Engendering Occupational Health and Safety:

RSI in the Poultry Processing Industry

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SYNOPSIS

This thesis explores the gendered discourses that surround the experience of Repetitive Strain Injury (RSI) for women workers in the poultry processing industry. RSI is a significant and debilitating injury and is one of the major occupational health and safety concerns for all assembly line workers. While there is a wealth of research on RSI, very few studies use a gender analysis to understand the experience of this injury. Despite RSI being a key concern for many women workers, women for the most part are ignored in research. When women are central to the analysis of RSI, injured women are labelled as neurotic, weak and marginal workers.

The thesis explains why women are represented in this way in the RSI literature. It identifies two powerful discourses at the centre of explanations of RSI, which also inform occupational health and safety research generally. The first, occupational health and safety discourse, ignores women or draws on a construction of woman that defines her primarily as wife and mother and excludes her from the category of worker. The second, medical discourse, centralises women in the analysis of occupational injury based on reproductive function, psyche and physicality. I argue that while each of these discourses conceptualise gender in a different way, they both draw on a modernist conceptualisation of gender which essentialises gender categories. Men and masculinity are used as a basis for all experience against which women’s experiences are compared and measured, thus limiting our understanding of those experiences. This has meant that women’s physiological, psychological and social differences to men are prioritised in women’s occupational health research, rather than the hazards and risks that they face at work.

This thesis offers a more meaningful explanation of women’s experience of RSI through postmodernist critiques of modernism. It deconstructs the essentialist conceptualisation of gender found in modernism and thereby disrupts the knowledge claims made about injured women workers. In particular, postmodernist insights serve to highlight the ways in which medical discourse constructs illness, disease and other social realities such as gender. However, recognising gender as a
constructed category also challenges its very utility as an analytical tool. This makes talking about women as a group problematic.

The central argument of this thesis is that we need to maintain gender as an analytical concept. I argue that to speak meaningfully about women as a group we need to expand on the modernist conceptualisation of gender by incorporating insights from postmodernism. Modernism reveals the material structures that impact on gendered experience while postmodernism reveals how those experiences are constructed via dominant discourses.

These dominant discourses surrounding gender were evident in the stories of twenty-five injured poultry process workers who were interviewed as part of this research. The workers’ narratives illuminate the dominant constructions of gender that surround contemporary experiences of RSI. At the same time, their narratives highlight how women contest and negotiate these constructions through defining themselves as workers rather than women.

The study demonstrates that reading the women’s stories through a modernist and postmodernist lens reveals how gender continues to structure our experiences. This has significant implications for both occupational health and safety research and feminist research. Engendering occupational health and safety research through the incorporation of postmodernism’s emphasis on the discursive provides new ways of understanding injury and disease at work. Utilising a broad definition of gender has the potential to yield new insights into not only women’s occupational health and safety concerns, but also men’s. Furthermore, engendering occupational health and safety could provide a deeper and richer understanding of the occupational health and safety implications of our globalised economy.

Finally, this thesis provides evidence that gender continues to significantly impact on our lives. Over the last two decades, there have been debates surrounding the utility of gender to adequately understand our experiences. This thesis clearly demonstrates that gender still matters. It matters on both a material and a discursive level.
STATEMENT OF ORIGINALITY

I certify that this work has not previously been submitted for a degree or diploma in any university. Further, to the best of my knowledge and belief, this material contains no material previously published or written by another person except where due reference is made in the thesis itself.

Bernadette Sebar

December 2007
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<tr>
<td>ASCC</td>
<td>Australian Safety and Compensation Council 2005-</td>
</tr>
<tr>
<td>CTS</td>
<td>Carpal Tunnel Syndrome</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>MSD</td>
<td>Musculoskeletal Disorders</td>
</tr>
<tr>
<td>NOHSC</td>
<td>National Occupational Health and Safety Commission</td>
</tr>
<tr>
<td>OOS</td>
<td>Occupational Overuse Syndrome</td>
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<tr>
<td>RACP</td>
<td>Royal Australian College of Physicians</td>
</tr>
<tr>
<td>RSI</td>
<td>Repetitive Strain Injury</td>
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ACKNOWLEDGMENTS

A project of this size is never the achievement of one person. My sincere thanks goes to the injured poultry process workers who shared with me their knowledge and experiences and challenged me to heights that I would not have reached without their insights.

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Finally, my most heartfelt thanks goes to my family: Robin, Nicholas and Georgina. Yes Georgina. It is done! Thank you all for living through this with me. Without your love and support I could never have achieved this. It is dedicated to you.
PREFACE

Fifteen years ago I worked as an occupational health and safety coordinator in a poultry processing plant in Queensland, Australia. During the four years that I worked in the industry I was struck by the magnitude of the injuries suffered by the workers. My job was to keep injuries to a minimum. One way I chose to do this was to weed out those that didn’t have work-related injuries and secondly to put into effect more efficient treatment of those deemed to be injured. So I consciously put many women through the gauntlet before I would be convinced that the symptoms they were describing were accurate. In the four years I worked there I developed the belief that one was “not injured until proven”.

Just prior to starting my PhD I bumped into an old friend of mine (not from the poultry industry) who had been suffering from a work-related RSI for the past 10 years. Following the initial injury she had undergone six unsuccessful operations and was left with a disability that meant that she could not use a knife and fork and had to have ergonomically designed ones made; she could only drive a power steered car which she couldn’t afford to buy; she couldn’t do up a bra; she couldn’t push a shopping trolley; she couldn’t hold her babies long enough to breast feed. She started drinking and taking analgesics to try to control the incessant pain. She was unemployable, but not eligible for a pension because she was married. She received a payout through the workers’ compensation system (4 years after the common law claim first went to court) and while as a lump sum it appeared to be a substantial amount, it added up to the equivalent of four years wages. She became unemployable at the age of 28. I knew this scenario well from the poultry industry
and her story prompted me to reflect on my previous job at the plant and re-think my role there.

I wanted to know why these injuries got so out of hand. Now that I was out of the industry, I could look more critically at the processes that occurred at the plant. I realised that the women’s injuries on the whole were not being acknowledged. Their pain was not taken seriously. It was clear that there was a web of complex relations impacting of ideas surrounding injury causation. I wondered how gender fitted into this web. Was it because they were women that their injuries were so easily dismissed? Or did gender have no role to play?

This thesis is an attempt to tackle these questions.
CHAPTER ONE

INTRODUCTION

This thesis is an exploration of the gendered discourses that surround women’s relationship to occupational health and safety. In particular it is interested in how constructions of femininity within occupational health and safety discourse and medical discourse have impacted on women’s experience of RSI (repetitive strain injury), a major occupational concern for many women workers¹. Despite the existence of a large body of research and knowledge regarding RSI, significant numbers of women workers continue to suffer from this debilitating condition. While there is a wealth of information on RSI, very few recent studies consider gender to be an important factor when identifying solutions to this significant occupational injury. This thesis addresses this gap through an exploration of the experiences of RSI for contemporary poultry process workers using discourse theory to investigate the role that gender plays in that experience.

Using gender as an analytical category in occupational health and safety research is a relatively recent undertaking. Most research conducted on women’s occupational health and safety identifies that there is very little known about the occupational determinants of health in women compared to men. Leading academics in the area

¹ RSI (repetitive strain injury) is an umbrella term for a number of disorders affecting the nerves and tendons. It results in tingling, numbness and eventually lack of ability to use the affected limb. There are a variety of terms used to describe this cluster of symptoms and signs. See Table 1 for a detailed list of conditions that fall under the umbrella of RSI. The term RSI which originated in Australia and has been adopted by the UK is the most understood and known term and will be used in this thesis. The US uses cumulative trauma disorders (CTD), and Japan and Scandinavia use occupational cervicobrachial disorders (OCD) (Pheasant 1991: 77). There has been other terms used such as OOS (occupational overuse syndrome) and WRULDs (work related upper limb disorders). See Chapter Two for a detailed discussion on the definitions of RSI.
of women’s occupational health, Karen Messing and Jeanne Mager Stellman (2006: 150) note that good research into women’s occupational health has been rare. Very few studies consider female workers and those that study male workers do not use gender as an analytical concept. In a special issue on women’s occupational and environmental health Karen Messing and Jeanne Mager Stellman (2006: 149) call for more research into women’s occupational health and safety which considers the complex relationship of gender and sex. They note the problem in past research where identifying biological differences has resulted in justifying job segregation or exclusion. In the same special issue Karen Messing and Donna Mergler (2006: 147) claim that within studies dealing with women’s occupational health and safety “dichotomous thinking about sex and gender is likely to be erroneous” and they argue that using a broad social category such as gender, (or class and ethnicity) may be limited in its explanation of what influences health at work.

This is where my thesis makes its contribution. The aim of the thesis is to bring new insights into the understanding of RSI, one of women workers’ most prevalent occupational concerns. In analysing RSI from both an historical perspective and via the experiences of contemporary poultry process workers suffering from RSI, I will examine the taken-for-granted conceptualisation of woman/gender that is embedded within occupational health and safety research using both modernist and postmodernist methods of inquiry. In doing so, I will explore the utility of gender as an analytical construct in the analysis of female poultry process workers suffering from RSI. The central argument of my thesis is that gender is indeed a useful category. However, in order to maintain gender as an analytical category it needs to be re-conceptualised in light of insights offered by postmodernism. For a more
adequate reading of women’s experience of RSI as well as other occupational injuries, modernist conceptualisations of gender, which focus on patriarchy as structure, need to be broadened to include patriarchy as discourse. Furthermore, it is necessary to deconstruct the binary division of gender as it is embedded within occupational health and safety research, which only allows a narrow understanding of women’s experience compared with that of men’s.

This introduction will map my research journey to make visible how my analysis of a group of poultry process workers’ experiences of RSI raised certain empirical, theoretical and methodological concerns which became central to the thesis. A focus on autobiographical analysis of what it is actually like to do research can provide useful insights into issues often hidden in conventional methodologies (Wise and Stanley 2006; Maynard and Purvis 1994: 1; Renzetti 1997; Campbell and Wasco 2000; Campbell 2002). I draw on feminist theory and methodology, (in particular Michelle Fine (1994) to weave together my story and those of the injured poultry process workers whom I interviewed (see also Richardson and St Pierre 2005; Lincoln and Denzin 2000). Writing the thesis in this way highlights the messiness of research (Fine 1994: 70) and as Laurel Richardson (2000: 930) articulates,

Writing is always…situational, and that our Self is always present , no matter how much we try to suppress it…Writing from that premise frees us to write material in a variety of ways: to tell and retell

The stories that were told to me changed the focus of the thesis from one that would demonstrate how the relationship between gender, illness and medicine at work impacted on the recognition and treatment of injured poultry process workers to one
which questioned the very utility of gender as an analytical category in understanding their experiences.

**Research Context: Initial Reflections and Assumptions**

The interest in this area stemmed from my experience working as an occupational health and safety coordinator in a poultry processing plant in Queensland, Australia which gave me (I believed) a good theoretical and empirical grounding into women’s injuries at work. At the time of writing, statistics indicated that while there was a reduction in the overall incidence of occupational injury and disease among male workers, the opposite was true for female workers. There was an increase in the number of long term workers’ compensation claims made by women (Industry Commission Report 1995: 38), and the average lost time per claim is higher–43 days compared with 36 days (Worksafe 1994: 15).²

It is important, however to note that official statistics do not reflect the real incidence of the injury. Most research into occupational injury maintains that a large percentage of injury goes unreported (see for example WHO 2002; Bohle and Quinlan 2000; Harber et al 2001). This claim is supported by my own experience in the industry where I saw many workers holding onto injuries. Compounding this is the disturbing fact that many claims made by women workers for injury compensation are rejected. According to a report into the Victorian workers’ compensation system, rejection rates differ dramatically for Australian and UK born

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² Given that RSI (or musculoskeletal disorders) is the most common occupational injury suffered by women workers it seems appropriate to assume that these statistics are reflective of the incidence of RSI. (see for example Punnett and Herbert 2000 and Chapter Two)
men (6.8%); Australian and UK born women (17.6%); other migrant men (19.7%) and other migrant women (35.4%) (Quinlan and Bohle 1991: 256).³

These statistics sparked off the initial directions for the thesis, which was to explore the issue of injury reporting. WorkCover Queensland⁴ had told me that the only reason for the rejection of a workers’ compensation claim was if the injury was not work-related (pers. comm. WorkCover Queensland 1999). If this is so, these statistics suggest that nearly one in five women are mistaken about the origin of their pain/injury or alternatively, they are outright malingering. More telling is that one-third of migrant women somehow got it wrong.

My search for research to explain this phenomenon revealed that none had been conducted at that time.⁵ The only comment that I have found regarding the rejection of women’s work-related claims (and by implication their work-related injuries) is from Rubenstein (cited in Cooney 1984: 21) who argues,

³ An attempt to get more up to date statistics from WorkCover Queensland failed. I was told that it was confidential information (pers. comm. WorkCover Queensland). These statistics did not appear in the second edition of this text published in 2000. In a recent presentation by WorkCover Queensland at Griffith University 28.11.2006 it was revealed that rejected claims were now most prevalent for stress injuries. While there was not a statistical breakdown based on gender, stress like RSI tends to be more prevalent among women workers (Peterson and Mayhew 2005).
⁴ WorkCover Queensland is the State government body responsible for the managing workers’ compensation fund and overseeing workplace occupational health and safety standards.
⁵ This comment refers to the literature I accessed prior to conducting in my interviews. For a recent article on the rejection of compensation, see Katherine Lippel’s (2003) Canadian study. In this article, she argues that three factors contributed to the refusal of compensation for women workers. First, repetitive injuries are controversial; second, scientific studies make it difficult to understand women’s injuries due to a lack of research and; third, women are considered to work in light occupations. See also Gender Equality, Work and Health: A Review of the Evidence (Messing and Östlin 2006). This report indicated that in Sweden 56.4% of men’s work-related claims were rejected compared to 77.2% of women’s. I will develop these points in Chapter Four.
It does not seem possible to explain these large variations in rejection rates except as a result of discriminatory practices by insurance companies. In particular it appears likely that the doctors employed by insurance companies to assess claims are more sceptical about injuries to migrants and women than of Anglo-Saxon men (cited in Quinlan and Bohle 1991: 256)

At that time, I agreed with Rubenstein’s analysis that high rejection rates were the result of sexual discrimination and so I looked for research that could provide such evidence. Overwhelmingly, occupational health and safety research focuses on male workers and there seemed to be an implicit belief that women work in ‘soft’ occupations and do not suffer from occupational harm (Messing et al 2003; Sen, George and Östlin 2002; Messing 1998; Mergler 1987; Bohle and Quinlan 2000). Research into women’s occupational health and safety concerns were either limited to reproductive issues (Samuels 1995; Mathews 1993) or ignored (Pantry 1995).  

The original aim of the thesis was to show that women did indeed suffer from occupational harm not necessarily related to their reproduction and that the reason they were largely absent from the texts derived from the dichotomous thought which underpins western philosophy positioning women as sick, neurotic and as actual and potential mothers. Being a worker is not part of the discursive construction of woman. Because men are defined as healthy, rational and as workers, it is only their stories that get told in occupational health and safety texts (Broom 1995). Therefore, I presumed that the absence of women was based on two main reasons. First, there was a lack of research carried out in female occupations.

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6 See also Chapter Four. The literature cited above is indicative of the literature I was reading prior to conducting my fieldwork. The lack of reference to women in occupational health and safety texts continues to be evident at least in Australia. See for example Toohey, Borthwick, and Archer (2005), Ellis (2001). There is a significant amount of research regarding women and occupational health coming out of Canada. See for example the works of Karen Messing 2005, 2004, 1998, 1997, 1995, 1983; Karen Messing and colleagues 2006, 2003, 2000, 1995; Donna Mergler 1995, 1987; Katherine Lippel 2003 and Ellen MacEachen 2005. It was Karen Messing and Donna Mergler’s early work which inspired me to think more broadly regarding occupational health and safety.
based on the assumption that there is no need (Lippel 2003; Sen, George and Östlin 2002; Messing 1998; Mergler 1987; Williams 1997; Hepler 2000; and see Chapter Four); and second, when a woman does report ill health it is usually put down to a defective psychology or biology based on the assumption that women are sick (Richman et al 2000; Kaufert 1999; Broom 1995). In the words of Karen Messing (1998: 92),

The nature of the work done by women is often confused with the nature of women because of the widespread tendency to adjust for gender rather than analysing the results separately by gender

Thus, I came to the conclusion that it was the dominant definitions of women as sick and as non-worker that denied women a voice in occupational health and safety texts. The initial aim of my research was to give voice to injured women workers thereby reconstructing the knowledge surrounding occupational health and safety and “write women” into the texts (O’Neill 1996: 131; see also DeVault 1999). As is the goal of most, if not all, feminist research, my intention was to produce useful knowledge that would make a difference to the lives of women workers (Letherby 2003). I initially located the thesis within the vast body of feminist qualitative or interpretive research which is premised on the assumption that women’s report of experience can be the focus of research (Olesen 1994, 2000, 2005; Eichler 1997; Fonow and Cook (eds) 1991; Stanley and Wise 1983, 1993, 2000; Stanley (ed) 1990; Smith 1987, 1990, 1992; Fine 1994; Reinharz 1992; hooks 1984; Renzetti 1997, Maynard 1994; Ollenger and Moore 1998, see also Wahab 2003, Liamputtong 2007). As Rebecca Campbell and Sharon Wasco (2000: 783) claim, one of the ultimate aims of feminist research is,

  to capture women’s lived experiences in a respectful manner that legitimates women’s voices as sources of knowledge.
To “capture women’s lived experience” of occupational injury I chose to conduct in-depth interviews. Using in-depth unstructured interviewing is the most commonly utilised method for feminist qualitative researchers (Reinharz 1992; see also Liamputtong 2007; Reinharz and Chase 2002). According to Nancy Schoenberg et al (2005: 92) in-depth interviews allow researchers to access complex knowledge from an insider “without the preconceived biases inherent in using existing structured instruments that may contain items irrelevant to local populations”. Furthermore, interviewing allows access to subjugated voices and subjugated knowledge (Hesse-Biber and Leavy 2005: 123).

Establishing Research Methods and Methodology

In 2000, I approached the poultry processing plant where I had been employed for a period of four years as an occupational health and safety coordinator to request access to speak to workers regarding their experience of injury for the purpose of improving the high rates of injury that were prevalent at the plant. This request was denied. As a former employee I was not surprised that the management was not amenable to taking workers off the line to speak to me, so I requested permission to post up the research project in the lunch room with my contact details and if workers were interested I could conduct the interviews off site. To my surprise, this request was not only denied but met with threats of litigation.\(^7\) I was informed that what was needed to curb the high level of injuries was research that would identify a gene that caused some women to sustain long-term injuries or alternatively “what is needed is a psychiatrist to set some of these whingers back on track” (pers. comm.\(^7\)).

\(^7\) During my time at this plant there were no problems with me per se that would have elicited this response.
Risk Manager Plant A).\textsuperscript{8} This conversation confirmed to me that I was on the right track, and so I approached the AMIEU (The Australasian Meat Industry Employees Union) and gained access to another poultry processing plant where I was given permission to conduct interviews during work hours over a three month period (September-November 2000).\textsuperscript{9} I was advised that the plant would be too busy from the beginning of December due to the Christmas rush for me to continue.

In negotiation with management and the occupational health and safety team, it was decided that all female workers at the plant would be approached by the occupational health nurse and asked if they wanted to take part in the research. Unknown to me, the first group of workers were not given a choice and were told that they had to come and speak to me.\textsuperscript{10} Fortunately, I found this out in the fourth interview and all further interviewees volunteered to take part in the research.\textsuperscript{11} In all, I interviewed twenty-five poultry process workers who had experienced or were experiencing a work-related injury. Having or having experienced an injury was not a requirement to be involved in the research. The fact that all the respondents were injured or had sustained an injury may be indicative of the level of injuries at the plant. Alternatively, it may be possible that the workers who volunteered were more likely to be concerned with the injuries sustained at the plant or to be dissatisfied with their workplace and wanted to air that dissatisfaction, especially

\textsuperscript{8} I refer to the plant where I didn’t get access to as Plant A and the one where I did get access to as Plant B.

\textsuperscript{9} The research was granted Griffith University ethics clearance (PBH/01/00/hec).

\textsuperscript{10} This raises an important issue regarding the utility of informed consent. Following a careful explanation of what was contained in the informed consent document, all the women who were “volunteered” signed the informed consent which clearly stated that they had volunteered for the research. This is a particular issue when researching vulnerable populations, who may unthinkingly agree to participate in research (Fisk and Wigley 2000).

\textsuperscript{11} As I discuss in Chapter Six, there were little to no inconsistencies in the stories of the first four participants, so they were included in the study.
given that they were offered the opportunity to do so in work time. This was certainly a concern of the Risk Manager, who claimed that I would probably only get the workers that wanted to complain about the company and had a grudge (pers. comm. Risk Manager, Plant B). However, given that I did not speak to the workers who did not volunteer, I have no way of knowing how self-selection biased my sample (see also Strazdins and Bammer 2004 who discuss this issue in their research). Also of note, is that the interviews were cut short (after 25) due to an accident occurring at the plant which I witnessed. I was advised that the workers were too upset to continue at that time, but later requests to continue where I left off were denied.

I went into the interviews wanting to ensure that the women and their stories were central to my analysis. Based on feminist methodologies I was aware of the power relationship between the researcher and the researched (see Olesen 2000; Stanley and Wise 1983, 1993, 2000; Fine 1994; Reinharz 1992; Renzetti 1997; Maynard 1994). I attempted to create conditions in which the objects of the research, that is, the injured poultry process workers could enter the research process as active subjects. Thus open-ended interviews lasting between one and one and a half hours allowed the participants to establish the focus of the study. This included allowing informants to propose what events or subjects they considered worthy of comment. I identified that my research interest was occupational health and safety, but I did not identify RSI as a research interest, nor did I raise the issue of gender. Importantly, I wanted the participants to be involved in the process of analysis.

