical work environment. Rather various psychosocial factors within and external to the workplace result in ‘intra-psychic’ conflict which manifests in this symbolic functional disorder. Consequently, workers require psychotherapeutic assistance to resolve their personal conflicts. This perspective was promoted by various psychiatrists, orthopaedic surgeons and rheumatologists who were employed by insurance companies to give evidence in legal proceedings. These experts argued that the (RSI) complaint is a neurosis which is not occupational in origin and so is not compensable (Lucire, 1986, 1988).

3. Malingering perspective. RSI is neither a medical nor a psychiatric condition, but malingering. It is deliberately faking illness and thus cheating society. RSI is therefore a hoax consciously used (though not invented) by workers to gain concessions (compensation payments, sick days etc). This perspective caused a public furore because it simultaneously impugned both the motives of workers and the diagnostic skills of the medical profession. Be that as it may, it is not unknown for people to feign illness to achieve personal ends (Anon, 1985).

4. Pain-Patient perspective. RSI can be characterised as a social movement built upon a changing set of behaviours toward the experience of pain at work. People who are in essence healthy but experience pain choose to
become patients with pain. By capturing the traditions and prejudices of Australian industrial life, the movement built upon RSI re-defined self from a state of health to one of illness. Bell (1989) and Spillane and Deves (1987) defended this perspective which was later labelled 'social constructionist' and criticised because ‘the intervention of the social constructionists has tended to support the insurance companies in their efforts to blame the victim’ (Hopkins, 1989:250) and ‘their analysis lends considerable support to the interests of employers and insurers attempting to deny the existence of a physical injury and also avoid the payment of workers’ compensation’ (Quinlan and Bohle, 1991: 27).

Whilst these models cannot be reconciled, because they differ on fundamental assumptions about the causes of RSI, the one theme that links the models is that of pain and ‘pain’ behaviour. The reporting of pain is intimately bound up with patienthood, the analysis of which cannot be ignored in this debate (Szasz, 1988).

**RSI AS A PAIN-PATIENT PHENOMENON**

The accepted medical criteria for diagnosing illness are signs (e.g. demonstrable physicochemical alterations of the body), with or without symptoms (e.g. experiences of pain).

The notion of RSI derives its main support from known medical conditions, such as tenosynovitis or carpal tunnel syndrome, with which it is often erroneously equated. A condition such as tenosynovitis can be diagnosed by its signs (for example, inflammation) and symptoms (for example, pain).
However, in the majority of cases of RSI - perhaps in as many as 90% of cases according to Lowy (1985) - diagnosis is made on the basis of symptoms alone (i.e. on the basis of a communication or complaint).

The idea of RSI is thus firmly rooted in the notion of complaint, unlike established diseases (for example, carpal tunnel syndrome) which are based on independent signs. A sore arm is a complaint, ’it’ might be a lie. Symptoms without signs are communications not diseases, complaints not ‘conditions’, until proven otherwise. The fact that medical diagnoses are made on the basis of symptoms alone does not mean they are valid.

Quinlan and Bohle (1991: 126) claim that “Spillane and Deves (1987) support this position by arguing that where symptoms exist, without physical signs, they should not be treated as diseases but rather as complaints or communications. This argument is based largely on uncritical acceptance of the familiar claim that where medical practitioners are unable to identify physical signs of injury it cannot be presumed to exist. As we have seen, it is also possible that medical practitioners really lack the diagnostic skills or the technology to identify the signs. Spillane and Deves overlook this possibility and, after noting claims (disputed elsewhere), that up to 90% of diagnoses of RSI rely on reports of subjective symptoms, they conclude that the assumption that RSI pain arises from repetitive movement at work ‘is unwarranted on the evidence.’ “

Never was a challenge so easily met. There is clearly confusion here about disease and its diagnosis. Spillane and Deves (1987) argue that no diagnosis can be valid unless a sign is present. In the absence of such signs
diagnosticians can at best suggest possibilities. They may be wrong: disease may exist. But they cannot maintain the position that medicine is objective and base diagnoses on their (subjective) impressions. Putative diagnosis is not valid diagnosis and putative disease is not real disease. Whilst it is nowadays commonplace to be told that medical practitioners believe such and such, their beliefs are not facts. Arguing by analogy: since in the law we are presumed innocent until proven guilty, so in medicine we are presumed healthy until proven sick. That doctors or their apologists want to pronounce on our health without evidence represents another manifestation of therapeutic paternalism – ‘medical mugging’ in the language of Szasz (1984).