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12 In fact he suggested that he chose the workers for the study so that I could “get a balanced view of what the work was really like in there” See Chapter Six for a more detailed discussion around this.
13 The most influential work that informed and continues to inform my methodological stance is Michelle Fine’s work. See for example, Fine (1994); and Fine, Weis, Weseen, and Wong (2000)
was unsure how to undertake this. However, the result was that the women’s narratives guided the fundamental structure of the thesis. Furthermore, in accordance with the feminist ethic of reciprocity I offered the women a copy of my findings. This was refused by most of the workers as they believed that nothing would come out of the research except the awarding of my degree. This was openly stated on many occasions.\textsuperscript{14} I did this with the ideal feminist intention to alleviate the view of the researched as passive givers of information, with the researcher acting as a sponge soaking up the details (see Fine, Weis, Weseen, Wong 2000).

**Reflexive Researching: Responding to Complexity**

As the interviews continued I became keenly aware that I was not going get what I originally expected. The workers did not raise gender as significant in explaining the vast numbers of injuries that were sustained in the processing plant. My belief that it was the omnipresent constructions of femininity that restricted the recognition of women’s injuries at work was becoming very fragile. This prompted three fundamental issues which needed to be addressed. First, it forced me to reflect on my own assumptions regarding gender, second, it raised concerns regarding how I would present the thesis and third, it led me to question what methodological and theoretical tools would be available to analyse the research.

The only point that the participants agreed on was that RSI was the main issue confronting the workers. In response to this, I decided to narrow my thesis from

\textsuperscript{14} This raises a further issue with the notion of informed consent. While many of the workers believed that the research “would be binned”, for some it was considered to be the only way that the women’s concerns would be heard by management. For an excellent articulation of the trade off between privileged researchers and marginalised groups see Fine et al (2000). In their research they claim that “They (and we) knew that we traded on race and class privilege to get a counternarrative out. And so they “consented”. They were both informed and informing” (2000: 115)
the general questions surrounding women and occupational health and focus more on the literature on RSI.

RSI has a dramatic history in Australia in that it was the centre of a major controversy played out by the medical profession, the media, unions and workers. The controversy was based on whether or not the symptoms that sufferers complained of were organic in origin or psychosomatic. If it was indeed found to be an organic condition the next major question was whether or not it was occupationally induced.15

Refining the Research Process

Exploring the Role of Gender as an Analytical Concept

On the whole, the RSI debate centred on questions of legitimacy and credibility. Unlike other studies in occupational health and safety research, studies into RSI include women. However, with the exception of a handful of authors (see for example Bammer 1990; Reid, Ewan and Lowy 1991; Bammer and Martin 1988; Meekosha and Jakubowicz 1986, 1991) a gender analysis was absent from the debate.16 Gender was not problematised. RSI is unquestionably considered an occupational injury sustained by women–although statistically this is not necessarily the case (67% of cases are women). Furthermore, the fact that the debate centred on issues of biological and/or psychological criteria did not illicit a gender analysis.

15 Sport or other recreational activities can cause RSI and it is interesting to note that there has been little controversy over the reality of sports injury. It would be easy to suggest that there is not as much to lose financially in the case of sports injuries, but one commentator suggested that the gendered construction of RSI as a female disease leads to sport induced RSI not to be labelled as such and therefore a masculine sports injury is maintained (Lorber 1997)

16 The authors that did attempt to voice a feminist analysis were not very visible. Even in more recent publications, these authors are only referred to fleetingly saying that there were some commentators that put RSI down to patriarchal relations (Bohle and Quinlan 2000)
On review of the literature it became evident that gender had everything to do with RSI. My reading of the RSI debate identified two major discourses surrounding RSI. It is these two major discourses which I named occupational health and safety discourse (industrial relations) and medical discourse (health) that helped me make sense of the literature and the women’s stories and shaped the structure of the thesis. I develop a theoretical framework which allows me to explore the two discourses surrounding RSI. In order to do this I draw on both modernist and postmodernist methods of inquiry which allows me to understand the material and discursive conditions which led to RSI and RSI sufferers being spoken about in the way that it was at the height of the controversy.

Interactive Researching: Seeking Narratives and Stories

However, I still had the problem that my interview data did not corroborate my argument. So I went back to the interview data and tried to construct some analytical categories from the themes that I had developed in the first round of analysis. It was then that I began to see a pattern in the women’s stories. As mentioned above, the women were adamant that RSI was an industrial relations issue not a health issue and management was the only key to solving the unnecessary numbers of RSI injuries found in the poultry processing industry. However, there was a contradiction apparent in the women’s stories. When the participants spoke about co-workers suffering with RSI injuries they easily slipped into an individualist explanation of the disease. That is, they often questioned the credibility of the person suffering from it raising suspicions of either physical or psychological defects. It was here that I realised that the women clearly moved between the two major discursive structures surrounding RSI which I had identified.
They spoke about RSI as being an industrial relations issue when they were speaking about their own injuries or strategies to address RSI; and as a health issue when they were speaking about other sufferers.

Despite the congruence between my reading and the narratives of the women regarding the two major discursive structures surrounding the experience of RSI, the dilemma of gender remained. This dilemma remained on three levels, empirically, methodologically and theoretically. At an empirical level, the injured poultry process workers denied that gender was at the core of their experiences. I disagreed with this on both a philosophical level based on my own lived experience and on a theoretical level based on feminist theory and my reading of the RSI debate. This led to the methodological dilemma of how to present the women’s stories and use material gathered from the unstructured interviews. I had asked the women about their experiences of injury and tried not to impose my ideas about the importance of the centrality of gender in understanding that experience. In the tradition of Barney Glazer and Anselm Strauss’ (1967) grounded theory, I wanted to let the concepts, explanations and interpretations of those participating emerge from the data (see also Charmaz and Mitchell 2001). The methodological dilemma that emerged was how to confront the discrepancies between the women’s stories and my interpretation of these stories based on my theoretical understanding. Michelle Fine et al (2000: 116) ask the same question as I did regarding my dilemma,

How do we connect theoretically, empirically, and politically troubling social/familial patterns with macrostructural shifts when our informants expressly do not make, or even refuse to make, the connections?

In other words, in whose voice should I present this thesis? My principal concern was how to discuss my research without “othering” the injured poultry process
workers, exploiting them or leaving them voiceless in the telling of their own stories (Finley 2005). Joan Acker, Kate Barry and Johanna Esseveld (1991: 142) raise this issue,

We have not solved this problem; we believe that the solution lies in accepting the dilemmas and maintaining an awareness of when and why we are not able to make the research process a true dialogue, thus giving full legitimacy to the subjectivity of the other as well as to our own. At least then we can articulate the difficult balance between granting respect to the other’s interpretation of her reality, while going beyond that interpretation to comprehend its underlying relations.

My thesis is an attempt to do this. Inspired by the postmodernist work of Michelle Fine (1994); Michelle Fine et al (2000); Pranee Liampputong (2000) (see also 2007); Laurel Richardson (2002); Sue Wise and Liz Stanley (2006) and Laurel Richardson and Elizabeth St Pierre (2005) this thesis endeavours to disrupt the academic convention of the absent, objective researcher and to lay bare the relationship between myself as researcher and the injured poultry process workers as subjects. This process is what Michelle Fine (1994: 70) has called “working the hyphen”. By this she means “rethink[ing] how researchers have spoken “of” and “for” Others while occluding ourselves and our own investments, burying the contradictions that percolate at the Self-Other hyphen”. To address this, I present the narratives of the injured poultry process workers alongside my own in an attempt to give legitimacy to both our voices. In doing this, I highlight the messiness of the research process and question the authority usually given to the researcher to theorise and present the narratives of the researched in an objective and neutral way.

Central Research Question: Thesis Argument and Contribution

On a theoretical level, the denial that gender had anything to do with RSI by the injured women workers was further questioned when both discursive structures that
I had identified in my historical reading marginalised women’s experience albeit in different ways. In occupational health and safety discourse, gender (read women) is ignored in analysis and women are either absent from the texts or considered to have the same needs as their male colleagues. In contrast, gender (read women) is centralised in medical discourse. Women are seen as intrinsically different from men requiring special attention. In this discourse, RSI is deemed to be the result of female biological or psychological deficit. This led me to my central thesis question: can gender be a useful concept in understanding women workers’ experience of RSI.

Questions regarding the utility of gender have been most prominent in postmodernist theorising. However, I was also interested in the contribution modernist theories had to offer. It is my proposition that we cannot talk about women workers’ experiences of RSI without taking into consideration the discourses that shape women’s and men’s lives.

As discourse is a central concept used throughout the thesis, it requires defining here. According to Joan Eakin (2005: 162) the notion of discourse refers to,

... a set of interrelated knowledge and ways of thinking that are embedded in language (words, texts), practices, (behaviours actions), and material objects and spaces (bureaucratic forms, physical arrangements). Discourse is produced and reproduced at multiple levels: it is simultaneously “out there” in public consciousness, the media, and organizational arrangements, and “inside” the subjectively lived experience of individual persons.

I draw mainly on Michel Foucault’s (in Gordon 1980) use of discourse where he argues that the self is not fixed in certain roles but individuals continually negotiate and renegotiate their subject positions within a range of different and conflicting discourses (see also Baxter 2002: 829). According to Foucault (1972: 49), these
discourses operate as “practices that systematically form the objects of which they speak”, which in turn produces an effect. A discourse is not something that is visible (Sunderland 2004: 3), nor something that can be analysed in isolation (Mills 2004: 15) but is detectable because of the “systematicity of the ideas, opinions, concepts, ways of thinking and behaving which are formed within a particular context, and because of the effects of those ways of thinking and behaving” (Mills 2004: 15).

Foucault’s ideas allowed an analysis of the imposition of powerful institutions to define disease and sufferers of disease in certain ways and allowed me to move away from reading the women’s stories as the narratives of victims suffering from false consciousness. However, while Foucault enabled me to discuss the power that the medical profession holds in creating subjectivities, it did not allow an understanding of non-institutional discursive structures that create and maintain female and male subjectivities. I conclude that for a more adequate reading of RSI as well as other occupational injuries modernist conceptualisations of gender, which focus on patriarchy as structure, need to be broadened to include patriarchy as discourse.

Research Limitations

This thesis does not attempt to give a new and definitive explanation of RSI. Nor does it attempt to offer solutions or strategies to curb the prevalence of this significant occupational health and safety issue. Rather, it offers an alternative reading of RSI. Furthermore, in spite of the appropriateness of limiting the interviewees to injured poultry process workers, this study does not explore first hand how gendered discourses impact on the experience of union officials,
management, doctors and WorkCover employees. It gleans this information via the experiences of the poultry process workers. The difficulty in getting access to a plant and maintaining that access meant that the data that were collected were not exhaustive. However this study does allow an in-depth view of occupational injury via the voices of those experiencing it first hand.

**Ethical Considerations**

While this study was largely theoretical in nature, interviewing injured poultry process workers clearly raises ethical considerations for the injured workers themselves as well as for the companies where they are employed. Prior to the conduct of the interviews, management and workers were informed verbally and in writing about the purpose of the study and were advised of their rights as research participants. To protect the identity of the companies used in the research reference was made to the poultry industry as a whole or to Company A, B etc. To protect the workers’ confidentiality, each worker was given a pseudonym. All identifying information was then expunged from the transcripts. This study’s design and methodology was approved by the Griffith University Human Research Ethics Committee (PBH/01/00/hec). (See Appendix 1)

**Structure of the Thesis**

In Chapter Two I present the controversial debate that surrounded the increase in RSI claims in Australia in the late 1980s and early 1990s. Fundamental to the debate were questions of credibility and legitimacy and the women suffering from RSI became central to many of the explanations. This chapter unpacks the debate through a gender lens and explores how women suffering from RSI were constructed in certain ways. This historical understanding is important as the major
explanations that were proffered at the height of the debate continue to have a major impact on the way RSI is diagnosed and viewed (see Bohle and Quinlan 2000; Keyserling 2000a, 2000b; Lucire 2003, MacEachen 2005).

In Chapter Three I develop a theoretical framework for analysing the conceptualisations of gender found in the discussions of RSI. I draw on both modernist and postmodernist methods of inquiry to understand and disrupt the knowledge claims made about RSI by academics, the media, government and the unions. Using both methods of inquiry allows a more meaningful examination of RSI from a gendered perspective rather than a narrow understanding of women’s experience compared to men’s.

In Chapter Four, I present a modernist reading by exploring women’s historical relationship to occupational health and safety. Specifically I examine how women entered occupational health and safety via protectionist policies which resulted in the belief that women were protected at work and therefore did not suffer from occupational harm and at the same time allowing men to be harmed at work. Furthermore, I examine the establishment of medical discourse as the only official voice permitted to discuss occupational health and safety issues for all workers. I argue that centralising medical discourse within occupational health and safety discourse resulted in different experiences of occupational injury and treatment for men and women, based on medical discourse’s power to define what constitutes ‘normal’ masculinity and ‘normal’ femininity.
In Chapter Five, I present a postmodernist reading of the RSI debate. I examine the power that medical discourse has in constructing an understanding of disease and of women. I explore the history of medicine and women and show how occupational health and safety discourse drew on medical discourse’s definition of disease and women to understand the large numbers of women who were making compensation claims for RSI.

In Chapter Six, I present a dialogue with twenty-five poultry process workers and myself regarding ideas around the role that gender plays in their experience of injury. I use both modernist and postmodernist conceptualisations of gender to explore the discourses surrounding contemporary experiences of RSI. In doing so, I highlight the continuity and discontinuity of powerful discourses which impact on our understanding of occupational health and safety.

In Chapter Seven, I revisit the theoretical discussions regarding the utility of gender as an analytical concept in understanding women’s experience of occupational health and safety. Using the insights of the injured poultry process workers, I offer an alternative reading of RSI. I argue that using both modernist and postmodernist theories will provide a richness and depth to discussions surrounding RSI in particular and women and occupational health in general.

I conclude that in order to understand the occupational health and safety concerns of both women and men, we need to move beyond the binary logic that underpins Western thought and reject the tendency to compare men and women. I argue that only drawing on modernist conceptualisations of gender, that is equating gender
with being a man or a woman or possessing male or female qualities hinders our understanding of what it means to be an injured woman worker. We need to broaden our understanding to include the hegemonic gendered discourses that shape men’s and women’s lives in particular ways. Engendering occupational health and safety in this way offers a more meaningful understanding of what impacts on women’s health and work and is essential to be able to address their occupational health and safety needs.
CHAPTER TWO

RSI DEBATE: INJURY OR NEUROSIS

Introduction

The aim of this chapter is to explore the constructions of women within the various explanations that surrounded the RSI debate in Australia in the 1980s and the 1990s. At the centre of the debate were female white-collar clerical workers who were making unprecedented numbers of workers’ compensation claims for musculoskeletal injuries of the upper arms and torso. Using a gender lens, I will explore how various constructions of woman were drawn upon to explain these injuries. These constructions not only played a large part in framing the terms of the RSI debate, but continue to impact on how RSI is diagnosed and viewed (see Bohle and Quinlan 2000; Keyserling 2000a, 2000b; Lucire 2003, MacEachen 2005).

I argue that while RSI had the potential to put women’s occupational health and safety concerns onto the map, it failed to do so because the problem was defined in terms of the women workers rather than the workplace.

RSI Debate: Causes and Controversies

The RSI debate was played out in the media, involving the medical profession, the unions, workers and academics. Despite the plurality of audible voices, the discussions were limited. With a few notable exceptions there was a lack of attention given to issues of class (see for example Gun 1990; Arksey 1998), or ethnicity (see for example Bammer 1990). The solutions to RSI were aimed mainly at ergonomic changes to working conditions in white collar industries and thus workers who are similarly or possibly more at risk of RSI—that is, blue collar
production line workers—continue to be at risk and furthermore have to deal with the legacy of a debate that had little or nothing to do with them.\textsuperscript{17} As Richard Gun (1990) argues, there is an endemic range of RSI-type conditions affecting blue-collar workers over which was superimposed an epidemic affecting white-collar clerical workers. In addition to limited class and ethnicity analysis there was a lack of attention given to the gendered dimensions of the disease (for notable exceptions see, Meekosha and Jakubowicz 1986; 1991; Bammer 1990; Bammer and Martin 1988 and more recently Strazdins and Bammer 2004).

The prolific debate and commentary on RSI was deliberately and abruptly halted by the \textit{Medical Journal of Australia} in 1987 as “specialist discussion came to be regarded as a contributory factor in sustaining the epidemic” (Arksey 1998: 30).\textsuperscript{18} Furthermore, statistics on RSI were no longer issued and according to Gabriele Bammer (1990: 22) these two factors combined to put a stop to meaningful analysis of this debilitating disease. This thesis is part of and extends some of the more recent work which attempts to unravel the perplexity surrounding RSI (see for example Bohle and Quinlan 2000; Strazdins and Bammer 2004; MacEachen 2005; Arksey 1998).

Philip Bohle and Michael Quinlan (2000: 172) purport that the polarised nature of the RSI debate was depressingly similar to that of the preceding debate over back strain. While I agree that the political and ideological nature of the debate is

\begin{footnotesize}
\textsuperscript{17} Richard Gun found that the extremely high rates of RSI were experienced by blue-collar workers rather than in the white collar workforce which was the focus of intervention and litigation (1990: 379).
\textsuperscript{18} Specifically, the \textit{Medical Journal of Australia} imposed a one-year ban on all letters and articles on RSI (MacEachen 2005: 492)
\end{footnotesize}
similar, one factor divides them. The debate over RSI centred on whether the condition even existed and reasons for it not to exist were couched in terms of neurosis and hysteria—mass or individual. Back strain on the other hand did not. Certain workers were considered to be malingering and there were certainly racist overtones to the debate, however it was never questioned that back strain/pain was occupationally-caused and that it was an injury. This is evident in some current texts and articles on occupational health where there is no mention of non-work related factors for the low back pain/strain compared with the upper limb disorders, which includes specific information on non-occupational factors and psychosocial factors (see Andersson, Fine and Silverstein 1995: 455-487; Keyserling 2000a and 2000b).

According to Helen Meekosha and Andrew Jakubowicz (1991: 23) the debate centred on questions of causation and legitimacy. Does RSI have an organic base? If it does, is it an injury caused by work? If yes, is it caused by physical movement at work or is it in response to poor working conditions and environment? If it is not caused by paid work, is it caused by knitting, arthritis, old age, being female or is it simply in the imagination of the worker, or a case of active malingering and not an injury at all? Questioning the legitimacy of the complaint had wide implications for workers suffering from the disease as well as employers and insurance companies. Employers were faced with the possibility of having to make expensive modifications to work stations and paying exorbitant compensation premiums; and insurance companies were faced with large payouts to injured workers. Thus, the interpretation of the injuries was of major importance to all concerned parties; albeit for diametrically opposed reasons (Hopkins 1989: 240).
While using slightly different categories to Helen Meekosha and Andrew Jakubowicz\textsuperscript{19} I will break down the debate into, first, the “standard view” which views RSI as a work-related injury in need of medical and/or ergonomic intervention. For the most part these texts ignored gender in the analysis. Second, psychiatric explanations whose views formed in opposition to the standard view and questioned both causation and legitimacy, and comprised four major theories. Psychiatric explanations claimed that people with RSI either suffered from a conversion disorder; were malingerers; suffered from compensation neurosis or that they were simply suffering from normal fatigue. These arguments clearly had women at the core of the analysis. Third, I will discuss the psychological view which accepts the definition of an injury but argues that psychological factors such as stress contributes to the development of the physical injury or aggravates a pre-existing one. As will be discussed below, an extreme of this argument is that workers can and do use pain as a form of industrial resistance. Finally, I will discuss the social constructionist perspectives\textsuperscript{20} which again do not refute the existence of a physical injury but rather argue that in order to explain the rise in compensation claims the social and industrial context in which the epidemic arose needs to be examined. These final two explanations do not attend specifically to gender and consider women workers needs to be the same as those of men.

\textsuperscript{19}According to Helen Meekosha and Andrew Jakubowicz, “the discourse of causation focuses on whether RSI is socially generated or physiological in origin. The discourse of legitimacy then tests the ‘social’ features in asking whether the social elements can be controlled by the sufferer—are they the outcome of psychological problems of the individual, or active malingering?” (Meekosha and Jakubowicz: 1991: 23).

\textsuperscript{20}There is some debate as to whether a ‘true’ social constructionist perspective was used in these accounts. Hilary Arksey (1998: 86) argues that authors claiming to use the social constructionist perspective tended to discuss the disorder in terms of standard sociological variables such as class and/or gender or as social movements or work alienation rather than in relation to contrasting explanatory models.
However, as I will argue later the implications for men and women when considering RSI from these perspectives are very different.

**Defining RSI**

Before I look at the historical debate a definition of RSI is needed. The pathology of RSI was and still is very unclear (see for example Toohey, Borthwick and Archer 2005; Yassi 1997; Reilly 1995; Higgs and Mackinnon 1995; Andersson, Fine and Silverstein 1995). RSI is an umbrella term for a number of disorders affecting the nerves or tendons of hand, wrist, forearm, elbow, neck, shoulder, back, hip, knee or ankle (see Table 1 below). Injuries in the poultry processing industry comprise mainly upper limb disorders so it is these that I will concentrate on. Initial symptoms of RSI include tingling in the fingers mainly at night, numbness and weakness. There may or may not be obvious swelling. Over a period of time, the discomfort and weakness increases to pain, which usually settles on days off, or at times when the affected limb is not being used. If aggravation continues, that is, if the worker continues to use the limb in a repetitive fashion or continues to maintain static load or use fixed working posture incessant nagging pain results and undertaking the most menial tasks can become excruciatingly painful. Injured workers may suffer from sleep disturbances. Physical signs may or may not be apparent and symptoms may last for months or years even with the cessation of work. Injured workers and interviewees talked of being unable to peel potatoes or push a shopping trolley or drive a car that did not have power steering. The

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21 This explanation comes from my experience of working as an occupational health and safety co-ordinator in a poultry processing plant. The explanation is well supported in the literature (see for example, Arksey 1998; Bohle and Quinlan 2000; McDermott, 1986; Higgs and McKinnon 1995; Yassi 1997).
symptoms appear after months or years of work rather than days. In white collar
work, RSI is usually attributed to keyboard work and in industrial production line
workers it is attributed to repetitive short cycle activities (Pheasant 1991: 78).

Table 1 Disorders Commonly Resulting from RSI

<table>
<thead>
<tr>
<th>Tendon-related disorders</th>
<th>Muscular Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tendonitis</td>
<td>Focal dystonia</td>
</tr>
<tr>
<td>Tenosynovitis</td>
<td>Fibromyositis</td>
</tr>
<tr>
<td>Stenosing tenosynovitis</td>
<td>Tension-neck syndrome</td>
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<tr>
<td>Peritendonitis</td>
<td>Myositis</td>
</tr>
<tr>
<td>Ganglion cyst</td>
<td>Myalgia</td>
</tr>
<tr>
<td>Epicondolytis (lateral or medial)</td>
<td>Myofascial Pain Syndrome</td>
</tr>
<tr>
<td>De Quervain’s Disease</td>
<td>Writer’s Cramp</td>
</tr>
<tr>
<td>Trigger Finger</td>
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<tr>
<td>Game Keeper’s Thumb</td>
<td></td>
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<tr>
<td>Hypotenar Hammer Syndrome</td>
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<thead>
<tr>
<th>Peripheral Nerve Entrapment</th>
<th>Joint/joint-capsule disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carpal tunnel syndrome</td>
<td>Osteoarthritis</td>
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<tr>
<td>Guyon tunnel syndrome</td>
<td>Bursitis</td>
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<tr>
<td>Radial tunnel syndrome</td>
<td>Synovitis</td>
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<tr>
<td>Pronator teres syndrome</td>
<td>Adhesive capsulitis</td>
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<tr>
<td>Cubital tunnel syndrome</td>
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<tr>
<td>Reflex Sympathetic Dystrophy</td>
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<tr>
<th>Neurovascular/vascular disorders</th>
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<tr>
<td>Hand-arm vibration syndrome (Raynaud’s Syndrome)</td>
<td></td>
</tr>
<tr>
<td>Ulnar-artery thrombosis</td>
<td></td>
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<tr>
<td>Vibration-Induced White finger</td>
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Very simplistically, RSI can be broken down into two broad types of disorders:
localised RSIs and diffuse RSIs (Arksey 1998: 21). Localised RSIs comprise those
conditions that present with clear physiological signs such as swelling, are easily
diagnosable and are understood medically. Conditions in this group include carpal
tunnel syndrome, epicondylitis (tennis elbow) and tenosynovitis. Diffuse RSIs, on
the other hand, present with obscure signs and subjective intractable pain. Hence
diagnosis is difficult. It is this second group of RSIs that are primarily, although not
exclusively, at the centre of the debate. Workers had no doubt as to the cause and legitimacy of their pain. However, they found themselves in the midst of a medical controversy where the very existence of the disease was in question. Where there were diagnostic tests that prove that the condition actually existed, questions arose as to whether the condition was work related or not. This is particularly so in cases such as carpal tunnel syndrome where the condition was known to be caused by many non-work-related factors (Bohle and Quinlan 2000: 145). It is to this debate that I will now turn.

The Standard Explanation of RSI: Invisible Women

RSI has long been recognised as an occupationally induced disorder. Bernadino Ramazzini [1713] (1964) is often cited as being the first to recognise RSI in clerks and scribes.22 It is not important to go into great depth about the medical aetiology of the disease and hence only a very brief overview of the medical explanations is offered. The standard view of RSI that was accepted in the early 1980s generally acknowledged that the complaint had an organic basis and that its origins were in the workplace. The injuries were thought to be caused by a number of factors, however the three most cited were rapid repetitive movement; forceful movements that are not necessarily rapid and static load (for full details see Stone 1983; Browne, Nolan and Faithfull 1984; Ferguson 1984; Fry 1986a and 1986b; Valencia 1986). In brief, the most cited definition was put forward by Christopher Browne, Bernard Nolan and Donald Faithfull (1984:330) which states that RSIs are,

22 Not all commentators accept this point. See for example Wright (1987: 233) who claims that "Contrary to popular assertion, Ramazzini did not describe "RSI"". My understanding of his work is that Ramazzini was describing localized as opposed to diffuse RSIs; and Bell (2001: 65) who claims that “To this day […] Ramazzini’s] speculation lacks substantiation except in clearly defined and recognizable conditions very different to RSI."
…musculotendinous injuries of the upper limbs, shoulder girdles, and neck caused by overload of particular muscles groups from repeated use, or by the maintenance of constrained posture, which result in pain, fatigue, and a decline in work performance.

They also identified RSI as a progressive disorder and classified three stages. In Stage One workers complain of aching and fatigue while at work. The pain stops when work stops. In Stage Two the pain starts on commencement of work and continues after work has ceased. There may or may not be accompanying swelling or inflammation. In Stage Three, pain becomes persistent, workers experience fatigue and weakness at rest and physical signs are present. Importantly, this definition and explanation was documented and legitimated by the National Occupational Health and Safety Commission (NOHSC) in 1983. NOHSC is a tripartite (federal government/employer/union) organisation and produced three prominent reports dealing with RSI: The Public Service Task Force Report (1985) and The Interim Report of the RSI Committee of the National Occupational Health and Safety Commission (1985), and the final report, Repetition Strain Injury: A Report and Model Code of Practice (1986).

There were three physiological hypothesis posited in The Public Service Task Force Report (1985). The first was that the synovial fluid that lubricates the tendons is exhausted when the number of movements overwhelms capacity. The second was that frictional heat generated by overactivity breaks down the synovial fluid, producing a toxic inflammatory by-product. Sustained muscle contraction (as in static muscle load) compresses blood vessels and leads to slower absorption of waste products. Over time the muscle fibres weaken and produce symptoms of chronic muscle strain. The third explanation was that a high level of muscle tension
reduces blood flow to the muscles. Energy requirements are therefore not met and metabolites are not cleared, leading to biochemical disturbance and damage to cellular structures.

According to the above explanation, the legitimacy of the disease was not in question. Nor was the cause. Proponents of the standard view accepted that the injuries presenting as RSI were work-related. It was purported that the massive increase in claims resulted from the introduction of new technology without concomitant changes in work procedures and practices (McDermott 1986; Tasker 1989). William Stone (1986: 681) lists a number of possible factors responsible for the epidemic indicative of the arguments put forward by those who supported RSI as a work-related injury. These include increased reporting due to heightened awareness of the early stages of the disease; heightened awareness among doctors of the injury which leads to more frequent diagnosis; increased production rates and longer working hours, incentive payments, limited task variety resulting from automation; lack of job rotation; less mobility with workers more likely to be tied to machines and less mobility between jobs due to the economic recession resulting in the inability of workers to leave jobs that are causing pain and injury and inadequate attention to ergonomic factors.

The standard approach focuses primarily on biomechanical factors and reflects the orthodox medical model of injury and disease. One of the most important underpinnings of this model derives from germ theory, which proposes that all disease has a biological basis that must be visible, diagnosable and treatable by a medical practitioner. Herein lies the dilemma. Many of the workers complaining of
symptoms did not have observable signs.\textsuperscript{23} That is, X-rays, muscle biopsies, blood
tests and nerve conduction studies did not identify any observable lesion/s. Diagnosis was generally made after taking into account workers’ self-reported symptoms, an occupational and clinical history and a physical examination (McDermott 1986: 199). The lack of clear signs was acceptable to many practitioners as well as NOHSC. NOHSC (1986: x) stated in its final report that RSI is characterised by,

\[
\text{discomfort or persistent pain in muscles, tendons and other soft tissues, with or without physical manifestations.}
\]

However, for many practitioners and academics the lack of signs indicated that there was no disease—and by implication no injury. As Hopkins (1988: 244) states the RSI debate is a good example of medical ideology at work in that it is very easy for medical practitioners to be sceptical of diseases that cannot be objectively diagnosed. He goes on to argue that,

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\text{An influential line of medical reasoning has it that if there are no signs, then regardless of the patient’s complaint, the malady cannot be real. Reality may be apprehended in scientifically objective ways, and an illness which evades apprehension in these ways cannot be real (Hopkins 1989: 244)}
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Not all critiques of the standard view went so far as to claim that the condition could not be real. As far as I can judge from the literature, there does not appear to be a “medical” debate as such regarding the condition, that is, a physiological argument.\textsuperscript{24} Medical critiques of the standard view take as their starting point the lack of signs and then surmise that people claiming to be suffering from RSI must be malingering or suffering from a psychiatric disorder (see Awerbuch 1985; Bloch

\begin{footnotesize}
\textsuperscript{23} A distinction is made in medicine between signs that can be detected by a medical practitioner and symptoms which are subjective complaints made by a patient (Hopkins 1989: 244).
\textsuperscript{24} Janelle Mullaly and Lyn Grigg (1988: 26) also make this point.
\end{footnotesize}
1984; Lucire 1986). These arguments will be discussed in more detail below. Other critiques of the standard view, while accepting the existence of the injury, questioned why given similar working conditions did some individuals develop RSI and others not, or questioned why RSI symptoms took so long to resolve and/or resulted in a permanent injury (Mullaly and Grigg 1988: 26-27). Furthermore, the question arose as to whether there was a distinct clinical entity separate from already recognised disorders such as carpal tunnel syndrome and epicondylitis. Those that disputed that RSI was a distinct medical condition claimed that the term itself was misleading. Before examining alternative explanations of RSI, a brief discussion regarding terminology is warranted.

**RSI Nomenclature**

The term “repetitive strain injury”\(^{25}\) was coined by John Matthews (a trade unionist) and first appeared officially in 1982 in the National Health and Medical Research Council’s (NHMRC) *Occupational Health Guide: Repetitive Strain Injuries* which considered RSI exclusively (Spillane and Deves 1987: 43). As mentioned above, RSI is an umbrella term that covers a cluster of conditions and symptoms and is not a diagnosis as such. Many commentators on both (or all) sides of the debate considered the term unsatisfactory. Francis T. McDermott (1986: 196) identified three points of contention which represents the views of many of the proponents of the standard explanation. He claimed that the term repetitive strain injury was unsatisfactory because:

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\(^{25}\) Most government documents, particularly those put out by NOHSC use the term ‘repetition strain injury’. Others use ‘repetitive strain injury’. As far as I am concerned the difference is of no importance. I will the more common repetitive strain injury, unless directly quoting NOHSC documents.
RSI Debate: Injury or Neurosis

1. Repetitive: implies an injury has been caused by repetitive movement, but can be caused by static muscle load,

2. Strain: implies a pathogenesis for RSI which is by no means certain

3. Injury: there is often no apparent injury present and there may be no discernible abnormality on examination.

Many of the proponents of the standard view suggested that the name needed to be changed to represent the syndrome more accurately. In 1986 and 1988 the Royal Australian College of Physicians recommended ‘occupational overuse syndrome’ (OOS) and ‘regional pain syndrome’ respectively (Arksey 1998: 20; The Royal Australian College of Physicians 1986) which portrayed the views of many of the supporters of the standard explanation. While these terms gained acceptance within medical circles in Australia especially from about 1989, they were and continue to be controversial.26 Furthermore, outside medical and government circles terms other than RSI have not received widespread recognition27 (Bohle and Quinlan 2000: 146). Importantly, discussions regarding which label was more appropriate to the condition did not question that RSI was a clinical medical entity. This is evident in NOHSC’s (1986: x) final report which endorses a new name without relinquishing the belief that RSI is a work-related condition albeit with or without signs,

RSI, also known as Occupational Overuse Syndrome, is a collective term for a range of conditions characterised by discomfort or persistent pain in muscles, tendons and other soft tissues, with or without physical manifestation. Repetition Strain Injury is usually caused or aggravated by work, and is

26 The controversy lays in the debate over whether or not RSI can be considered an occupational injury and/or whether or not a muscle can be overused (see for example Hadler 1989)
27 In the general community RSI is still the most readily recognised and understood term. Hilary Arksey (1998: 21) aptly states that, “irrespective of any second and third generation terminology, RSI has now reached acronym status and permeated the English language.”
associated with repetitive movement, sustained or constrained postures and/or forceful movements.

In contrast, other discussions regarding the terminology argued that the name itself had far reaching effects on the spread of the epidemic. David Ferguson (1987: 213) claimed that the term RSI itself was responsible for the epidemic. He argues that the term implies injury and cause where neither may exist and that this influences diagnosis, management and treatment, attitudes of patients, industry and governments as well as influencing the direction of research. This argument reflects a move away from the standard view of RSI which sees it as a musculoskeletal problem that is work-related and reflects the changes in the broader debate. By 1986, input into the RSI debate from psychologists and psychiatrists had become significant. Their disagreement with the term RSI was based on a number of factors. First, it implied that there was a disease state despite the fact that there was usually no signs; second, the word injury “implies an unjust or wrongful action, or a violation of rights” (Brooks 1986: 170) which implicates the legal system and compensation. Once the person with symptoms becomes a patient with a diagnosis, workers’ compensation is warranted and litigation is possible.

More succinctly Nortin Hadler (1986: 184) argues,

> The inescapable implications of this label include the following: this cluster of symptoms is a pathophysiological entity; the task is causal (inherent in the ‘RS’) and therefore the employer is culpable; and potential exists for damage (the ‘I’ of RSI)

In a similar vein, Yolande Lucire (1986: 324) contends that the term RSI is incorrect,

> The term repetitive strain injury introduced a new name, which is simultaneously a “cause” and a “diagnosis”, and is reputed to affect those whose work includes rapid repetitive movements and load bearing. An “incidence” is attributed to it on the basis of a new nomenclature for symptoms
in the arms. Keyboard operators are asserted to have RSI which is caused by the “RS” of keyboard work. Movement at work is, by a linguistic trick, elevated to the status of the “cause” of an “injury”.

These criticisms of the RSI nomenclature clearly reject the belief that the symptoms that workers are complaining of are musculoskeletal problems. As will be discussed below, theories which disputed the standard medical explanation varied from physiological explanations relating stress to muscle tension (Ryan 1986; Wall 1985 in Hopkins 1989: 257; Browne et al 1984: 330) through psychological explanations that pain is depressing and stress increases pain perception (Shadbolt 1988) to accusations of malingering (Ireland 1986); conversion disorder (Lucire 1986); compensation neurosis (Bloch 1984; Rush 1984) and/or simply a case of normal fatigue (Hadler 1986).

The controversy over nomenclature reflected the broader movement in the RSI debate. In the early years of the debate the standard explanation was dominant in the literature. As mentioned above the influence of psychologists and psychiatrists moved the terms of the debate. This is reflected in NOHSC’s final report which identifies that psychological factors may be a factor in RSI,

> Psycho-social factors, including stress in the working environment, may be important in the development of Repetition Strain Injury. Some conditions which fall within the scope of Repetition Strain Injury are well-defined and understood medically, but many are not, and the basis for their cause and development is yet to be determined (NOHSC 1986: 2-3).

Furthermore, the work of David Ferguson is worth mentioning here. His 1971a article in the Medical Journal of Australia sparked the RSI debate. In this article he focused attention on physical factors and gave little credibility to psychological ones. Later that year (1971b) he links occupational cramp and neurosis and states
that social and psychological factors both in and beyond the workplace need to be taken into consideration; in 1984 he again emphasised the work process. By 1987 his view was clearly more toward the psychological/psychiatric aspects of the condition,

> With hindsight, the gigantic and costly Australian epidemic called "repetition strain injury" ("RSI") can be seen as a complex psychosocial phenomenon with elements of mass hysteria, that were superimposed on a base of widespread discomfort, fatigue and morbidity…It is important to examine the epidemic in the hope that its recurrence in some other guise may be prevented (1987: 213).

The next sections will discuss the alternative explanations put forward from about 1986 on. The rise of alternative explanations came about due to a number of factors: the sheer numbers of complaints (in the form of compensation claims) was staggering and the chronic nature of the complaints did not improve despite active discussion and medical and ergonomic intervention. Furthermore, the numbers of new cases slowed down and many reflective works on the nature of the debate were published. These will also be discussed below.

**Alternative Explanations of RSI: Gendering the Debate**

One of the prominent features of RSI is that it is a condition suffered primarily by women. While this point is made by most, if not all, commentators, a cursory reading of the RSI debate finds that this is dealt with in one of two ways. Either

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29 This point is also open to question. Meekosha and Jakubowicz (1986: 391) claim that the “feminisation” of the RSI means that men who do suffer repetitive strain injuries resist the diagnosis of RSI. Also, Hocking (1987: 220) claims that the finding that women are most affected is the usual clinical experience; however, his research showed that women were not excessively prone to RSI among telephonist. His research found that within the telephonist group under study, 27% of women were affected with “RSI”, which, in statistical terms, is significantly more than the 20% of male telephonists who were affected. However, these prevalences show that the condition is by no means minor in men; in administrative terms there is little difference. This will be discussed in more detail in Chapter Four.
women are absent from the explanation or women are centralised. I have divided the alternative explanations into these two themes and it is along these lines that I will read the debate. In the texts where women are absent from the debate, initial mention is usually made regarding women’s overrepresentation as sufferers but there is little to no explanation offered as to why this is.  

There are two main foci in these texts. The first is Marxist in orientation focusing on the labour process and/or work organisation as the key to understanding the epidemic of RSI. The second is psychological. This argument focuses on psychosocial aspects which may contribute to the onset and/or aggravate an existing condition. Both of these explanations accept that there is a physiological state of disease and treat workers’ complaints of pain as real. On the other hand, in the texts where women are central, psychiatric explanations are the major focus and little credibility is given to the theory of RSI as injury.

The psychiatric explanations disputed RSI as a work-related injury and chronologically most of the work using this line of argument was published prior to the psychological/social constructionist arguments. The psychological/social constructionist arguments did in the main critique the psychiatric stance as well as question the inability of the medical view to explain the chronicity and the epidemic nature of the complaint. The next section will examine the psychiatric approach to explaining the RSI epidemic. While this explanation was not accepted unquestioned in medical circles, it became popularly discursive and was interpreted

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30 Of note here is that NOHSC’s *Interim Report on RSI* initially had a section on women that was removed prior to publishing the final version (Meekosha 1986: 6).

31 As mentioned above, a notable exception to this is the works of Meekosha (1986) and Meekosha and Jakubowicz (1986).
in the debate as enabling employers and legal practitioners to justify not making changes to the workplace or not paying out compensation (Bohle and Quinlan 2000). In the words of rheumatologist, John Quinter,

> The power with which psychiatry can be used to influence Western societies was demonstrated by the alacrity with which otherwise rational Australians embraced the ridiculous theory of hysterical contagion to explain the epidemic nature of RSI (in Mayman 1990: 610).

Of importance however, is that despite the fact that the psychiatric approach centralised women in its analysis, little to no comment was made of this fact in the critiques. This again raises the issue of how to attend to gender. In the standard or medical explanations gender was ignored in the analysis and in the psychiatric explanations gender becomes centralised. I explore this issue in greater detail in Chapter Three where I discuss how gender is read in occupational health and safety research and explore its usefulness as a concept. In Chapters Four and Five I will examine the implications of ignoring gender and centralising gender on increasing our understanding of women workers’ occupational health and safety needs. For now, I will discuss the psychiatric argument that was presented in the medical journals, the media and the courts at the height of the epidemic.

**Psychiatric Explanations of RSI: Neurotic Women**

**Psychiatric Explanations of RSI: Conversion Disorder**

Psychiatric explanations were proposed by psychiatrists, rheumatologists and orthopaedic surgeons. Yolande Lucire (1986), a Sydney psychiatrist, was the most outspoken advocate of the psychiatric explanation for the epidemic of RSI in

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32In 2003, she published *Constructing RSI: Belief and Desire* based on her PhD research. Her argument throughout this book reflects those she proposed in the 1980s. I will refer to her later work in future chapters while I focus on the 1980s debate here.
Australia. Her work attracted copious amounts of criticism from academics, medical personnel, the media and RSI support groups, as well as attracting modest but influential support from some medical and legal professionals (see for example Black 1987, Bell 1989, Hadler 1986).

Yolande Lucire (1986: 324) argued that because there were no organic lesions detectable by medical practitioners that could account for the pain and the disability complained of by RSI patients an alternative explanation was warranted. In addition to the lack of discernible signs, she claimed that there was evidence of geographical discrepancies in the number of cases between states; evidence that there were virtually no cases of RSI reported in countries where compensation was not paid; and evidence that shows a high rate of upper limb discomfort in the general population at any given time. She argued that this evidence supported her case for the need to look outside the workplace and the physical body for the origin of the complaints. Lucire found psychogenic explanations were the key to understanding RSI. While she accepted that there was initial pain (and possibly even a minor injury), she claimed that sufferers with organic problems present very differently to sufferers of psychogenic illness. Sufferers presenting with task-related injuries, such as sports injuries, present with an organic disorder and have a diagnosable lesion which heals predictably with treatment and/or rest. On the other

34 In 1971, 25% of reported cases of “cramp symptoms” in keyboard telegraphists were from Sydney compared to 4% from Melbourne (Lucire 1986: 324).
35 Yolande Lucire claims that studies have shown that 9% of the adult male population and 12% of the adult female population experience neck pain with or without associated arm pain at any given time.
hand, patients presenting with psychogenic illness, present without diagnosable lesions coupled with debilitating symptoms which firstly “cannot be explained by any known pathophysiological mechanism”, and secondly would be “catastrophic if it were organic” (1986: 323). Their “complacent acceptance” of the level of disability is indicative of a very common emotional disturbance: neurosis. In her own words,

A neurosis\textsuperscript{36} is a very common emotional disturbance, a way some persons deal with their thoughts and beliefs. It is not caused by steel-nibs, keyboards, movements, trauma or Agent Orange, but when these entities acquire new meaning, becoming symbols of physical danger or economic insecurity, a vulnerable minority will act neurotically to them (Lucire 1986: 325).

The particular neurosis that Lucire attributed to RSI sufferers based on her own experience with litigious patients was conversion disorder (hysterical neurosis conversion type) where physical pain and symptoms occur as the result of psychological conflict. The psychological conflict (not necessarily work-related) mimics, complicates or prolongs a physical injury in persons “with compulsive or dependent personalities”. These dependent persons convert their conflict into acceptable symptoms thereby achieving a primary gain by suppressing the conflict,

So the powerless and dependent, and those who cannot otherwise express their righteous rage at their supervisors, employers and spouses, resort to the use of their exquisitely symbolic pain and incapacity as a mode of communication of their distress (Lucire 1986: 325).