RSI is based on complaints of pain. Clearly one individual cannot experience another’s pain. Pain cannot be observed directly, although it is often inferred from an individual’s communications: the experience of pain is private and the expression of pain is public. Therefore, when a woman says she has pain we may believe her because she appears to be distressed. However, we may choose to believe that she does not have ‘pain’ but is merely pretending to have pain for some unstated end. The point is that we can only guess. Conversely, when people experience pain they may communicate it, complain about it or conceal it.

Those who complain of pain generally define themselves, or are defined by others, as patients. One can experience pain but choose not to be a patient. However, should there be an incentive to become a patient, it is understandable that some people with (and without) pain will choose to become patients with pain. This is a plausible explanation for the dramatic
increase in RSI-related workers’ compensation cases reported in Australia in the 1980s.

Some people who are diagnosed by medical practitioners or psychologists as patients do not in fact suffer from an illness and do not want to be patients. When people with pain are told that they (may) have a crippling disease which demands urgent medical treatment, both disease and patient role are applied to the experience of pain. Furthermore, turning individuals into patients exposes them to a medical/legal game which few understand or escape from happily. If they are not labelled as sick patients they risk being labelled as psychiatric patients or malingerers. A humane approach to this problem is difficult when workers claim managers made them sick and managers retaliate with company doctors, lawyers and accusations of malingering.

Pain is an inexorable aspect of the human condition and the causes of much chronic pain remain largely a mystery. When employees report pain and suggest possible causes thereof, the responses they encounter influence their subsequent behaviour. When people with pain believe their complaints about work are unimportant, and no workplace changes are forthcoming, they may choose to communicate their dissatisfaction in various ways, e.g., by becoming patients. Where the climate encourages medicalising work behaviour, some individuals are easily induced to become patients. Thus, morals are confused with medicine, values with valium.

RSI was a social movement and not a medical epidemic. It was characterised by a significant increase in the number of people who, in the absence of
diagnosable signs, chose to become, or were defined by others as, patients (with or without symptoms). This situation is summarised in Table 1.

Table 1: Being Ill and Being a Patient – Signs, Symptoms and Patienthood

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It is not possible, given the subjective nature of symptoms, to allocate numbers of people to these categories. As we have seen, the majority of ‘RSI sufferers’ are in categories 5 and 7, yet the attitude is maintained that they should be treated as if they are patients with illness (category 1). Whilst categories 1 to 4 are characterised by observable signs, we are simply not in a position objectively to allocate ‘sufferers’ to categories 5 and 7. The actual rate of malingering can never be known.
THERAPEUTIC PATERNALISM

Australian work researchers have long noted the widespread distribution of pain and discomfort at work. Despite the prevalence of these complaints there were few examples of large numbers of individuals entering the medical system for protracted periods or seeking claims as compensation for ‘damage’ or ‘injury’. Workers who were experiencing pain directed their energies to overcoming their symptoms and the assumed causes. They were neither inclined nor encouraged to adopt the helpless and dependent role of patient. And neither did they seek to use their personal experience of pain in a political arena, despite the availability of this line of redress, either because their problems were dealt with locally or because they risked penalties for complaining. In the 1980s, this historical pattern changed from consultation and cooperation to confrontation and stand-offs. Parties invoked the advice of medical and legal authorities to justify an adversarial stance.

In the absence of clinical signs to substantiate the diagnosis of somatic disease, workers were accused of malingering or categorised as mentally ill. Having had their motives impugned and personal experiences invalidated, workers (and their trade unions) retaliated through medical certification. Many RSI complainants were thus judged to be ill and were removed from the workplace for indefinite periods.