\textsuperscript{36} Lucire (1986: 323-324) clarifies the term neurosis which she claims refers to “any group of physical symptoms, without localizing signs, for which no pathophysiological mechanism could be found or postulated. As the ideas, memories, experience and behaviour that accompanied such disorders were recognized and acknowledged, the term became “psychoneurosis” and it took on its present meaning.”
Theoretically, Lucire bases her argument on Freud’s theory of repression of unacceptable memories, ideas, needs and conflicts which manifest themselves in physical symptoms. In her own words, she argues,

His theory of the repression of unacceptable memories, ideas, needs and conflicts, which gain symbolic representation in symptoms, gave us the theoretical structure against which a psychogenic illness could be understood and treated, and ideogenic and iatrogenic illnesses avoided (Lucire 1986: 325).

She clarifies this further by stating that,

Post-Freudian views allow that the repressive forces of the society in question are internalised and block the expression of unacceptable sexuality, of anger, of wishes to be cared for, of fears for security, of wishes for self-fulfilment, and of other needs that are in conflict with the demands of the self or of the environment (Lucire 1986: 325).

In order to explain the epidemic nature of RSI in Australia, Lucire argued that it was a process of “hysterical contagion” (1986: 325) which could be explained in two ways: epidemic hysteria on the part of the patients, and the result of misdiagnosis on the part of doctors who were misreading endemic symptoms prevalent in the community (Lucire 1986: 323). She supported her position by stating that there is a history of epidemics similar to the RSI one experienced in Australia in the 1980s and these epidemics have been cited in neurological, psychiatric and occupational health texts since 1888 textbooks as neurosis.37 She asserted that because RSI sufferers came from a large number of occupational categories endemic symptoms gave rise to epidemic hysteria. She quotes from the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (III)* to

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37 Lucire cites Gowers (1888); Jelliffe (1910); Price (1922 and 1966); Culpin, (1931); Brain (1962) and Hunter (1971). However, of note here is the different meaning of neurosis used in the texts that Lucire cites. In contrast to the Freudian definition utilised by Lucire, neurosis in earlier occupational health texts did not presuppose a psychological origin, but rather a disorder of the nervous system coupled with repeated fatigue (Hopkins 1989: 246).
articulate that in conversion which is ideogenic and contagious within a complex psychosocial system,

an individual achieves a primary gain by keeping an internal conflict or need out of awareness; the symptom has a symbolic value that is a representation and partial solution of the underlying psychological conflict. The secondary gains are the advantages that are obtained from the neurosis (in Lucire 1986: 324).

The advantages include the ability to avoid not only monotonous paid work and housework but to also gain social emotional and financial support. Lucire thus concludes that such an epidemic can be understood in the light of accepted theories of hysterical contagion (Lucire 1986: 325). An hysterical belief is one that is defined as “one which empowers an ambiguous element in the environment to threaten or destroy” (Smelser 1962-1970 in Lucire 1986: 325) and is disseminated without appropriate verification. The condition receives sympathetic attention and widespread publicity and there is no initial challenge to the origin of the cause of the disease. She claims that medical practitioners actually encourage, if inadvertently, the sick role behaviour. The real cause of the strain is unacknowledged as it either cannot be identified clearly or it is too closely identified with a valued aspect of people’s lives to be admitted and therefore is attributed to some factually incorrect powerful agent or force (Lucire 1986: 325). She claims that early reporting causes a reduction in the pain threshold and “influences others unconsciously to claim the same primary and secondary gains as those who were affected” (Lucire 1986: 325). It becomes epidemic when the situation is not controlled and the hysterical belief is allowed to prevail. The intensity of the belief is governed by the “desire for the consequences of believing” (Lucire 1986: 325).
The psychiatric argument was not only played out in the medical journals, but also in the media and the courts. In the media, RSI was sensationalised. Below are a few examples of how RSI was packaged and presented to the public. There were colourful and inflammatory labels such as Retrospective Supplementary Income, Runaway Social Invention, Golden Wrist (Spillane and Deves 1987: 41); headlines such as “RSI Linked with Sex and the Devil” (Illawara Mercury 1985); and quotes from an unsuccessful litigant in the Sydney Morning Herald (1988) claiming that her manager asked her “does your mind think that your hand is better now?” The portrayal of the typical RSI sufferer was also publicised in the media as “small, fat, unassertive, underachievers who cry in front of their doctors” (Sydney Morning Herald 1989 in Ewan, Lowy and Reid 1991: 169). Medical professionals were also extensively quoted in the media. Peter Brooks, a professor of rheumatology who was an expert witness at the first and one of the most prominent RSI cases (discussed below) was reported in the Sydney Morning Herald (1987) as claiming that RSI was a “media-generated” disease with very little evidence of pathological damage to muscle tissue. He claimed that RSI could be a minor or a major problem “depending on the sufferer’s belief system,” and that “if you think that it is a simple problem you will do your exercises, tell your boss to get off your back and get on with it” (in Reid and Reynolds 1990: 174).

The court case mentioned above is a good example of how the psychiatric argument was used, and used successfully in the courts. It was the first case out of over 400 claims pending in 1987 to be defended by the Commonwealth (Vic), and therefore as a “test case” a lot was at stake for insurers, employers and injured workers. The litigant was Susan Cooper, a 28 year-old employee of the Australian Taxation
Office\textsuperscript{38}. Her history is typical of many RSI sufferers. For years she suffered with pain in her hands, arm and neck. She underwent medical treatment and rehabilitation which included modified duties and periods of leave. Eventually she developed disabling pain and at the end of 1986 she was certified as unfit for work. She took the Commonwealth to court for negligence seeking common law damages. The case reflected the broader argument that was being played out in the medical journals, and in fact, many of the authors of the articles and letters to \textit{The Medical Journal of Australia} were used as expert witnesses.\textsuperscript{39} Of interest here is that only the defence’s argument was reported in the press, thus influencing the public’s opinions on the causation and legitimacy of RSI (Reid and Reynolds 1990: 174).

According to the account given by Janice Reid and Lyn Reynolds (1990: 173-175) the defence supported its initial argument that Cooper was a malingerer with film evidence of her carrying her child and shopping. When this line of argument was quashed with twelve health professionals claiming that her condition was genuine, the defence moved to claim that she was the victim of union- and media-induced hysteria. The defence supported its hysteria argument with the (unsubstantiated) claim that RSI did not exist in other countries and therefore her condition was not organic but psychogenic. The jury found that Cooper did not have a work-related injury and the costs of litigation were awarded against her. In their analysis of the Susan Cooper case, Helen Meekosha and Andrew Jakubowicz (1991: 19) claim that the legal advice for the defence made recommendations that “every attempt be made

\textsuperscript{38} For a more in depth exploration of the case, see Meekosha and Jakubowicz (1991) and Reid and Reynolds (1990). Reid and Reynolds (1990: 174) state that the case received extensive media coverage and was a prominent news item on the evening news in Australia throughout the hearings.

\textsuperscript{39} Expert witnesses for the plaintiff included David Ferguson, William Stone and Hunter Fry and for the defence, Damien Ireland, Mark Awerbuch and Peter Brooks (Reid and Reynolds 1990: 174).
to colour the defence to allege a strong psychological component in the plaintiff’s complaints…in an attempt to create an impression of mass hysteria associated with arbitration…psychiatrists should claim mass hysteria created by the union…” This point is not to make a case for conspiracy theory. In fact I would argue, as Andrew Hopkins (1989: 246) does, that the neurosis explanation was employed to shift the responsibility of RSI onto the worker, and any explanation that could do this would have been utilised. My point, however, is to draw attention to the feasibility of using a psychiatric argument when dealing with female litigants when the often-tried malingering tactic (also used extensively with male workers) is not successful.

More important for now are the implications that this had/has on other sufferers. As Meekosha and Jakubowicz (1991: 19) state:

The case in 1987, in which a jury found that Cooper had not contracted RSI through her work, marked the turning point, in the sense that Cooper’s loss of her claim for damages validated the ‘hysteria’ model sufficiently to support wider attacks on the legitimacy of the condition.

The acceptance of the hysteria model was evident in other court cases as well as in the continuing debate in the Medical Journal of Australia. While the Susan Cooper case had used psychiatrists to validate the diagnosis of hysteria, in other cases this was not always necessary. As Andrew Hopkins (1989: 244) found in his research orthopaedic surgeons and rheumatologists could be relied on to give evidence that the litigant was suffering from a psychiatric rather than an organic disorder. Below are two examples of evidence given in court by an orthopaedic surgeon and a rheumatologist respectively,

The (pain) symptoms…defy rational, anatomical or physiological explanation and are without objective physical signs or changes on X-rays available. Organic (i.e. physical) disease is an unlikely cause of her symptoms (quoted in Davis 1987: 38 in Hopkins 1989: 244).
I am dealing with the facts and I cannot see on physical examination any reason why this lady could not do full-time clerical work...the objective fact is there is nothing wrong with this lady...The facts are the physical signs lead me to only one conclusion. This is a totally non-organic problem...It can only be, unfortunately, a psychiatric complaint. The cause of that I do not know. But there is no medical explanation for it (quotations taken from the transcript of a hearing before Dainer, S. M., Canberra, 11 July 1986 in Hopkins 1989: 244).

The psychiatric explanations were not always that of conversion disorder. Other explanations such as malingering, compensation neurosis and inappropriate reactions to normal fatigue were also put forward by psychiatrists, orthopaedic surgeons and rheumatologists. In a similar vein to Yolande Lucire’s conversion disorder, many of the explanations presented below were not accepted unquestioned, but were used extensively in the courts to discredit litigants (see Hopkins 1989) and in consultations between physicians and patients to discourage RSI sufferers from pursuing compensation claims (see Reid and Reynolds 1990) and in the media (see Meekosha and Jakubowicz (1991)). The views that people with RSI are malingerers differed from Lucire’s conversion hypothesis in one important aspect. Lucire argued (at least theoretically) that the patients’ desire for primary and secondary gain was unconscious, whereas the malingering explanation presented below was based on the belief that patients with long-term RSI complaints were consciously exploiting the sick role for gain (see Awerbuch 1985, Bloch 1984, Rush 1984).

Psychiatric Explanations of RSI: Malingering

Malingering is rarely stated explicitly in occupational health and safety literature. However, for workers it is one of the most powerful tools used against them in their

40 Commentators who were sceptical of RSI as a genuine disease did at times use a combination of these alternative explanations to explain the epidemic.
pursuit for either improved working conditions or for receiving compensation for injury or disease (Bohle and Quinlan 2000). Malingering refers to the belief that workers do not have an injury at all and that they are consciously faking it in order to receive compensation payments, be allocated lighter duties or get time off work.

This perspective found its voice mainly in the media with headlines such as “Chronic fake patients cause real pain to casualty wards” in *The Australian* (1985), and “RSI unknown outside Australia–Doctor” *The Mercury* (1985). In 1987, the popular Willesee programme on Channel 9 ran a segment showing a researcher who had obtained employment in a clothing factory, faked RSI symptoms and received compensation payments of $4 000 from the Government Insurance Office (GIO). The show claimed that it demonstrated first, how easy it was to dupe the compensation system, second, how easy it was to fake RSI symptoms and third, that doctors were either incompetent or corrupt (Meekosha and Jakubowicz 1991: 23).

In a particularly racist tone in regards to immigrant workers and RSI, the then President of the Returned Servicemen’s League (RSL) stated in the media,

> You’ve only got to look at what’s going on in the tribunals in Melbourne and just ask the bosses...about workers’ compensation and how it’s being worked to death...People who can’t even speak English know the...Act backwards and forwards...They are able to work the Act for payments that are incredible, yet offer nothing to Australia (quoted in Alcorsco 1988: 4).

However, it was not only in the media that the malingering explanation was found. Damien Ireland, an orthopaedic surgeon, argued that it was the political and social climate in Australia that encouraged “susceptible patients” to fake injury,

> When Australia has a political system that encourages honesty and integrity and society accepts the necessity of a ‘work ethic’, a reduction of ‘susceptible patients’ would save Australian taxpayers millions of dollars (Ireland 1986: 415).
He does however intimate that there is a legitimacy to their claims. He goes on to say that RSI is more common in workers who are dissatisfied with their jobs due to boring, dull repetitive work. He claims that he has never seen a self employed person with RSI and his experience leads him to conclude that RSI is,

an occupational neurosis affecting young to middle aged (predominantly female) employees engaged in low paying, monotonous, ‘low glamour’ occupations (Ireland 1986: 416).

He believed that if the affected women had a desire to be treated, they could get well, but it would require them to undertake psychiatric therapy (Ireland 1986: 416). In contrast, Mark Awerbuch (1985: 237-238) openly dismissed patients who claimed to have RSI. He labelled it “Kangaroo Paw” which Christine Ewan, Eva Lowy and Janice Reid (1991: 169) claim alluded to other derogatory labels for compensable occupational injuries of uncertain aetiology (such as Mediterranean guts ache, Greek back, and migrant arm). Awerbuch’s argument raised most attention due his belief that RSI was purely an Australian phenomenon. Another psychiatrist, Issy Pilowsky highlighted the extent to which patient malingering was considered to be widespread according to medical doctors. His article in the Medical Journal of Australia titled “Malingerophobia” (1985) outlined treating medical practitioners’ fear of being tricked into providing care for patients who “masquerade as sick” but who have no illness or who are not as ill as they are claiming (Pilowsky 1985: 571).  

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41 Pilowsky (1985: 571) referred to RSI as ‘kangaroo paw syndrome’.

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Psychiatric Explanations of RSI: Compensation Neurosis

A related and almost similar view to malingering is the view of compensation neurosis. The major difference is that this view holds that there is an injury, but the unconscious desire for secondary gain results in a delayed recovery. The secondary gain is usually financial, but it can also be gains from the invalid status, attention from others and freedom from unwelcome work (Bammer and Martin 1988: 351). In three letters to the Medical Journal of Australia, physicians stated clearly their views regarding patients presenting with RSI symptoms. David Bell, a psychiatrist, argued that the secondary gain for women was not only to be freed from work, but also from their responsibilities at home,

Prolonged absences from work occurred when “there was little clinically to show” and some women claimed to be experiencing such great pain that they could not do their housework, yet, presented with normal arms (Bell 1989: 281).

An orthopaedic surgeon claimed that in his experience RSI is only seen in workers making compensation claims and if seen in other groups “for example sportsmen and musicians, it always gets better with rest” (Rush 1984: 615). This argument is taken further by Bernard Bloch (1984) who blatantly states that people presenting with debilitating RSI are clearly out for financial reward,

Return to work duties neither tiring nor repetitive is declined or barely attempted. Resolution has followed on satisfactory court awards (Bloch 1984: 685).

42 At times it is very difficult to ascertain whether an author believes that there is no injury (malingering) or that there is an injury (compensation neurosis), and at times there is obvious overlap in the argument—especially as the secondary gain is usually considered to be compensation payments. For the purposes of this thesis it is not important to analyse this.
A final explanation put forward which denies the presence of a genuine injury is the argument that the “discomfort” felt by RSI sufferers is simply fatigue. The most articulate proponent of this explanation is the American rheumatologist Nortin Hadler (1986). He cites a study which indicates that at any given time as many as 9% of the adult male and 12% of the adult female population experiences discomfort in the neck with or without associated arm pain and that 35% of people can recall such an episode (Hadler 1986: 193). Hadler maintains that the discomfort may or may not be associated with work, but it is feasible that when a worker is unaccustomed to a work task discomfort can result. He argues that the reason for the epidemic is the “charged climate of occupational medicine” in Australia where workers are encouraged not to ignore any discomfort. The RSI epidemic therefore is an epidemic of discomfort reporting (Hadler 1986: 195).

While Hadler did not argue that patients presenting with RSI were suffering from a psychiatric condition explicitly, his arguments were often construed as such and were used as fuel for the compensation neurosis and conversion disorder hypotheses. For example, in a statement from the Royal Australian College of Physicians (RACP) (1988: 6-7), the College concluded that RSI/OOS was a non-work-related pain syndrome influenced by “an incorrect community belief in relation to the effects of work on bodies”. It claimed that the incorrect community belief system was appropriately referred to as “a mass hysterical phenomenon” and that treatment should concentrate on “changing the patient’s beliefs that they are injured”. It needs to be noted that not all physicians agreed with the College’s
position. However, Peter Brooks, Professor of Rheumatology (1986: 170-171) agreed with the premise and took it one step further,

Musculoskeletal symptoms are extremely common in the workplace and we need, perhaps, to ask ourselves when it is that normal fatigue becomes dis-ease or abnormal illness behaviour…We have a responsibility to provide Australians with the best possible work environment, but we also need to understand that fatigue is a normal part of hard work…An enormous amount of hysteria has been associated with occupational pain syndromes; this has been based on few facts and promoted widely in the daily press, in medical publications, in union publications and in the publications of patient-support groups.

Brooks alludes to another important facet of the neurosis/hysteria argument, namely, the role that the medical profession played in the promotion of the RSI as a “disease”. As mentioned above in the controversy over nomenclature, some commentators argued that incorrect diagnosing and thus incorrect treatment resulted in RSI reaching epidemic proportions. In other words, RSI was an iatrogenic disease.

_Psychiatric Explanations of RSI: Medical Iatrogenesis_

A recurring theme at the heart of the RSI debate was the struggle of a reductionist medical science to deal with a presenting clinical problem in the absence of a discernible disease or injury. This led to the belief, as discussed above, that RSI was a psychiatric problem without a physical base. The explanations presented above focus on the patients as active agents in their condition. There was, however, another school of thought that claimed that doctors themselves were responsible for the epidemic spread of RSI because doctors medicalised complaints of pain as

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43 See for example Mortimer (1989a and b). Derek Mortimer, a rheumatologist, stated that it was a “very damaging document” (1989a: 22) and that it was “unscientific, “arrogant” and served the interests of employers and insurers (1989b: 15).
illness. Proponents of this view tend to argue that mistaken diagnosis and treatment on the part of doctors led to the epidemic of “psychogenic illness”,

In the early history of this condition, the uncritical stance of the medical practitioners who argued that “RSI” was a work-caused injury was not countered by opposing arguments and those who adopted their ideas generated “an epidemic of psychogenic illness in a passive and dependent group” (Bell 1989: 281; in quote Lucire 1986: 323-327).

A unique Aussie “disease”...“Kangaroo Paw.” Perhaps “Kangaroo Poor” would be more appropriate, as that’s the likely result of the burgeoning spiral of costs associated with an epidemic which...could only be perpetrated with the approbation of the medical profession, either through ignorance or avarice or both (Awerbuch 1985: 238).

Commentators who put forward these arguments made reference to Ivan Illich’s position of “medicine as a disabling profession” which turns ills into illnesses and turns citizens into patients needing to be saved by experts. The end result is a citizenry that is incapable of dealing with indisposition or discomfort (Bell 1989: 284). In the case of RSI in Australia, David Bell claimed that,

The gains of expansionism help to explain why such illogical and naïve notions about “RSI”, or even chronic pain, enjoyed such wide currency. The ideas favour the complainant who seeks gain through adopting the disguise of illness and they are not resisted by practitioners who are prepared to administer to anyone (Bell 1989: 284).

In a criticism of Illich’s argument, Bell (1989: 284) claimed that Illich’s position was one-eyed in its view of an unjustifiable expansionist profession and a defenceless citizen ripe for exploitation. Bell argued that in fact medical expansionism was encouraged by an active citizenry. The RSI epidemic “required the collusion of citizens” and ceased once the benefit to the patient ceased. It was this belief that allowed Bell to argue, that RSI was in fact an “iatrogenic epidemic of

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44 Two main texts are cited. Illich, I., (1976), Limits to Medicine, and Illich, I., Zola, I.K., McKnight, J., et al (1977), Disabling Professions.
simulated injury” where doctors fail to conform to standard diagnostic procedures which leads to abnormal illness behaviour in patients, and this is invariably compounded by inappropriate treatment (Bell 1989: 281; also see Awerbuch 1986). Of interest here, however, is that while the role of (individual) doctors is held to be partially responsible for the epidemic, science (or the “medical model”) is not questioned,

The experience with “RSI” has the appearance of a major medical blunder, but the débâcle did not result from the failure of the medical model, which was applied “inconsistently, sporadically and under considerable societal constraint” (Bell 1989: 282; in quote Hadler 1986).

The dilemma that conditions such as RSI pose for the belief that medical knowledge is the result of an objective and value-free science was a springboard for many of the social constructionist arguments that will be presented below. However, before examining these explanations for the RSI debate, I would like to briefly outline how women have been portrayed in the psychiatric explanations.

**Women, RSI and Psychiatry**

Few writers explicitly connected RSI to female frailty or female neurosis. However, as argued by Janice Reid and Lyn Reynolds (1990: 176), implicitly there is a clear indication that the hypothesis of compensation neurosis and conversion disorders are about women. In most texts reference was made to the “fact” that nearly all sufferers were women, all examples of recalcitrant patients were women and all examples of litigants were women. One telling example was a case where an orthopaedic surgeon did not diagnose a male journalist suffering from pain in his hands and his wrists resulting from word processing because the journalist was “self-employed, highly motivated, intelligent and male” (in Reid and Reynolds
1990: 176). Furthermore, the following quotes\(^{45}\) from interviews with women suffering from RSI in the late 1980s indicate the ease with which diagnosis of conversion disorder can be made to women,

[The doctor said,] “If you got pregnant it would probably all clear up.”

Then she [the doctor] started asking me, did I like my house tidy, did I like my children to be home on time and things like that…and she said, “You’re one of those people that are overactive and you’ve been under a lot of strain” or something.

This Dr A [assessing psychologist]…told me I was greedy…that I couldn’t be a mother and a wife and an employee, that I was living above my means, and that I should have been home with my children.

I was amazed that he [the doctor] said it was my maternal instinct that made me want to stay home.

The fact that the majority of the patients that Yolande Lucire diagnosed with conversion disorder were women was a concern for her,

The “injury” theory should rile feminists as it creates a “victim” of women (who are more commonly affected by RSI than are men)...This “diagnosis” deems such a woman to have been damaged by unavoidable activity. She seeks to be called “injured” but deemed thus, she becomes encouraged in her dependency on those who benefit from the validation and promotion of her ill health. The perception of a woman as unable to accept that her disorder is caused or complicated by emotional factors exposes her to useless investigation and ineffective treatment in the guise of unwillingness to give offence (Lucire 1986: 323).

The psychiatric approach highlights two important points. First is the ease with which a psychiatric explanation is proffered when there is no other scientific explanation and second is the ease with which the psychiatric explanation is unquestionably attributed to women with little or no gender analysis. These two issues will be dealt with in more detail in Chapter Five where I will examine the

\(^{45}\) These quotes come from research conducted by Janice Reid, Christine Ewan and Eva Lowy (1989) cited in Janice Reid and Lyn Reynolds (1990:176-177). As will be discussed in Chapter Six, my own research conducted 18 years later revealed similar experiences.
role that medicine and medical discourse played in the construction of RSI and secondly, I will examine the recurrent pattern in the way that the medical profession has treated women throughout the 20th century which often attributes psychiatric explanations for women’s physical illnesses.

**Psychological/Sociological Explanations of RSI: Androgynous Women**

The second group of explanations consists of the psychological and labour process arguments. Chronologically, this group of literature emerged as the epidemic began to subside and rather than question the legitimacy of the disease many of the works attempted to explain the epidemic nature of RSI. Underlying many of these explanations was a new consensus which purported that the epidemic was in fact a “complex psychosocial phenomenon with elements of mass hysteria” (Ferguson 1987: 213). Furthermore, another underlying assumption in these explanations was that high levels of stress and anxiety are experienced by workers in employment which entails low-skill, limited decision making possibilities, low job satisfaction and repetitive work which therefore accounted for why it was experienced in only certain workplaces (Reynolds and Shapiro 1991 in Bohle and Quinlan 2000: 157). These explanations referred to women as the majority of sufferers but did not question this phenomenon. These accounts extended from physiological explanations relating stress to muscle tension through to psychological explanations stating that pain is depressing and stressful and stress increases pain perception. Interpretation of these accounts varied considerably and was often used to support the psychiatric arguments presented above. For the sake of coherency and conciseness, I will highlight four of the most cited explanations to overview this group. These include Janelle Mullaly and Lyn Grigg’s psychosomatic explanation
(1988); Robert Spillane and Leigh Deves’ pain-patient model (1987); Leslie Cleland’s social iatrogenesis argument (1987); and Evan Willis’ social process thesis (1986). All these accounts accept the definition of RSI as a physical injury, but emphasise its psychosomatic component. The origins of the problem either stem from the individual or from the work process.

Psychological/Sociological Explanations: Psychosomatic Explanation

Janelle Mullaly and Lyn Grigg’s article set out to test the major theories of RSI and to propose a “best” theory. They disputed that there was a distinct clinical entity that could account for the array of symptoms and the chronicity of the complaints. One of the main propositions put forth by Mullaly and Grigg (1988) was a rethinking of the standard explanation which they argued could not account for why all workers under similar circumstances did not suffer from RSI. They purported that physiological predisposition may account for some of the explanation, but claimed that it is limited. They conclude that while RSI cannot be considered a conversion disorder or a case of mass or epidemic hysteria, any condition that is not a distinct clinical entity must be considered as a psychosomatic disorder.46

Drawing on the works of Karasek (1981) and Sen, Pruzansky and Carroll (1981) who state that stress is inherent in employment that is low skill, low decision-making and low job satisfaction coupled with the works of Beith (1981) and O’Hanlon (1981) who state that stress is attributable to repetitive work, they ask why some workers and not others who are equally exposed to the same stressors develop stress-related illness. They do not dispute that there is an injury to begin

46The thought that medical science may not have the technology to be able to detect the organic signs of RSI was not apparently considered in this study, as in the psychiatric explanations presented above.
with, but claim that due to psychological predisposition certain patients “induced by
the pain experience may initiate a chronic pain cycle which persists beyond physical
injury” (Mullaly and Grigg 1988: 29). They draw on Littlejohn’s and Miller’s
(1986) hypothesis that classifies RSI into three types:

- **Type 1 RSI:** consists of well-known disorders comprising soft tissue lesions or
  strains of the muscle-tendon unit

- **Type II RSI:** consists of chronic pain syndromes with no identifiable lesion or
  inflammation. The symptoms include pain, paraesthesiae, poor grip strength,
  numbness and diffuse aching. Littlejohn and Miller regard this as a regional
  pain syndrome that is usually associated with psychological stress. It would
  appear that Mullaly and Grigg also agree with this. Littlejohn and Miller claim
  that this stage is reversible and does not result in residual tissue damage.

- **Type III RSI** occurs when a diagnosable lesion (Type I injury) acts as a focus of
  pain which is amplified by psychological and physiological mechanisms. The
  consequent chronic pain syndrome may then dominate the symptomatology (in

**Psychological/Sociological Explanations: Pain-patient model**

Robert Spillane and Leigh Deves’ (1987) pain-patient model suggests that RSI can
be characterised as an industrial movement. This movement is built upon changing
attitudes and behaviours towards being sore at work. They argue,

People who are in essence healthy but experience pain *choose* and are
*encouraged* to become patients with pain. The existence of this, indeed any,
social industrial movement cannot be attributed to a single cause. By
capturing the fears, traditions and prejudices of Australian industrial life, the
movement built upon RSI leads to a redefinition of self from a state of health
to one of illness (Spillane and Deves 1987: 45; italics in original).
They argue that there is not any convincing evidence to demonstrate a causal link between hand usage in occupational activities and carpal tunnel syndrome (CTS) (an objectively diagnosable condition) and that there has never been an epidemic of carpal tunnel syndrome. In contrast, the epidemics occur with conditions that have been diagnosed based on symptoms rather than signs,

The idea of RSI is thus firmly rooted in the notion of *complaint*, unlike established diseases (for example, CTS) 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 (Spillane and Deves 1987: 46).

In a nutshell, Spillane and Deves argue that the RSI epidemic is a *pain phenomenon*. One cannot know for sure whether or not a person complaining of pain is on the level or not. Furthermore, the person with pain can choose to either communicate the pain or conceal the pain. They do concede that excruciating pain may be difficult to conceal but that on the whole the communication of pain is a choice (Spillane and Deves 1987: 46).47 Those who complain of pain define themselves or are defined as patients. Some people choose not to become patients and others based on economic and psychosocial incentives choose to become patients with pain,

This, we believe, is a plausible account for the dramatic increase in RSI-related workers compensation cases reported in Australia since 1980…Some people who are diagnosed by medical practitioners, psychiatrists or others as patients, do not in fact suffer from an illness and do not want to be patients. There are serious psychosocial consequences when people with discomfort in the arm are told that they may have a crippling disease that demands urgent medical treatment and cessation of physical activities. Both disease and patient role are thereby applied to an inexorable human condition called pain (Spillane and Deves 1987: 47).

47 Andrew Hopkins argues that for a significant number of RSI sufferers the pain is so intense it is impossible not to report (Hopkins 1989: 253). My experience in the poultry processing industry also supports this argument.
Spillane and Deves go on to say that these people are then subject to a medical/legal game that few understand or can escape from easily. If they fail to pass as medical patients then they are labelled as psychiatric patients or as malingerers. They argue that a humane approach to this problem is difficult as there is a clash of interests with one party claiming that the other one has hurt them and the response being one of experts and accusations of malingering (Spillane and Deves 1987: 47). They base their arguments on the belief that humans will do anything to avoid pain and if the workplace is believed as being the source of pain and is not doing anything to stop the pain then workers are likely to “communicate their dissatisfaction in various ways, for example by resigning, striking, becoming patients, malingering and so forth” (Spillane and Deves 1987:47),

Where the social climate encourages striking, some individuals are easily induced to strike. Where the climate encourages the medicalisation of work behaviour, some individuals are easily induced to become patients. Thus, morals are confused with medicine, values with valium, behaviour with bodies (Spillane and Deves 1987: 47).

In conclusion, Spillane and Deves argue that,

RSI is a social movement not a medical epidemic. It is characterized by a significant increase in the number of people with pain who choose to become pain-patients. This individual choice is a moral one and we pass no judgment on it (Spillane and Deves 1987: 48).

They go on however to say that members of society will have to choose whether or not to pay compensation to people who complain of pain but have no diagnosable condition, that is, see them as patients or treat them,

as autonomous working people communicating various dissatisfactions. Our adversary is not medical illness, epidemic, psychiatric disorder or malingering. It is the dogmatism of those who, for whatever purpose, want to reduce human problems to medical theology (Spillane and Deves 1987: 48).
Leslie Cleland (1987) takes the pain-patient model one step further. He agrees with Robert Spillane and Leigh Deves that RSI is not a medical epidemic, but rather one that has been socially created. He argues that RSI has reached epidemic proportions,

In a setting where treatments, advice and communications from a variety of professional, official and media sources have created mutually-reinforcing expectations of a high risk of a distressing, disabling condition, which is putatively caused by the use of the upper limbs in tasks that involve repetitive movement or sustained postures. These “treatments” are likely to have a causal role in the development of this syndrome, which may therefore be regarded as an example of “social iatrogenesis” (Cleland 1987: 236).

Iatrogenesis refers to diseases that are caused by medical treatment or intervention. In this case Cleland claims that the treatments for RSI plus the knowledge creation through publications—both official and lay that reach the public in an effort to educate, delay the onset of disease and create a more supportive environment that has caused the spread of the disease to epidemic proportions. Cleland defines his term,

Social iatrogenesis refers to diseases that are caused by this broader range of societal inputs, and contrasts with clinical iatrogenesis, which describes diseases that arise as a direct result of treatments that are applied by doctors to their patients (Cleland 1987: 236).

Cleland (1987: 236) argues that RSI is not appropriate as it does not recognise that RSI is a syndrome not a clearly defined medical disorder. In medical terms "injury" denotes that there has been some damage to the tissues which is not the case in RSI and that the qualifiers "repetitive" and "strain" imply that the presumed injury is caused by repetitive mechanical forces that are applied to, or generated within, tissues. He argues,

However, there is no convincing basis to implicate these factors as the primary or major cause of the postulated injury, nor is there any information regarding
the frequency, rate, duration, magnitude or other characteristics of the putative forces that render them noxious (Cleland 1987: 236).

Furthermore he claims that,

clinical observations suggest that the pain may be due to a disturbance of sensory function rather than due to a chronic unhealed tissue injury…with the model of sensory dysfunction, sufferers can be reassured that no evidence of injury has been found. They can be told that increased sensory awareness makes them inappropriately sensitive to sensations that arise from use of the limb (Cleland 1987: 238; my emphasis).

He goes on to say that the pain that the patients are feeling is not giving rise to an injury or damage to the tissue as is the case when one normally feels pain. Patients should not focus on the affected area but rather,

therapies…should include advice and non-focused exercise prescriptions that are designed to improve over-all fitness, well-being and posture (Cleland 1987: 238).

In his denial that RSI is a work-related injury, he clearly demarcates the pain reported by workers to that of an overt injury. He argues that in adopting the "RSI" model, in which treatment uses immobilisation and splints, and patients are advised that activities that cause pain may be causing further injury, is not effective. He argues that the injury takes longer to heal than an overt physical injury due to the expectation of compensation,

In an industrial context, sufferers with the status of victims of an accident can expect monetary compensation for their suffering, disability and handicap (Cleland 1987: 238).

With the model of disturbed sensory perception, one can predict a number of the effects of environmental influences upon disease expression and severity. Educational programmes, diagnosis of an "injury" focuses the victims’ awareness on the affected part,
The result is that no task can be performed without enhanced attention to discomfort and apprehensive concern as to the potentially damaging affects that are associated with it. Through this process, otherwise trivial discomfort may become transformed into a protracted, painful, disabling condition which precludes effective work and degrades the quality of life (Cleland 1987: 238).

He goes on to say that rather than paying compensation for injuries as was the idea of workers’ compensation, now there are other categories that include the disability—that is loss of function due to injury and handicap that is impact of injury and disability on interpersonal relationships, feelings of well-being, and so on of the victim and his or her family. Cleland argues that the shift of compensation from the injury (i.e. objective category) to impact/consequences of injury (i.e. subjective category) makes assessment more difficult and there is more chance for the fabrication of injury or disease (Cleland 1987: 239). New technologies and changes in work processes have meant that workers are more tied to machinery than previously where they were more likely to be craftsmen,

Trained to machines, workers perceive their labour as being increasingly unnatural and potentially harmful. Activities that are thought to be unhealthy cause distress and discomfort. Pain and dysfunction, which are dressed as compensable injury, provide a physical escape and raise false hopes for emotional and financial release. Those who seek this refuge become embroiled in medicolegal procedures which heighten their distress and aggravate their discomfort. A distant settlement terminates a process which feeds an industry of futile professional activity and which may render its victim beyond recuperation (Cleland 1987: 239)


The final psychological/sociological explanation is Evan Willis’ social process thesis (1986). Sociologists within occupational health and safety studies are interested in how social and organisational factors impact on both the incidence of injury and disease at work as well as the propensity for workers to report injuries and to claim compensation. In the case of RSI, sociologists accept the existence of
the injury, but argue that its emergence as an occupational health and safety issue can only be understood by examining the social and industrial context in which it occurred (Bohle and Quinlan 2000: 163). An underlying thread in the social process thesis is that the struggle over RSI represented a form of industrial resistance to the dehumanising and alienating forms of work under capitalism (Willis 1986: 215). Willis argues that health related issues become vehicles for struggle and change and states that the key to understanding RSI is as a “metaphor for alienation” (1986: 215). Drawing on Karl Figlio’s (1982) study of miners’ nystagmus in Britain, he argues that both instances were examples of resistances to changes in technology and work processes. The resistance was supported by the emergence of influential movements such as the workers’ health movement, the women’s movement and the union movement.

While these four psychological/sociological explanations denied adherence to the psychiatric explanations purported by Yolande Lucire, interpretations have allowed commentators to focus on the psychological component and ignore or play down the work tasks responsible. In a recent literature review conducted by the Australian Safety and Compensation Council (ASCC)\(^{48}\) (2006b: 5) the authors bear this out. They argue that while current evidence confirms that RSIs are indeed work related, the psychosocial component can have a substantial influence. I suggest that this move from considering the hazards of RSI as physical as well as psychosocial is readily accepted when the injury has obscure aetiology and the cost of compensation for injured workers is high for either male or female workers.

\(^{48}\) The ASCC succeeded the National Occupational Health and Safety Commission (NOHSC) on February 7 2005.
Furthermore, as Ellen MacEachen (2005: 490) argues, current thought surrounding RSI “privilege[s] ideas about RSI being problematic in certain *types of workers* rather than in types of physical work environments” (emphasis in original). I argue that when the “type of worker” is a woman the psychosocial component readily falls into a psychological/psychiatric explanation as can be seen in the history of RSI.

**Gendered Workers: Identifying Discursive Constructs**

My reading of the RSI debate through a gender lens demonstrates that the construction of woman played a large part in framing the terms of the debate. However, this construction was not consistent. In the standard explanations of RSI women were invisible in the text. This was on two levels. On one level, women were absent from the text, suggesting that gender is of no consequence in understanding the experience of an occupational injury. In contrast other texts noted the prevalence of women, however, gender was not considered important as an analytical concept. In these texts women’s biological and social differences to men were raised but not questioned nor analysed. Constructions of women were most visible when alternative explanations were proffered as a critique to the standard definition of RSI as a physical injury. In these texts women and gender became centralised in the analysis and psychological and psychiatric explanations dominated the discussions in both academic and popular discourse.

In making sense of these conceptualisations of gender, I suggest that in order to understand the increases in injury claims made by women each of these explanations drew on one of two powerful discourses within occupational health and safety. I refer to the first discourse as occupational health and safety discourse
which considers men and women to be the same with the exception of biological and social reproductive roles. It is premised on labour process theories and considers work organisation to be the key to understanding occupational injury. In analysing occupational health and safety concerns, gender is only a useful concept when women’s experiences differ from men’s. The second discourse, which I refer to as medical discourse, considers men and women to be inherently different. In this discourse gender is centralised and therefore any discrepancies in injury between men and women can be explained by biology, psychology or reproductive differences. Each of these discourses will be discussed in detail in Chapters Four and Five.

**Conclusion**

A question that arises from this reading of the debate is how these conceptualisations of gender became dominant in our understanding of RSI. This reading raises some key issues regarding the utility of gender in our understanding of occupational injury. If either ignoring or centralising gender is not to the benefit of women, how can women’s occupational health and safety concerns be meaningfully researched? How do we address gender without negating women’s needs or falling into biological determinist arguments? I will address these questions in the next chapter where I will develop a theoretical framework that can sensitively attend to the issue of gender. This theoretical framework will allow me to offer a deeper and richer understanding of why the RSI debate took the form that it did and to more effectively explore the two discourses that surrounded the understanding of RSI in the late 1980s and 1990s.
CHAPTER THREE

READING GENDER IN OCCUPATIONAL HEALTH AND SAFETY RESEARCH

Say that menstruation is painful and distressing, and women will be arbitrarily barred from occupations that involve concentration and responsibility. Say it is unnoticeable and that we are as consistently as healthy as males are supposed to be, and all women will be required to lift the same weights and work the same long hours required of men regardless of the degree of discomfort experienced. Say that the last months of pregnancy are difficult, and we will be fired at the first sign of swelling. Say that ‘there is nothing wrong with being pregnant’, and we will be held to eight hours a day, five days a week. There are real dangers—for all of us—in either understating or exaggerating our needs as women (Ehrenreich and English 1974: 88)

Introduction

The aim of this chapter is to develop a theoretical framework in order to analyse the conceptualisation of gender in the RSI debate presented in Chapter Two. The conceptualisation of gender is central to this framework as my reading of the RSI debate clearly indicates that how gender was used/not used in analyses had major implications for the recognition and treatment of RSI. I argue that two powerful discourses dominated the debates surrounding RSI in the 1980s and the 1990s. Each discourse conceptualised gender differently. As I stated in Chapter One and showed in Chapter Two in occupational health and safety discourse gender is ignored in analysis and women were either absent from the texts or considered to have the same needs as their male colleagues. In contrast, gender is centralised within the medical discourse. Women are seen as intrinsically different from men requiring special attention. In this discourse, RSI is deemed to be the result of female biological or psychological deficit. This discussion is not abstract. The
implications of absence; ignoring difference or centralising difference between men and women have important ramifications as I have highlighted in the discussion on RSI. Very simply, ignoring difference led to an examination of how the organisation of work in capitalist society resulted in the development of RSI. An underlying assumption of this is that women’s relation to work is the same as that of men. On the other hand, centralising difference allowed an examination of women’s biological and social differences to men. This resulted in the foregrounding of women’s psyches, with the workplace and its hazards being ignored in the analysis.

A question which arose from my reading of the RSI debate was why RSI and sufferers of RSI come to be spoken about in this way. Addressing this required the need to ‘understand’ and to ‘disrupt’ the knowledge claims made regarding RSI and necessitates the use of both modernist and postmodernist theories of inquiry (DiPalma and Ferguson 2006: 137). Carolyn DiPalma and Kathy E. Ferguson (2006: 136-137) define these two approaches in the following way. ‘Understanding’ is a modernist approach. It is a narrative inquiry that analyses the production of understandings over time in an attempt to create alternative accounts. It is modernist in that it attempts to interpret reality, and in particular it searches for distortions of that reality by those in power. In a similar vein as Mary Evans (2006: 474), I intentionally do not use apostrophes around reality as I argue that there is a reality, a reality that is experienced very differently by men and women. Using the words of Judith Lorber and Susan A Farrell (1991:1-2 in Emslie, Hunt and Macintyre 1999: 34),

The reason for gender categories and the constant construction and reconstruction of differences between them is that gender is an integral part of
any social group’s structure of domination and subordination and division of labour in the family and the economy. As a major social status (if not the major social status) gender shapes the individual’s opportunities for education, work, family, sexuality, reproduction, authority and the chance to make an impact on the production of culture and knowledge...Gender is built into the social order...The major social institutions of control—law, medicine, religion, politics—treat men and women differently (see also Judith Lorber 2006: 470 where she claims that “gender is so deeply embedded in our lives because it is a social institution” (my emphasis)).

‘Disruption’ on the other hand, is a postmodernist approach. This approach questions claims to knowledge by asking how certain knowledges come to be accepted (DiPalma and Ferguson 2006: 136-137). Postmodernists are not interested in discovering ‘the truth’ but are interested in how knowledge and truth are produced and what effects these truths have (Zaleweski 2000: 117). Postmodernist inquiry asks “why are we asking this question?” It is an historical approach which attempts to destabilise knowledge claims through questioning their claims to neutrality and objectivity. Postmodernists critique the Enlightenment’s “will to truth”, that is, the need to discover a single truth to explain a phenomenon (DiPalma and Ferguson 2006: 136-137).

Another important factor of postmodernist inquiry is that it questions the taken-for-granted categories found in modernist inquiry such as race, class and gender (DiPalma and Ferguson 2006: 136-137). Importantly for my thesis, the denaturalisation of gender calls into question the very utility of gender as an analytical category, which brings me to the central question of the thesis: can gender be useful in understanding women workers’ experience of RSI? This chapter will examine this question through an investigation of current discussions within feminist theory locating the analysis within discussions between modernity and postmodernity. Locating my argument here will do three things. First, it will allow
an exploration of the concept of gender as a useful analytic category using current discussions in feminist theory, which I will discuss below. Second, it allows me to draw on each approach to ask different questions to more effectively explore the discourses surrounding the RSI debate which I present in Chapters Four and Five. Third, it will allow an exploration of the utility of gender through the examination of the gendered experiences of female poultry process workers currently suffering from RSI which I present in Chapter Six. These insights will allow me to revisit the discussions surrounding RSI and offer a deeper and more meaningful account in light of those experiences. I will do this in Chapter Seven.