Armed with certification, Australian workers had medically sanctioned access to a compensation system that did little to encourage recovery. Personal activity was discouraged because insurance companies, facing large payouts, employed private investigators whose evidence, admissible in industrial courts, could prove embarrassing to plaintiffs. Faced with the prospect of
jeopardising their claim, many workers adopted, or were placed in, the patient role - a state of dependency - thus leading to iatrogenic consequences (depression, anxiety). These secondary conditions required further medical/psychiatric intervention. Dependency was thus required and promoted through medico/legal intervention and this probably accounts for the persistence of symptoms beyond reasonable expectations.

RSI is not and never has been medically recognised for clinical purposes. The term is a residue constructed from differential diagnostic practice. According to the inventor of the term, John Mathews, it was never intended for use in proceedings allied to, or arising from, litigation. The ACTU’s 1982 recommendations, whilst offered with positive intentions, crossed an invisible line; the prevention of RSI was different from the prevention of, say, occupational deafness where the physical cause was clear (Mathews, 2002). RSI then gained legitimacy upon usage in medical journals, government reports and investigations conducted by government authorities.

That ‘RSI’ escaped from this limited context to gain widespread acceptance in medico-legal proceedings is the result of injudicious medical (and psychiatric) practices. Consequently RSI was routinely referred to as a ‘crippling disease of epidemic proportions’ and management’s efforts to substitute malingering or mental illness served only to stiffen trade unionists’ resolve to combat this ‘disease’. Subsequent government reports further institutionalised RSI by issuing codes of practice and dicta that failed to take account of psychosocial factors even though researchers had emphasised their importance (Spillane and Deves, 1988). Worse still, the guidelines offered by the National Occupational Health and Safety Commission, though ostensibly aimed at
constructive work reform, resulted in establishing coercive work routines, standardising work practices and scrutinising workers. These guidelines are almost the complete antithesis of work reform strategies which emerged from occupational research during the twentieth century and which were based on the principle of responsible autonomy for all members of the workforce (Gardell and Johansson, 1981).

The real victims of the RSI phenomenon were both managers and workers. By failing to take constructive local action and by allowing important work issues to go unresolved and escalate into formal and industrial disputes leading ultimately to government intervention, both parties lost an important opportunity to work cooperatively towards the constructive reform of work conditions and practices.

The legally sanctioned use of the medical model in Australian working life has had unfortunate consequences. By medicalising conflicts in work relations, constructive work reform has given way to therapeutic paternalism which replaces moral conflicts with medical ‘conditions’ frequently ‘diagnosed’ in the absence of signs. Two consequences are: the increasing power of medical practitioners to determine who is healthy and who is ill, and the increased dependency of those who adopt or are placed in the role of patient.

The RSI “epidemic” which represented a tenfold rise in claims has subsided. In 1995 an RSI consensus statement attributed the causes of the RSI “epidemic” to the following factors: technological change (automation, transition from typewriters to computers); poor management practices (failure to address workers’ complaints); unions’ increased attention to workers’ health
and safety (and compensation for work-related “illness”); the spread of RSI from blue- to white-collar workers and publicity about large compensation payouts (some of which was sensationalist and irresponsible); workers’ discontent transformed into “illness”; medical practitioners’ confusion about diagnosis, pathogenesis, treatment and prognosis; RSI support groups that reinforced patienthood; government reports that enshrined a mechanistic model of RSI instead of considering psychological factors (Australian Faculty of Occupational Medicare, 1995).

After the promulgation of the Workers’ Compensation Act in 1987 large lump-sum payments through common law claims dropped dramatically in N.S.W. For example, Comcare claims for Occupational Overuse Syndrome (OSS) for period 1995/6 to 1999/2000 have roughly halved, but so have all injury claims. Claims for OSS accepted by Comcare in the same period have decreased from 1333 (10% of total) to 179 (13% of total) (Comcare, 2002).

The ideological issue of which RSI was one manifestation continues. Today it may be called burnout, chronic fatigue syndrome, personality disorder, adult attention deficit disorder, mental illness, or stress (which now represents 3% of total injury claims accepted by Comcare but 17% of expenditure). Yet many stress claims are based on “problems”, such as getting on with people at work. Until we rethink the issue of what constitutes an injury or illness or allow the possibility that we misuse these concepts at our peril, the medicalisation of work behaviour will continue to inhibit constructive work reform.
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