In this chapter, I will explore the concept of gender through an examination of how it has been conceptualised in feminist theoretical debates. Philomena Essed, Davis S. Goldberg and Audrey Kobayashi (2005: 2) highlight the difficulty facing feminist theorists to clearly articulate the meaning and use of gender in what they refer to as the “slippery terms of gender”. Specifically, I will examine the concepts of patriarchy and the sex-gender distinction as they have informed both occupational health and safety discourse’s and medical discourse’s reading of RSI and sufferers of RSI. I will do this in light of postmodernist critiques, which problematise these terms in order to renegotiate the taken-for-granted conceptualisation of women/gender that is embedded within occupational health and safety research. These ideas will be explored in more detail in Chapters Four and Five when I analyse how gender has been used to discuss RSI and sufferers of RSI.
Feminist Explorations of Gender

Gender as a concept came into widespread use during the second wave of feminism in the 1960s and the 1970s. Second-wave (modernist) feminism was built on what Mick Carpenter (2000: 36) terms “twin pillars of analysis”. The first pillar was the modernist or structuralist concept of patriarchy which has been a central concept to feminist theorising. It is broadly defined as the institutionalised system of male dominance and female oppression (Carpenter 2000: 37). Michèle Barrett and Anne Phillips (1992: 2) argue that despite significant disagreements among second wave feminists regarding the causes of women’s oppression49 “feminists united around the need to establish theories of social causation and to specify sites of oppression for women as an oppressed group”. They claimed,

1970s feminism assumed one could specify a cause of women’s oppression. Feminists differed substantially as to what this cause might be—male control of women’s fertility, a patriarchal system of inheritance, capitalism’s need for a docile labour force—but did not really question the notion of cause itself. Nor was there any difficulty with the idea of oppression which seemed to have self evident application. Important too was the assumption shared by most feminists that the cause being sought lay at the level of social structure (Barrett and Phillips 1992: 2).

The second pillar was based on the belief that inequalities between men and women were not the product of a biologically given sex, but a socially constructed gender (see for example Oakley 1972). Feminists argued against the belief that biology determined what opportunities should be offered to men and women (Mitchell 2004). In the 1960s and the 1970s, stereotypes, socialisation and conditioning were

49 There were three main schools of thought with second-wave feminism. The first were the liberal feminists who argued that individual women should have the same rights as individual men. See for example Harriet Taylor Mill 1970; Mary Wollstonecraft [1792] (1978). The second group were the Marxist feminists who argued that capitalist society used women as cheap labour; as unpaid reproducers of the next generation of workers and as carers of existing male workers. See for example Sheila Rowbotham 1973; Michèle Barrett 1980. The third group were the radical feminists who defined men as the problem. They argued that men as a group controlled and oppressed women as a group. See for example Andrea Dworkin 1974; Shulamith Firestone 1970 and Adrienne Rich 1976 (Scambler 1998: 102)
central to explaining the inequalities evident between men and women. As Joan Eveline and Carol Bacchi (2005: 498) show sex role theory was used to explain any systematic differences between men and women in terms of social expectations rather than biological differences. In order to decrease inequalities women were required to reject the expectations made of them. Women were empowered to struggle against male domination and encouraged to challenge themselves in areas traditionally reserved for men especially in employment areas such as mining, engineering and management.

The twin pillars of second-wave feminism came under increasing scrutiny in the late 1980s. Some feminists questioned the desirability of women to be like men (Ferguson 1984). This resulted in some theorists valorising women’s difference (Chodorow 1978; Gilligan 1982), which left intact the male norm as dominant (MacKinnon 1989; Bacchi 1990). Furthermore, Bob (Robert) Connell (1987) argued that sex role theory’s definition of gender was simply the addition of roles onto sexed bodies thus maintaining the unequal status quo between biological men and women (see also Connell 2000). In a seminal article, Candice West and Don Zimmerman (1987: 129) argue that “gender was not a set of traits, nor a variable, nor a role, but the product of social doings” (see also Wickes and Emmison 2007). Moira Gatens (1983) contended that the ‘add women and stir’ approach which defined gender as a social attribute negated the importance of the body. Importantly, at this time, there were charges of essentialism. Elizabeth Grosz (1995 in Brooks 2007: 211) argued that the sex/gender distinction was no longer useful and that we should return to the term as both are social constructions. Judith Butler argues that the discourse that we know as gender constructs sex as binary thus
bringing its use into question (Butler 1990; also see Htun 2005). Other commentators highlighted how “gender” was considered a problem only for women. The ‘feminine’ became something to be shed, denied or revered (Eveline and Bacchi 2005: 498). In the words of Michèle Barrett (1992: 202),

…contemporary Western feminism, confident for several years about its ‘sex-gender’ distinction; analyses of ‘patriarchy’, or postulation of the ‘male gaze’ has found all these various categories radically undermined by the new ‘deconstructive’ emphasis on fluidity and contingency.

These criticisms were part of a wider challenge to structural analysis which Harriet Bradley (1996: 1) contends resulted in a “crises in stratification theory”. Firstly, they questioned whether grand theories such as feminism and Marxism could adequately describe the social world (Annandale and Clarke 2000: 51). Secondly, influenced strongly by the work of Michel Foucault, the omnipresent power of patriarchy came under question (Carpenter 2000: 42 and see Chapter Five). Thirdly, and more crucially, as mentioned above questions were raised as to whether the commonsense categories of women and men had any inherent meaning at all (Bryson 2003: 226).

Critiquing Modernist Conceptualisations of Gender

Two schools of thought were most prominent in the critiques, women of colour and postmodernism. Women of colour proffered prominent critiques through highlighting the universalistic, ethnocentric and racist assumptions of the white, middle-class feminism that dominated academia and popular discourse (Holvino 2003). These critiques centred on two main points. The first was the neglect to consider race and class as sites of oppression. This point is clearly articulated by bell hooks (1984: 4 in Brooks 1997: 16),
Race and class identity create differences in quality of life, social status and lifestyle that take precedence over the common experience women share—differences that are rarely transcended.

Second, the theorising and application of the concept of patriarchy was considered problematic. This was based on the argument that “black men have not held the same patriarchal position of power that white males have established” (Carby 1982: 217 in Brooks 1997: 17). According to Bobbi Sykes (1984: 63 in Brooks 1997: 17),

White women merely have less power and control than white men. I do not doubt that white women experience this state acutely but in comparison to both black women and black men white women are extremely powerful and have control over many resources.

Elsa Barkley Brown (1997: 276) goes further and argues that “all women do not have the same gender” and that “one cannot write adequately about the lives of the white women in the United States in any context without acknowledging the way in which race shaped their lives” (emphasis in original). In a similar vein, Third World women argued that white feminists generalised their own concerns and assumed that they were the same for all women. Women’s emancipation or progress was measured according to western liberal standards based on the belief that there was a global system of patriarchy through which “differences are treated as local variations on a universal theme” (Liu 1994:574 in Bryson 2003: 227; see also Holvino 2003).

According to Patricia Hill Collins (1990: 225) black feminist contributions to white feminist theory allowed feminists to identify other systems of oppression such as sexuality, age and disability and to recognise that individuals are positioned in a matrix of oppressions and privileges. Accepting this approach resulted in exploring the interrelations between systems in historically specific situations and in doing so rejected the idea that there are hierarchies of oppression. This, to a large extent has
been taken on by white feminists (Ransby 2000; Puwar 2000). However, how to analyse and “weigh” the impact that each of these divisions had on an individual was problematic (Carpenter 2000: 42). Both the issues raised by black feminists, that is, the question of patriarchy as the primary oppression and the issue of diversity has been raised by postmodernism, which brings me to the second school of thought at the forefront of the critiques of modernism: postmodernism.50

Postmodern Challenges

Putting postmodern ideas in a nutshell is a very difficult endeavour. Janice McLaughlin (2003: 91) suggests two reasons for this. The first is that the ideas are very complex and they challenge many taken-for-granted notions. Second, the term itself is ambiguous and is often used interchangeably with poststructuralism. Judith Butler (1992: 14 in McLaughlin 2003: 91) distinguishes between the two by arguing that in poststructuralism “the subject never existed”, while in postmodernism “the subject once had integrity, but no longer does” (emphasis in original). Susan Bordo (1993) argues that postmodernism is analysed as a stage of capitalism, a rejection of the Enlightenment, a particular historical movement, and a new form of aesthetics (in McLaughlin 2003: 92). It is beyond the scope of this thesis to discuss all of the issues raised by postmodernist thought. Following on from Valerie Bryson (2003), I use postmodernism to refer to a range of theories that question the modernist perspective which claims that we can know reality through seeing the world around

50 For the sake of clarity I have separated Black feminist thought from postmodernist thought. This is an arbitrary division. As Valerie Bryson (2003: 233) states, “these [Black feminists] arguments owe much to postmodernism”. Further on she claims that postmodernists were simply making claims that feminists had been grappling with for some time. For example postmodernist questions of objectivity and claims to truth are very similar to feminist critiques of the partiality of male reason and the limitations of binary thought; postmodernist stresses on difference and diversity align with feminists rejection of essentialism (Bryson 2003: 235; see also McLaughlin 2003: 91).
us and considers categories such as class and gender as stable. I will focus on the key concerns which will help me to examine the concept of gender as a useful analytical category. In particular I will examine the issue of diversity and difference, the rejection of the grand narrative and subjectivity.

As with black feminist critiques of patriarchy and the insistence on diversity, postmodernist analysis decentres the subject and explores ways in which knowledge and identities are constructed. In doing so it rejects the ideas that there is a single truth out there waiting to be discovered and that there is a correct way of viewing the world (Bryson 2003: 233). The challenge to grand theories as explanatory frameworks came from both within and outside feminism. In the words of Nancy Fraser and Linda Nicholson (1990: 22) whose work in this area has been seminal,

The postmodern condition is one in which ‘grand narratives’ of legitimation are no longer credible. By ‘grand narratives’ he [Lyotard] means in the first instance, overarching philosophies of history like the Enlightenment story of the gradual but steady process of reason and freedom…The story guarantees that some sciences and some politics have the right pragmatics and, so are the right practices (italics in original)

Two grand narratives in particular came under the spotlight: liberalism and Marxism. Liberalism was criticised for its beliefs that it was based on objective science; its institutions were neutral and that objective truth can and should be distinguished from subjective biased accounts. Liberal philosophies argued that everything in principle is knowable through human reason. Postmodernists rejected the very possibility of objectivity (Bryson 2003: 233). In liberal thought, philosophies such as feminism were considered to be ideologies, rather than a philosophy, because of the supposed lack of objectivity, rationality and abstraction (Moitra 2002:100). Marxism was strongly criticised for its systematic, essentialising and hierarchical conceptual categories which reduced complex social
formations to modes of production. It also “subordinated struggles and “resistance” of all sorts to the economistic primacy of the “class struggle”” (Callari et al 1995: 3). According to Barbara Marshall (1994: 96),

There [was] increasing doubt cast on the premise of orthodox Marxist theory that an individual’s identity, consciousness and in essence social being, are derived from one’s position in the social division of labour.

The rejection of the modernist grand narrative was justified because it was considered an artefact of particular historical periods. Postmodern societies were characterised by fragmentation and diversity in all spheres of life. As with black feminist thought people (or subjects) were considered as sites where multiple forms of oppression operate in fragmented and uncertain ways (Carpenter 2000: 42).

Thinkers associated with seminal postmodernist ideas include among others Jacques Derrida and Michel Foucault. Derrida (1986; 1976) argued that while objects have a material existence, they cannot be given an inherent meaning. For Derrida, reality including meaning and identity is mediated through the operation of language (McLaughlin 2003: 96). He argued that language produced meaning through binary oppositions. That is, words can only derive meaning via a relation with another word or other words. For example, ‘woman’ only has a meaning in relation to other words such as ‘man’, ‘girl’ or ‘boy’. Furthermore, Derrida claimed that each pair of words is hierarchically ordered. Dominant terms, such as good, white, masculine, culture and heterosexual are valued over and derives their meanings from the suppression of the subordinate opposite term, that is, bad, black, feminine, nature and homosexual. In other words, ‘woman’ can only gain meaning from the standard ‘man’ but not vice versa.
Derrida ascertained that this binary logic allows meaning to appear fixed through oppositions and exclusions, but in reality no meaning is secure. The instability arises firstly because the dominant term in the binary pair depends on that which is excluded (Finlayson 1999: 64). Secondly, meaning is understood differently by different people at different times. That is, reality is experienced by different people in different ways which negates the possibility of a grand narrative explaining ‘the truth’ and suggests individual and ever-changing subjectivities (Finlayson 1999: 64). For Derrida, reality and the individual are constructs of language with no inherent meaning outside of their dominant/subordinate relationship (McLaughlin 2003: 93).

Derrida’s deconstruction or deconstructionism as it was termed (Finlayson 1999) highlighted the role that binary thought played in the construction of meaning. Deconstruction does not attempt to abolish, celebrate or reverse the dichotomies. Rather, the intention was to,

...play with the opposition, removing the slash between the two terms...The chief mode of inquiry is the critical analysis of texts to challenge the internal oppositions and differences through which they come to have meaning. The implication for notions of the subject is that she is a product, an embodiment, of a set of discourses or codes of signification that construct her actions, beliefs and her notion of self, with a social nexus of structures of knowledge, meaning and power (McLaughlin 2003: 93)

As can be seen in the above quote, Jacques Derrida’s linguistic theories have been broadened to be more applicable to the social and political world. Theorists use the term discourse to refer to the way language systematically organises concepts, knowledge and experience and in doing so excludes alternative ways of knowing. Discourse theorists argue that authority may be held and legitimated through the establishment of a particular system of meaning presented as universally applicable.
This conceptualisation blurs the boundaries between language, social action, knowledge and power (Finlayson 1999: 62). One of the most prominent discourse theorists to connect the formation of knowledge with power is Michel Foucault. I will discuss Foucault in more detail below (and also see Chapter Five). For now I will discuss how feminists have taken Derridean ideas to understand the ways in which women have been subordinated through binary logic and then discuss the implications of this on the conceptualisation of gender.

Derridean thought has been adapted by feminists to show how women are systematically oppressed or excluded through phallocentric systems of meaning (see for example Cixous 1980; Irigary 1985; Kristeva 1984). According to Jane Flax (1990: 29), postmodernist deconstruction reveals how the category of ‘woman’ which is dependant on its binary opposite ‘man’ to be understood, artificially divides people into two hierarchical groups with opposite and opposing characteristics. This artificial divide needs to be deconstructed as the real life experiences and attributes of men as a group and women as a group do not support this analysis (Annandale and Clark 1996: 22). The opening up of the binary opposites undermines the universalising assumptions about men and women, such as men are healthy and women are not; men are rational and women are irrational. In doing so it helps us move beyond seeing gender as normal, natural and binary. In other words, it subverts the legitimacy of the entire gender order (Lorber 2000). However, deconstructing the binary opposites also undermines patriarchy as a concept bringing into question its analytical power (Bryson 2003: 240-241) and crucially raises the question of whether gender is a useful conceptual category. This of course raises major concerns for feminist theorising.
According to Marysia Zaleweski (2000) there are two broad feminist concerns with postmodernism. First, the denial of truths undermines the concept of patriarchy making it difficult to name gender inequality. This leads to the inability to act on the behalf of women. The second concern deals with the notion of subjectivity. The deconstruction of the subject makes it difficult to name women. I will discuss each of these in turn.

*Postmodernist Critiques of Patriarchy*

First, the denial of truths makes it difficult to declare that women do not have equal rights with men. This concern is similar to the one raised by black feminists regarding the grand theory of white feminism—patriarchy—discussed above. The multiplication of identities means that a single oppression is not possible. The concern for many feminists is that the material reality points to inequalities between women as a group and men as a group. Stevi Jackson (1999:143) argues that there is truth, there is a reality, and that the world does exist and it “remains obdurately structured by a dualistic, power-driven gender system”. Sylvia Walby (1992: 36) contends that,

> Postmodernists are correct to point out that many of the existing grand theories of patriarchy have problems in dealing with historical and cultural variation. But their solution of denying causality itself is necessarily defeatist…Postmodern critics go too far in asserting the necessary impossibility and unproductive nature of investigating gender inequality

Feminists point to the material inequalities evident for the vast majority of women. Valerie Bryson (2003: 243-244) outlines these inequalities. For women who do not live in the West many lack basic rights and legal protection; work in dangerous industries for little remuneration; are subject to religious fundamentalism and ethnic conflicts. For those of us in the West, most have a degree of independence and
have a range of choices scarcely dreamed of as little as 50 years ago. However, these gains are not shared equally. Women continue to be significantly underrepresented in political and legislative bodies; they work longer hours than men, receive less financial rewards; are more likely to live in poverty and live in the fear or reality of male violence (see also Young 2002). It is realities such as this that led to Nancy Fraser and Linda Nicholson’s (1990: 258) question,

How can we combine a postmodernist incredulity toward metanarratives with the social-critical power of feminism? How can we conceive a version of criticism without philosophy which is robust enough to handle the tough job of analyzing sexism in all its ‘endless variety and monotonous similarity’?

Before I address this question I will discuss the second major concern of postmodernism raised by feminists: the deconstruction of the subject.

Postmodernist Critiques of Subjectivity

The main concern with the deconstruction of the subject is that for feminist theorising or activism, a subject, however defined is essential. Some feminists consider the focus on deconstruction and difference dis-abling which “denies women the possibility of constructing political identities from which to name their oppression” (Jackson 1999: 5). First and second wave feminism was built on attempting to achieve a subject position for women individually and collectively. If an identity cannot be articulated, there is no way that feminism can act on behalf of or with women (Di Stefano 1990). The extreme of this position is that a feminist position is not possible as “none of us can speak for ‘woman’ because no such person exists” (Flax 1990: 56). According to Rosi Braidotti (1994:141) rejecting the importance of the subject is only useful for those in a position to voluntarily give it up,
One cannot deconstruct a subjectivity one has never been fully granted... In order to announce the death of the subject one must first have gained the right to speak as one.

Rosi Braidotti (1994: 140) also shows how the loss of the subject is compounded by postmodernism’s use of feminine subjectivity as a “powerful vehicle for conveying the critical attempts to redefine human subjectivity”. Janice McLaughlin (2003: 97) highlights how Jacques Derrida, Jacques Lacan and Jean Baudrillard use the metaphor of the feminine to symbolise the ‘other’ of male subjectivity. In modern modes of language and subjectivity Derrida discusses the disfiguration of the “living feminine” (1985: 21). Jacques Lacan (1968) claimed that the unconscious feminine is the ‘other’ of the dominant symbol of meaning—the phallus. Jean Baudrillard purports,

I consider woman the absence of desire. It is of little import whether or not that corresponds to real women. In is my conception of femininity (quoted in McLaughlin (2003: 97)

Conceptualising the feminine in this way draws on essentialist notions of femininity and ignores differences between women as well as ignoring men’s complicity in the powerlessness of women (McLaughlin 2003: 97; see also Coole 1993: 211-212). Nancy Hartsock (1998: 211) claims that postmodernism is a “failure of imagination” and asks why is it that subjectivity needs to be authenticated,

Why is it, exactly at the moment when so many of us who have been silenced begin to demand the right to name ourselves, to act as subjects rather than objects of history that just then the concept of subjecthood becomes ‘problematic’? Just when we are forming our own theories about the world, uncertainty emerges about whether the world can be adequately theorized (1998: 210).51

At its very worst, the postmodern stance on subjectivity is considered to be no more than traditional academic elitism (McLaughlin 2003: 98).

51 Some radical critics have claimed that postmodernism itself “is a patriarchal ploy to deny women’s collective identity just at a time when they were learning to act together politically” (Bryson 2003: 241; see also Bell and Klein (eds) 1996).
However, many feminists have adopted the postmodernist stance on subjectivity in order to deconstruct fixed and gendered subject positions and create new multiple possibilities (see for example Braidotti 1994; Butler 1990; Gatens 1983; 1996). Marysia Zaleweski (2000: 39) states that for postmodern feminists “it is not a question of choosing between retaining the subject or not, rather it is a question or revisiting our understanding of what the subject is” (emphasis in original). Judith Butler’s 1990 seminal text *Gender Trouble* explores subjectivity as ‘performative’. By this she means that gender is the effect of routine repeated acts which are discursively regulated. Through the enactment of behaviours and attitudes read as gendered, gender appears stable and fixed (1990: 25).

In a similar vein, Moira Gatens (1983; 1996) drawing on the work of Michel Foucault argues that identity is situated and known through a multiplicity of effects (see Chapter Five for a more detailed explanation of Foucault’s notion of power). She shows that expressive effects of power are not simply representational and argues, as did Derrida, that what is said about the body, identity and power is always incomplete “despite continual striving within organised language and cultural formations to ‘fix’ the truth of any privileged utterance” (Colebrook 2001: 82). In Moira Gatens (1996: 183) words,

> Any plane of organization selects possibles from the plane of immanence and attempts to pass these possibles off as actual—the *only* possible actual (emphasis in original)

The importance of Moira Gatens’ work here is that it highlights the need for feminists to address both the fixed realities that organise our social possibilities, while at the same time, understanding the possibilities that our lived experiences...
create (Gatens 1996: 178; see also Colebrook 2001 for a detailed account of Gatens’ thought and works).

This is a key point for my thesis. While it is important to acknowledge the postmodernist critiques of the universal subject and recognise that there are multiple realities and that grand narratives cannot offer the truth, this rejection does not imply “that there is no system, no interpretation or understanding, and no reality” (Braidotti 1994: 141). This brings me to the work of Michel Foucault (1972; 1973; 1977; 1979; and see Chapter Five) who offers a way to interpret and understand the connection between the formation of meaning, knowledge and subjectivity. As I stated in the beginning of this chapter, postmodernism is not interested in discovering ‘the truth’ but is interested in how knowledge and truth are produced and what effects these truths have (Zaleweski 2000: 117).

Foucault and Discourse

For Foucault, knowledge and truth are socially mediated and a product of discourse. Foucault (1972: 45) argued that via institutions certain “discursive formations” make it possible for certain statements and attitudes to be held and others to be excluded. He defined a discursive formation as a “set of rules by which objects, subjects and strategies are formed.” For Foucault (1972: 45), in order to understand any phenomenon it is necessary to analyse the relationships between “institutions, economic and social processes, behavioural patterns, systems of norms, techniques, types of classification, modes of characterisation”. The importance of Foucault’s work for this thesis is that it allows an understanding of the ways in which knowledge is produced, legitimised and maintained. Specifically, Foucault’s ideas around discipline and surveillance help explain the gendered dynamics of power in
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contemporary society (see Bordo 1993; Bartky 1998). While Foucault himself paid no attention to the gendered nature of society his approach helps to move feminist analysis away from a single cause of oppression (patriarchy); allows an analysis of subjectivity that is both socially produced and self disciplined; and allows recognition of moments of resistance (I will develop these points in more detail in Chapter Five).

Using both modernist and postmodernist thinking permits an analysis of gender albeit in different ways. Modernist conceptualisations of gender enable theorists to name gender as a problem. That is, gender equates with being a man or a woman or possessing masculine or feminine qualities. Postmodernist conceptualisations of gender on the other hand use gender as a verb. That is, gender is something that we do, something that is done in discourses and material structures. The main difference according to Carolyn DiPalma and Kathy E. Ferguson (2006: 128) is that in modern thought gender is an aspect of life that we have found and want to make it work differently. In postmodern thought gender is a category that we have produced or created and we want to produce or create it in a different way.

My reading of the RSI debate indicates that both occupational health and safety discourse and medical discourse utilise the modernist conception of gender premised on the binary divisions between women and men, male and female, sex and gender. As Ellen Annandale and Judith Clark (1996: 18, 24) argue the consequences of this binary thought is threefold: first, gender differences are universalised and/or valorised; second, female difference is conceptualised as abnormal with a focus on reproductive abnormalities and third, the neglect to
centralise gender inhibits a clear understanding of either women’s or men’s health issues. This is consistent with most of the research conducted in occupational health and safety. When reviewing the literature on women and occupational health there is a clear lack of research conducted on women (Messing and Östlin 2006; Niedhammer et al 2000; Doyal 1995, 2000) based on the fact that more men are traumatically injured at work. When women’s occupational health is researched it focuses on reproductive health (Figá-Talamanca 1998) or stress due to women’s double day (Lundberg 2002 and see Chapter Four). As I discussed in Chapter One, Karen Messing and Donna Merger (2006: 147) argue the usual methods used to deal with sex and gender in occupational health and safety research need to be expanded.

This is where my thesis makes a contribution. Using both modernist and postmodernist methods of inquiry will allow me to examine the taken-for-granted conceptualisation of woman/gender that is embedded within occupational health and safety research and in doing so explore the utility of gender as an analytical construct. The thesis attempts to address the question regarding combining “a postmodernist incredulity toward metanarratives” with an analysis of gender inequalities posed by Nancy Fraser and Linda Nicholson’s question cited above. The central argument of my thesis is that gender is indeed a useful category. However, I argue that in order to maintain gender as an analytical category it needs to be re-conceptualised in light of insights offered by postmodernism. For a more adequate reading of women’s experience of RSI as well as other occupational injuries modernist conceptualisations of gender, which focus on patriarchy as structure, need to be broadened to include patriarchy as discourse. The deconstruction of the binary division of gender will allow a more meaningful
examination of RSI from a gendered perspective and not a narrow understanding of women’s experience compared to men’s.

**Conclusion**

In the next two chapters I apply this theoretical framework in an attempt to understand and to disrupt the knowledge claims made regarding RSI. In Chapter Four I present my modernist reading of the RSI debate in order to understand why RSI sufferers came to be spoken about in this way. To do this I explore women’s historical relationship to occupational health and safety and work in general. I explore how gender has shaped women’s opportunity to be considered full industrial citizens at work and within occupational health and safety research. I show how women have been marginalised in occupational health and safety discourse through occupational health and safety legislation and policy; job markets and wage scales, unions and research. Specifically, I explore how the protectionist policies rendered women as workers invisible based on then dominant constructions of femininity which narrowly defined women as wives and mothers. I argue that gendered crowding and segregation of work, gendered differential wage scales, union complicity towards women workers and constructions of women as mothers and wives as enshrined in occupational health and safety law and policy served to negate significant research into women’s occupational health and safety and constrained how women’s and men’s occupational health and safety needs could be discussed.

In Chapter Five, I present a postmodernist reading of the RSI debate. In this chapter I ask how did the knowledge claims regarding RSI come to be accepted. In particular, I ask how did women workers suffering from RSI come to be defined as neurotic or suffering from a psychiatric disorder. I explore this through an
examination of the power of medical discourse to construct an understanding of disease and of women using Michel Foucault to frame the analysis (1973, 1977, and 1979). Specifically, I examine how medicine came to be a dominant discourse through the validation of medical knowledge via claims to rigorous scientific method and objectivity. Importantly, I show how the knowledge claims made by medicine extends further than simply defining health and illness (is RSI a disease?) and includes defining other social categories such as what constitutes being a ‘normal’ woman and what constitutes being a ‘normal’ man.

This discussion provides the framework for a meaningful dialogue with the poultry process workers regarding ideas about the role that gender has in understanding their experiences of injury which I explore in Chapter Six. Now, I will present my modernist reading of the RSI debate through an examination of women’s historical relationship to occupational health and safety.
CHAPTER FOUR

IGNORING WOMEN: OCCUPATIONAL HEALTH AND SAFETY DISCOURSE

Introduction

The aim of this chapter is to explore how gender is situated within occupational health and safety discourse. In order to do this, I draw on a modernist conceptualisation of gender which allows me to name gender as a problem and to discuss women as a group. As discussed in my reading of the RSI debate two major discourses dominated the discussions, occupational health and safety discourse and medical discourse. In this chapter, I will examine occupational health and safety discourse in which either women were ignored or women workers’ needs were considered to be the same as their male colleagues. In doing this, I attempt to understand how and why women have been marginalised within occupational health and safety discourse and the implications that this has had on the understanding of one of their most significant occupational concerns, RSI.

Over the last three decades there has been an increasing awareness among government agencies, unions, workers, employers, medical professional and the general public of the need to address the occupational health and safety needs of workers in Australia. This has been particularly the case since the compilation of the Robens Report in Britain in 1974 (Bohle and Quinlan 2000). This interest however has not spread significantly to women workers. The literature reveals that the specific needs of women workers have been under-investigated despite evidence
which indicates that there are problems in this area that warrant serious attention. Statistics indicate that while there is a reduction in the overall incidence of occupational injury and disease among male workers, the opposite is true for female workers. According to the Australian Safety and Compensation Council (ASCC) (2006a) there was a decrease in the number of new claims for male workers from 72.1% in the 1996-1997 period to 68.6% in the 2002-2003 period compared to an increase for female workers from 27.9% to 31.4%. Furthermore, specific research into women’s occupational injury shows that women’s work-related sick leave lasts longer than men’s (Messing et al 2003; Islam et al 2001; Industry Commission Report 1995: 38). Compensation data showed that the average lost time per claim for women is higher—43 days compared with 36 days for men (Worksafe 1994: 15; see also Islam et al 2001). Despite this evidence there is still the widespread belief that women do not suffer from significant occupational harm, and that they, unlike their male counterparts work in “soft” occupations (see for example Messing et al 2003; Messing and Stellman 2006; McDiarmid and Gucer 2001). This section will examine why this belief has come to be and why there is such a dearth of information on women workers’ occupational health needs.

The lack of research can be attributed to several factors: a) traditional occupational health and safety discourse in Australia focuses attention on reducing death and traumatic injury sustained on the whole by male workers; b) the segregation of the workforce means that women and men do not do the same jobs and therefore if a researcher is conducting research into the effects of a certain work process, s/he is more than likely to come across either a predominantly male or female workforce and for reasons discussed in further sections the male workplace is more likely to be
chosen; c) occupational health and safety discourse in Australia particularly for women is based on two periods of protection policies which have shaped research and thinking regarding women’s occupational health needs and; d) health research in general defines sick women in particular ways which is also apparent at times where women’s occupational health needs have been examined. The following two chapters will elaborate on these points and explain the bind for women workers in Australia which neglects to research their occupational health needs and based on that lack of research have made the claim that women do not suffer from occupational harm.

The Pyramid of Injury Management

Traditional occupational health and safety research has focused on life-threatening and traumatically serious injuries, which for the most part are sustained by male workers (Bohle and Quinlan 2000; Sprout and Yassi 1995: 120). Men are more likely to die at work than women and are more likely to suffer from traumatic injury or disease (ASCC 2006a: 12; Messing et al 2003: 620; Bohle and Quinlan 2000; Industry Commission Report 1995; Worksafe 1994). Even with the increase of women entering the workforce over the last few decades and the concomitant increase in injury, the frequency and incidence rates for women are still far below those of men. Statistics indicate that men suffer nearly twice as many lost time injuries than women and make two and a half times more workers’ compensation claims (ABS 4120.0 2007; Messing and Östlin 2006: v). Recent US figures show that women make one-third of all compensation claims (Messing et al 2003: 618).

While it is understandable that research prioritises reducing death and serious injury in the workplace, a review of the literature indicates that even “minor” problems
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suffered by men at work warrant more research and attention than those suffered by women (Breslin et al 2007). Furthermore, even in cases when there is a recognised occupational injury, when it is suffered by women workers it is not always acknowledged. This can be seen in the argument that the prolonged lost time is not attributed to the seriousness of the injury but rather to women’s reluctance to report the injuries.52 Thus, the potentially minor injuries suffered by women are exacerbated.

Consultants to the Industry Commission Report (which is the most recent report targeting specifically women’s occupational health in Australia) argue that women fail to report injuries because of the desire to curb criticism from management, the medical profession and some members of the community who see claimants of workers’ compensation as malingerers. Therefore women underreport because they are able to conceal the more minor strain and sprain type injuries whereas men cannot hide the more obvious workplace health problems consistent with traumatic injury (Geoff McDonald and Associates (GMA) in Industry Commission Report 1995: 38). The report argued that the seriousness of women’s injuries tends to be ignored and fault is attributed to reporting behaviours rather than work process.

Other researchers propose that women’s roles as wives and mothers and/or men’s roles as breadwinners impacts on the length of time required to heal. For example Karen Messing et al (2003: 620) suggest that women may heal more slowly due to

52 This under-reporting of ill health is in direct contrast to most beliefs surrounding women and health. Women are usually attributed with high reporting of health issues, and it has been suggested that this contributes to women’s high use of health services and longevity.
domestic responsibilities or to differences in treatment. Alternatively, men may feel more pressure than women to return to work as quickly as possible.

**Gendered Segregation of the Workforce**

Another important factor that contributes to the marginalisation of women in occupational health research is the fact that men and women participate in the workforce at different rates and on the whole do different work. The participation of women in the workplace in Australia and elsewhere is increasing (ABS 2006; Hakim 1992; Newell 1993; Ginn et al 1996). In the 2002/2003 period the female participation rate had increased to 56.8% compared with the male participation rate which had declined to 72.3% (ABS 2006). Globally, women make up 42% of the workforce (ILO 2000; Messing and Östlin 2006: 2). Despite increasing numbers of women in the workforce and equal opportunity legislation occupational segregation along gendered lines continues to be a feature of most workplaces in both developing and developed nations (Stellman and Lucas 2000: 514). Of 12 OECD countries, Australia has the highest index occupational segregation by gender with 56% of women employed in two occupations: clerks and salespersons compared with 53% of male workers employed as tradespersons, labourers and related workers and managers and administrators (McLennan and Goward 1997: 73-74). According to one set of US statistics about three-quarters of all working women would have to change jobs in order for the workforce to be distributed evenly between the genders (Messing 1998: 1).

Another important feature of the workforce impacting on occupational health and safety is that the workforce is not only segregated, but women are crowded into a
very narrow range of occupations (ABS 2006; Lewis 1996: 107). Segregation indicates that men and women do different jobs, (e.g. men are construction workers and women are nurses) whereas crowding indicates that women are found in a very narrow range of occupations. Australian Bureau of Statistics data indicate that there are five main areas of women’s employment (employing 69% women): health and community services; retail trade; education; property and business services and manufacturing. This is in contrast to men’s occupations in which 72% male workers are found in eight occupations: manufacturing; retail trade; construction; property and business services; wholesale trade, transport and storage; agriculture, forestry and fishing; and government, administration and defence (adapted from ABS 2006). In a more recent publication Karen Messing et al (2003: 619) found that only one occupation—retail sales clerk—is found in the top ten jobs for both men and women. One of the main effects of occupational crowding that is relevant to this thesis is that working class women are primarily found in occupations that require repetitive work and hence are subjected to occupational overuse injuries (Punnett and Herbert 2000; Messing et al 2003: 620; Messing 1995: 186-7).

Segregation and crowding are not limited to separate workplaces. Even in occupations where both men and women work, the actual job titles held and the jobs performed are usually quite different (Messing et al 2003: 619; Stellman 1994: 815-820). Furthermore, even in workplaces where the job titles held by men and women are identical, the actual job performed is not necessarily the same (Messing et al 2003; McDiarmid et al 2000; Pottern et al 1994: 811). For example, men and

53 Lewis’ article is examining occupational crowding as a contributing factor to continuing wage differences between women and men.
women in the poultry processing industry with the same job title—process worker—perform different tasks. Women perform the sedentary repetitive tasks and men are responsible for moving product from one part of the factory to another. Of interest, however, is that jobs that are considered male and jobs that are considered female differ from plant to plant.\textsuperscript{54}

Feminist sociologists argue that the segregation of the paid labour market is similar to the domestic division of labour and is based on the prevailing ideology of women’s supposed “natural” inferiority based on biological differences (Lee 1998: 93, Messing 1983: 146). Women’s work roles are therefore associated with their social roles such as teaching, household service and caring professions. In a seminal text on women and occupational health, Jeanne Mager Stellman (1994: 814-815) argues that although many hazards can and do exist in the home and in service industries these are generally considered safe and not in need of investigation. Furthermore, she argues that women are considered to be marginal workers and simply working for “pin money” with their real life functions being childbearing, family care and homemaking. The result of this is twofold. First, there is a dearth of information or research carried out in female-intensive industries; and second research is usually carried out in male workplaces which results in the male worker’s experience being accepted as the norm and women’s experience either being read off as the same as men’s or considered deviant (Breslin et al 2007).

\textsuperscript{54} In one plant the boning room was staffed solely with women as “women are better at the detailed work required to bone a chicken and do not pose a threat to each other with knives” (OHS Manager). In contrast, in another plant in the same city, the boning room was staffed solely with men as “men are much more adept using blades and suchlike…I don’t think many girls would want to do that” (Phillipa, interviewee; see Chapter Six). (See also, Ratcliff 2002: 91; Messing 1997: 43).
Women and Unionisation

Another prominent reason suggested in the literature for the lack of research conducted on women and occupational health is the lack of unionisation of many women workers. Many writers attest that because women tend to work in precarious employment (part-time casual, insecure tenure) they tend not to be unionised (Ratcliff 2002: 91-92). Michael Quinlan (1996: 412) argues that the weak or non-existent unionisation of women workers has resulted in lower reporting of injuries due to women being unable to give up family responsibilities as well as understanding that their claims are likely to be contested or questioned. Furthermore, he argues that occupational health and safety legislation can only be effectively utilised in industries/workplaces that are strongly unionised (Quinlan 1996: 413). In addition, it is difficult for women in non-unionised workplaces to access benefits such as OHS education and legislative protection, exposure standards and ergonomic controls, and other benefits such as maternity leave and re-assignment for pregnant women exposed to health risks (Williams 1999: 530).

Protection Policies

The marginalisation of women in occupational health and safety research goes deeper than job segregation, crowding and lack of unionisation. I maintain that both the lack of research and the research that has been conducted to date has been constrained at one level by the legacy of legislation that was enacted in the latter half of the 19th century and the earlier half of the 20th century which placed women’s relation to work and occupational health and safety discourse outside of the workplace. Social reformers and legislators utilised dominant definitions of femininity and masculinity to inform restrictive provisions and in turn perpetrated a
construction of woman that denied her the definition of worker at the same time as reinforcing her definition as mother and wife.

The following section is informed primarily from Claire Williams’ (1997) convincing article which makes this claim. She argues that the protective legislation rendered women as workers invisible, placed men at the centre of occupational health and safety discourse at the same time as legitimating the harm incurred by working class men. Women workers were constructed as needing protection, firstly as working class workers who could not protect themselves from the greedy capitalists and secondly as actual or potential mothers whose role in populating the new country with healthy babies was paramount. The creation and perpetuation of gendered constructions is a central theme in the thesis and will be explored further in the relationship between women and medical discourse discussed in Chapter Five.

Another significant argument articulated by Claire Williams is that the ‘protecting’ of women played a role in the establishment of contemporary occupational health and safety discourse which includes (most importantly for this thesis) victim blaming for injury occurrence rather than cleaning up hazardous workplaces and the introduction of medical knowledge as the official voice in occupational health and safety matters.55 It is at the interface of occupational health and safety discourse and medical discourse that this thesis is located. Before examining the implications

55 The relationship between women and medicine is a very complex one and will be dealt with in more detail in Chapter Five.
of the protection policies for contemporary Australian women workers, it is necessary to outline the historical and social setting in which protectionism arose.

*International Labour Relations and Protectionism*

Internationally, the first period of protectionism for women workers occurred at the end of the 19th century with rapid industrialisation in the developed nations and the concomitant increase of women seeking industrial work. While there were obvious and important differences in the course and content of protection legislation among various countries,\(^{56}\) feminist historians agree that the initial impetus of protective legislation was the desire of the state, and/or the trade unions and/or the workers—both male and female—to control and regulate the negative effects of capitalism for all workers (Mutari 1999: 639). International congresses\(^{57}\) were convened and elaborate discussions took place regarding the role that the state should play in curbing the negative consequences of unimpeded capitalism (Wikander 1995: 29). One of the most articulated concerns regarding industrialisation focused on the negative impact on the family. It was believed that the family was a risk because of the level of poverty experienced by the factory workers and the equivalent demand for female and child labour as well as male labour (Kessler-Harris et al 1995: 6). The demand for women’s labour became a central concern because of the perceived negative impact that women’s waged work had on the family. Thus labour

\(^{56}\) For a comprehensive discussion of the different yet similar paths of protective legislation in eleven countries throughout the world, see Wikander, Kessler-Harris, and Lewis (eds) 1995.

\(^{57}\) Six international congresses were held prior to WWI (with a seventh cancelled due to the war) that focused on general protective labour legislation. These congresses lead to the establishment of the International Association for Protective Labour which was the predecessor to the International Labour Organisation (ILO). Protective labour legislation was also discussed at nine congresses of the Second International between 1889 and 1914. Furthermore, there were seventeen international women’s congresses were held between 1878 and 1914. While the international women’s congresses covered many areas in relation to women, protective legislation was frequently discussed (see Wikander 1995: 33; Appendices 1, 2 and 3: 54-56).
legislation was designed to find solutions to what was known as “The Social Question”. It focused on wages and hours for all workers and reproduction, both biological and social that would enhance family life without threatening industrial progress. Although the delegates at the international conferences disagreed on the justification and types of regulation needed, there was a general consensus that women needed special protection (Wikander 1995: 29).

Alice Kessler-Harris et al (1995: 8) discuss three types of legislation that emerged in one form or another in most industrialising nations. The first group was explicitly gendered dealing with pregnancy, childbirth, lactation and maternity leave. The second group was potentially gender-neutral dealing with hours and wages. However, in many cases (as will be discussed below in the case of Australia), advocates who fought for lower hours and minimum wages for all workers focused on legislatively restricting women’s and children’s hours in the hope that it would be eventually lead to shorter hours for male workers as well. The final group of legislation which was also potentially gender-neutral was primarily limited to women, for example, bans on night work.

Several agendas were played out in the international debates on protective legislation. These include the issue of motherhood and waged work; the question of the homogeneity of women; and the link between the “protection” of the “most

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58 Many of the authors used in this section cite Friedrich Engles as one of the more significant commentators on the negative implications of women work on the stability of the family and the societal problems that world ensue following a disruption to existing gender relations. See, Engels, Friedrich [1845] (1958), Henderson, W. O., and W.H., Chaloner, W. H., (trans).
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weak and needy”\(^{59}\) and civilisation (Kessler-Harris et al 1995: 10). Industrial legislation in this period had a very different impact on male and female workers, in that any restrictive provisions were primarily limited to female workers. This in effect reinforced and extended the gendered division of labour which protected male jobs at the expense of women’s jobs (Kessler-Harris et al 1995: 4). Furthermore, it also raised the issue of women’s right to work which still plagues women workers today and reinforced paid work as a basic right for all adult men (Williams 1997: 49).\(^{60}\)

Despite the similarities for working women internationally, it is important to discuss the historical and social context in which Australia came to have protective legislation for women and minors which for the most part remained untouched until the late 1970s.\(^{61}\) Two of the main differences between Australia and other developing nations were: first, Australian white women had gained the franchise;\(^{62}\) and second, colonial Australia considered itself as progressive, a nation that could accomplish the economic and social change that was being fought for in the ‘mother country’ and that this change could be brought about by the state (Howe 1995: 319).\(^{63}\) This belief meant that the labour movement did not see the state as oppressive and considered its goals as being in the same interest as its own.

\(^{59}\) I took this from the title of Efi Avdela’s chapter (1995).
\(^{60}\) See discussion with interviewees on this point in Chapter Six.
\(^{61}\) I have drawn the history from Howe’s chapter which examines the introduction of protective legislation in the colony of Victoria. This was the first colony in most instances to enact such legislation and in most cases it was very closely followed by the other colonies (and later states).
\(^{62}\) By 1901 all white Australian women over 21 were franchised and had the right to run for public office (Howe 1995: 334, footnote 1).
\(^{63}\) Stuart Macintyre (1991: 34) states that Australia at this time considered itself as “the coming nation, the redeemers of their European legacy who were able to realise the potential of that parent civilization because they had escaped its constraints and were accordingly freer, more equal, less cynical, better able to invent the future” (in Howe 1995: 319).
Expelled from the Working Class: The First Phase of Protection Policies, 1880-1910

The first period of protection for women workers occurred at the time when manufacturing was developing in the capital cities in Australia. Manufacturing was fostered to substitute expensive imports and depended on government protective tariffs as well as low-paid women workers to be sustained (Howe 1995: 320). The number of women looking for work increased at this time due to a surplus number of women in the population compared to that of men (Williams 1997: 35). The increase of women taking on factory work at low rates triggered debates regarding the exploitation of women workers in regards to wages and working conditions (Howe 1995: 320; Williams 1997: 36). These debates informed provisions in the factory acts that were to have a lasting impact on women’s relationship to occupational health and safety.

The initial Factory and Shops Act (1873) was directly imported from Britain\(^\text{64}\) which had emerged as the result of the Ten-Hour Movement first established to reduce the working hours of all workers. Amendments made in 1885 and 1890 (Victoria); 1894 (South Australia); 1896 (New South Wales and Queensland) and 1897 (Western Australia) included provisions for the introduction of inspectorates,

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\(^{64}\) D. R. Biggins cites three British Acts as establishing the framework for Australian legislation: The Health and Morals of Apprentices Act of 1802 which restricted the hours of work by child apprentices and included health, education and religious provisions; The Factory Act of 1833 which introduced the factory inspectorate and further limited the hours that children could work; and the Factory Act of 1844 which limited the hours that women were permitted to work; again reduced the hours that children were permitted to work, increased children’s education requirements and established some basic safety stipulations in relation to the guarding of machines (Biggins 1993: 218). One Act that Biggins does not cite is the Mines and Collieries Act of 1842 which excluded all females from working underground in mines. The debates which led to the passing of this clause is significant as it set the stage to link immorality and waged work for women as well as allowing women’s reproductive capabilities, both social and biological, to be linked to the national interest (Lewis and Rose 1995: 97).
set in place requirements on safety conditions in workshops employing more than six people and limited the hours that women and children could work with the banning of nightwork in SA, NSW, QLD and WA (Howe 1995: 320).

The initial legislation only affected women working in factories and did not deal with female outworkers or very small workplaces where the conditions were far worse. The Depression of the 1890s brought with it an increase of underpaid workers into the clothing and footwear industries and with it a powerful anti-sweating movement emerged. The main articulated aim of the anti-sweating movement was to protect women workers from below living standard wages. A basic assumption touted was that women were unable to protect themselves (as they were not as unionised as men) so therefore rather than resolving women’s industrial exploitation via negotiations between employers and employees (as with male workers), women workers were subjected to protective legislation (Howe 1995: 320).

The campaign was played out in the public as well as the workplace arena. Women’s working conditions were portrayed as “matters of public debate, as moral and social rather than as industrial issues” (Howe 1995: 321). The anti-sweating campaign relied on the media and current definitions of femininity based on helplessness and docility to stir up public sentiment. Claire Williams claims that “narratives of danger”65 were circulated regarding girls’ preferences to work in factories rather than in domestic service and that this was being touted as unhealthy and a threat to reproductive capacity (Williams 1997: 35). These debates used a

65 Claire Williams credits Kathleen Canning for the initial use of this term (see Canning 1994).
similar rhetoric that was expressed in Britain by advocates of the restriction of women working underground in mines. Rather than focusing on the occupational dangers for women working in collieries resulting in miscarriages and stillbirths, the arguments centred on the immorality of women ‘choosing’ to work rather than keeping house (Lewis and Rose 1995: 98).66

The campaign was successful in that Australia was the first nation to legislate a minimum wage for women workers. The *Factories and Shops Act* 1896 set in place wages boards to determine what minimum rates would be, although as in other countries this became the maximum rate (Lewis and Rose 1995: 115). This Act was more inclusive than the previous one in that it regulated outworkers as well as factory workers. The hours for all women workers—factory and outworkers—were limited to a forty-eight hour week, ten-hour days and no work after nine o’clock at night (Howe 1995: 321). Because manufacturing was protected via government subsidies there was little resistance by employers to the reduced hours of work stipulated by the Act.67 As the Act was the first internationally to legislate a minimum wage for piecework, the then chief inspector of factories considered it as “probably the most advanced Factories and Shops Act in the world” (in Howe 1995: 322), and it was regarded as a “charitable intervention by the state on behalf of the

66 The following poignant quote highlights the link made between morality and domesticity in the 1840s: “let her attend to a mother’s and a housewife’s duties; and you will soon change the moral condition of the collier” (cited in Pinchbeck [1930] (1981) in Lewis and Rose 1995: 98).

67 This is in direct contrast to what occurred in the US where by the end of the 19th century the doctrine of the “freedom of contract” ensured that the courts “would not interfere with a workers’ “individual right” to negotiate with an employer” thus aiding industry to expand and profit unencumbered (Kessler-Harris 1995: 339). Alice Kessler-Harris argues that this did not protect American women workers from restrictive legislation but rather placed them in a “special circumstance” category, which effectively limited their citizenship rights and set up a contradiction between motherhood and work (Kessler-Harris 1995: 340; 353).
innocent and helpless” (Rickard (1976) quoted in Howe 1995: 321). However, Renate Howe argues that,

Although the dominant discourse of the antisweating campaign had been one of preventing the exploitation of women and child outworkers, concern over the effect of this exploitation on male wage rates was never far below the surface. The protection of male industrial workers from the competition of women was as much the issue as was the protection of women workers from exploitation by greedy capitalists (Howe 1995: 322).

The minimum wage which was first aimed at protecting women workers was soon extended to men. The wages set for men was more than double that of women’s work (Howe 1995: 323). No consideration was taken into account of the family situation of the workers and therefore a single adult male worker with no financial dependants earned double that of a breadwinner woman worker (Williams 1997: 39). Furthermore, women’s hourly limit and night work restrictions meant that overtime payment was available only to men (Howe 1995: 324; Williams 1997: 39). Even so, many women in factories were better off than they had been hitherto. As employers had to pay outworkers and factory hands the same wage, they increasingly used factory labour eliminating a large need for outwork (Howe 1995: 324). Thus those women who were unable to conform to regular working hours (that is those who headed households with young children due to the lack of a breadwinner husband) lost work altogether. Howe argues that,

The effect on these households was to make them reliant on haphazard colonial charity. Thus, the income needs of women with dependents largely became a welfare rather than an industrial issue (Howe 1995: 324).

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68 The protection of women from unscrupulous capitalists was readily accepted by the public. The same sentiment was rarely extended to male workers and Ray Strachey (1978: 82) argues that the protection of women workers “enabled men to secure for themselves, behind the women’s petticoats, protection which public opinion was not yet ripe for conferring on men” (in Howe 1995: 323).
Furthermore, the wages board helped to preserve and extend gender segregation in the workforce. It did this by determining that traditional male jobs were paid at higher rates and considered skilled such as cutting and pressing whereas sewing was considered an unskilled female job (Howe 1995: 324-325). The demand for equal pay by women effectively forced women out of certain jobs because if employers were given a choice to employ men or women at the same rate, they would choose men. Jenny Lee maintains that without the wages board,

"It is inconceivable that the trade unions could have managed by industrial action to re-establish the boundaries between men’s, women’s and boy’s work as swiftly and decisively as they did with the assistance of the state (Lee 1987 in Howe 1995: 325)."

Thus Renate Howe claims that wage legislation was not passed in the interest of women workers but rather to protect male jobs and to protect them as skilled against the threat of women’s cheap labour. She argues that many women supported the protective legislation as it increased security despite the fact that in effect it restricted women to low-paying jobs (Howe 1995: 327).

The impact of the initial phase of protective legislation for Australian women workers was significant then and now. As discussed above, the introduction of an unequal minimum wage and the restriction of women to work at night redrew the boundaries of what was/is considered to be the working class by excluding outworkers and women (Williams 1997: 36). It also restricted women’s employment to low paid unskilled work and by implication segregated male and female jobs. Of greater significance to this thesis, however, is the utilisation of the then dominant definitions of femininity that informed these legislative decisions and
set in place the boundaries of how questions regarding women’s occupational health and safety needs can be asked and answered. Vulnerable women were now protected from the evils of industrialism and hence were not subjected to hazardous working conditions. More broadly, it created and perpetuated a construction of woman that denied her the right to define herself as worker. Jane Lewis and Sonya Rose (1995: 91) argue that the debates surrounding protective legislation in effect made the notion of the “working woman” a contradiction in terms. As will be discussed in the next section the second phase of protection policies narrowed this definition by making woman and mother synonymous terms. This definition of woman was in direct opposition to the social construction of man. Men were first and foremost workers; they were not vulnerable and therefore did not need the protection that the state conferred on women (Williams 1997: 31). 69 Furthermore, the heterosexual family with a breadwinner male and a homemaker female is reinforced as the norm and those who fall outside of that norm such as women who work after marriage and women with dependants are rendered invisible within occupational health and safety discourse (Williams 1997).

**Woman as Mother: The Second Phase of Protection Policies, 1911-**

The second phase of protection policies came about at the time when women made up 40% of the Australian workforce (Howe 1995: 319). In contrast to the first period nationalistic discourses came to the fore and debates moved from the protection of women from unscrupulous employers to the protection of women as

mothers and potential mothers to aid in the building of the new nation (Howe 1995: 327).\textsuperscript{70} Claire Williams argues that the second period saw a change in the discourses surrounding women and protection. In the first period women were cast as workers and class was the central concern. In the second period all women were recast as mother—potential or actual—and gender replaces class as central to the discourses surrounding protection (1995: 42). The new Commonwealth of Australia wanted a larger healthy population. It deemed that women who worked were unable to fulfil their primary obligation as Australian citizens, which meant producing and rearing healthy, happy, moral children (Howe 1995: 328). For example the 1911-1912 Royal Commission Report lists six negative effects of factory work on women. First, contraception was practiced; second, there was a higher risk of miscarriages; third, mothers did not breastfeed which led to a higher infant mortality; fourth women’s energy went into making money instead of keeping house; fifth, men became idle; and sixth “it placed unmarried girls under the often unhealthy influence of married women” (Report of Royal Commission 1911-1912: 1142 in Howe 1995: 328).

The need to protect potential mothers called for new protective measures for working women and girls and recommendations were made to the Royal Commission which included the prohibition of mothers working for four weeks after giving birth; the prohibition of girls under sixteen working in factories because factory work was detrimental to the development of a healthy maternal body; and a

\textsuperscript{70} Renate Howe claims that the changing debate is evident by comparing the parliamentary inquiry into sweating in the late 1800s which was dominated by social reformers and the 1911-12 Royal Commission on Female and Juvenile Labor in Factories and Shops in New South Wales which was dominated by the medical profession and focused on protecting women as mothers (Howe 1995: 327).
prohibition of married women working unless they were the sole or chief support for the family (Howe 1995: 328; Williams 1997: 37). Very few of these recommendations were translated into legislation. However, the construction of woman as mother placed all women in one category regardless of their economic, social, marital status, age or class. The category of woman was defined in direct opposition to the category of man. Women workers were defined as a special category in need of special treatment and therefore their right to be considered as part of the working class was further diminished (Williams 1997: 32, 42). The divide of the working class along gender lines was and continues to be a major factor hampering women’s occupational health and safety needs being addressed. Women are considered deviant workers and their needs are based on their difference to men rather than in relation to the work process. The centrality of biological difference entered occupational health and safety discourse with the entry of medicine into the protection debates in the 1920s. Williams argues that “narratives of eugenics” were espoused by the medical profession at the time and occupational health and safety for women centred on risk to the maternal body (1997: 42). The entry of medicine into occupational health and safety discourse as the only valid source of knowledge\(^\text{71}\) legitimated women’s difference to men and gave credence to biological difference as being the key to understanding the needs of women workers.

Three representations of women were forwarded and legitimated by the medical profession. The first was that women were weak compared to men; the second was

\(^{71}\) Medicine’s standing as an unquestioned vehicle to the “Truth” will be discussed in more detail in Chapter Five.
that paid work was detrimental to the actual or potential maternal body; and the third was that girls possessed “alertness, patience and dexterity… [and that they] do not tire of repetitive work” (Osbourne (1927) in Williams 1997: 43). It is these three representations that I argue still have greatest impact on working women today. That is, women are considered weak, they are defined primarily as mothers or potential mothers and they are capable of performing repetitive work. When repetitive injuries do occur they are ignored or trivialised because women are not ‘real’ workers and their bodies are capable of doing this kind of ‘easy’ work. Prenatalist narratives have expanded to include child rearing practices which further restrict women’s right to meaningful work. As I will argue later in the thesis, this is particularly acute for injured women workers who are subjected to the assumption that they either should not be working or that they do not have to work.

The belief that women do not have to work is a powerful assumption in contemporary society which owes its legacy to the protection periods. At the same time that women were being primarily defined as mother, their right to define themselves as worker was further eroded through the introduction of a basic family wage in 1907 to be paid to all working adult males. The setting of the minimum wage did not consider women’s wages at all until 1919 when women’s wages were set at 54% of men’s. This cemented the view of the earlier period that women’s wages were supplementary and not central to a family’s finance (Howe 1995: 329).  

72 Single and married men were paid the minimum wage but self-supporting single women and female breadwinners were still paid at the 54% rate (Howe 1995: 329). It was not until the 1970s when women finally achieved equal minimum wages with men (Williams 1997: 39).
**Implications for Contemporary Occupational Health and Safety Discourse**

The legacy of the protectionist era is far-reaching. While most of the provisions restricting women from certain types of work have been repealed since the implementation of the Federal Sex Discrimination Act in the 1980s, the underpinning narratives that were espoused continue to inform the way that women’s relation to work in general and men’s and women’s relation to occupational health and safety in particular is considered. Before outlining the implications for women workers, it is necessary to identify the broader ramifications of the protection era on current management practices within occupational health and safety discourse and its impact on all workers. Claire Williams identifies seven features which have formed the discursive framework of contemporary occupational health and safety management:

- Fragile categories such as women and children are excluded;
- Hazards are rarely addressed or removed;
- Regulations and precautions are imposed onto workers’ bodies;
- Injuries are seen as accidents and the fault of workers/lifestyles;
- There is a separation of occupational health and safety discourse from industrial relations;
- Scientific discourse becomes the legitimate form of knowledge and those not possessing it (such as workers and trade unionists) are excluded; and
- Science and science-based medicine establishes the correct discourse in which occupational health and safety problems and solutions can be officially discussed (Williams 1997: 40-42).
According to Claire Williams (1997: 34), an understanding of these controversial aspects of contemporary occupational health and safety discourse cannot be understood in terms of class alone but also requires an analysis of gender. I would further add that it also cannot be understood using an analysis of gender that equates gender only with the category ‘woman’. To put it another way, while women and men have different occupational health and safety concerns, these have evolved in relation to each other and men’s occupational health needs are as clearly based on the gender politics of the protectionist era as are women’s. The debates which culminated in restrictions on women working underground, overtime and at night were predicated on a social construction of gender that defined women as weak and needing protection in direct opposition to the definition of men who were defined not only as the legitimate members of the working class but that definition also entailed a definition of men as not vulnerable. As Williams succinctly states regarding the forbidding of women working underground, it

re-inscribed the male miners’ bodies with one of the central defining features of hegemonic masculinity for working class men, that ideal work should exclude women. Not only did it serve to enforce a more rigid binary that had existed hitherto, but it strongly reaffirmed the notion that working-class men were not vulnerable and that their work could remain unsafe (Williams 1997: 33).

Williams (1997: 34) claims that the internalisation of the hegemonic definition of masculinity allows an understanding of why working class males accepted large numbers of fatalities and injuries at work. She supplements W. G. Carson’s conventionalisation of factory crime thesis, which argues that the inability of the inspectorate (which was an integral part of the factories legislation) to prosecute employers/owners of dangerous workplaces, instituted a system of enforcement that persists today (Carson 1985: 68).
In short, Carson (1985: 64-68) argues that industrialisation was causing a major social upheaval and that the class conflict at the time had the potential to deligitimate the new industrial bourgeoisie. The inspectorate, which comprised “classless bureaucrats”, defused class conflict by taking injury and disease out of the arena of industrial relations and made it the responsibility of state regulation. The enforcement of regulations was ineffective for a number of reasons. First, employers made claims that they were being hauled before the courts on “mere formality” for minor technicalities. This was reinforced by the magistrates who were often mill owners themselves and therefore penalties were often mitigated. The third factor was that violations of the act were widespread and legal enforcement would mean “collective criminalisation” with the possible result that “[t]he moral contours of this industrialising society would [be] pushed badly out of line with the contours of its social structure” (Carson 1985: 68).

The inspectorate attempted to address these problems. In the first instance, employers were assured that prosecutions would not be instituted unless criminal intent (*mens rea*) was involved. In court, however, criminal intent was not made an issue and therefore moral responsibility was taken away from public view thus institutionalising ambiguity which Carson argues is one of the distinctive features of current workplace violations (Carson 1985: 70). The problem of dealing with politically powerful employers was solved through the inspectors being instructed to be conciliatory and to issue warnings rather than prosecutions (Carson 1985: 68-70). Carson claims that ‘softly, softly’ approach became “rapidly institutionalised” (Carson 1985: 70).
The ‘softly, softly’ approach entailed more than just the ineffective enforcement of legislation. In order to enable the non-prosecution of offences, workers’ behaviour rather than employers or work processes became the focus of injury causation. ‘Accidents’ were being attributed to “worker carelessness”, “misadventure” or the lack of personal protective equipment (Williams 1997: 41). This ‘blame the victim’ mentality continues to permeate contemporary occupational health and safety discourse. Contemporarily, there are four popular explanations of victim blaming: accident-proneness, ignorance/carelessness, machismo and malingering. Quinlan and Bohle (1991: 101) argue that despite the fact that individual victim blaming for injury causation has been discredited both conceptually and methodologically; employers, insurance companies and some health professionals continue to support this belief (see also Bos and Farr et al 2003; Bohle and Quinlan 2000). My own research in the poultry processing industry also indicates that workers themselves have to a certain extent internalised this notion and often blame the poor work practices of their colleagues as being the reason for their injuries. As will be discussed in Chapter Five, this victim blaming has another major component in the case of women workers. The medical profession, management and women workers themselves consider that the female ‘defective’ body and/or mind to be the source of explanation for the high rates of injuries sustained in poultry processing.

This brings me back to the initial point made earlier by Claire Williams that the factories legislation which includes the establishment of the inspectorate cannot be understood in terms of class alone. She argues that the legislation was successful (in that it was implemented rather than effective) because male workers legitimated the values that were accorded the working class male. Men were the protectors and
women were the protected. Women were vulnerable, men were not. Men could be exposed to injury because they are men. Women need (and were granted) protection and therefore could not sustain injuries. As Williams (1997: 34) states, masculinity is part of subjectivity and identity and therefore male workers accepted large numbers of injuries within the working class. They did/do this because as Spence (1993) has argued one’s gender identity “represents a blending of self-images, self perceptions, and perceived comparisons to others as well as some degree of adherence to stereotypical role expectations (in Snyder and Hasbrouck 1996: 594). In a similar vein, I explore in this thesis how the gendered definition of workers, that was formed during the protection era and has been consolidated and re-worked in the ensuring years, has impacted on how contemporary poultry process workers view sufferers of RSI (be it themselves or colleagues). This will be discussed in Chapter Six.

The construction of women as marginal workers and as reproducers has meant that women’s occupational health and safety has been researched in particular ways. In the next section, I will present an overview of the literature dealing with women’s occupational health and safety issues to highlight how the protectionist era which defined women as weak, wives and mothers has constrained meaningful research in this area. This is recognised in much of the work dealing with women’s occupational health and safety which often begins with the claim that research concerning women’s health at work is severely limited (see for example Messing and Östlin 2006; Messing 1998; Stellman 1994; Infante and Pesak 1994). As I will show in the next section, research into women’s occupational health and safety draws on modernist definitions of gender that result in research that compares her to
men or focuses on her needs as a biological and/or social wife and mother. This is not only seen in the amount of research that is carried out on reproductive hazards but also the amount of research that compares the health of working and non-working women.

Implications on Women’s Occupational Health and Safety Research

The research that has been carried out on women’s occupational health falls into three main categories. The first is research that attempts to debunk the myth that women’s work is safe; the second is research that examines women’s double roles and focuses on stress and the third is research on the effects of occupational hazards on reproductive function. While it is not important to go into these works in great detail, it is necessary to understand what the field of women’s occupational health looks like in order to be able to move forward. In particular it is important to understand how gender has been used in these works. It must be mentioned here that I am focusing on research conducted in the First World. As researchers such as Lesley Doyal (1995: 156-175) and Jeanne Mager Stellman and Andrea Lucas (2000: 514) clearly show, the impact on health of women’s work differs dramatically from country to country depending on economic status and socio-political culture. However, Stellman and Lucas (2000: 514) also state that “despite the vast economic differences that can be found among nations, the basic socioeconomic factors affecting women as workers are startlingly similar”. This question of speaking of women as an homogenous group was dealt with in some detail in Chapter Three and will be further explored in Chapter Seven.
Debunking the Myth of “Safe” Work

There is a growing amount of literature that sets out to address the invisibility of women’s occupational health needs. This research has shown that women suffer significant occupational harm in occupations considered “safe”. Underlying this research is the attempt to ascertain when biological differences between men and women compared with exposure differences are responsible for women’s ill health at work (Messing 1983, 1995, 1997, 1998, 2004; 2005; Messing and colleagues 1995, 2000, 2003, 2006; Mergler 1987, 1995; Lippel 2003; MacEachen 2005). This field of literature rightly asserts that many studies ascribe differences to injury rates as resulting from biological sex differences prior to determining differences in exposure. While this literature uses modernist conceptualisations of gender, researchers in this area are at the forefront of attempting to ascertain how to use gender in occupational research in a meaningful way for both women and men. I will return to their work again in Chapter Seven.

Main areas of research have focused on the hazards of office work (see Messing 1998; Doyal 1995) emotional work such as nursing and teaching (see Aiken et al 2002; Messing 1998; Doyal 1995); occupational cancer (see Zahm and Blair 2003; Messing 1997; Stellman 1994; Potterm, Zahm, Sieber, Schnieder, LaRosa, Brown, Collman Fingerhut, and Waters 1994; Neis 1995), housework (Ratcliffe 2002; Quinn, Woskie and Rosenberg 1995), health care workers (see Infante and Pesák 1994), as well as specific hazards suffered particularly by women workers such as sexual harassment (Gutek, 2001; Sprout and Yassi 1995; Koh and Chia 1992) violence (see Mayhew 2003; Messing 1997) and RSI (see Chapter Two and Five); pregnancy (see Matthews 1993; section on reproductive health below) menstruation
Jeanne Mager Stellman (1994: 824) argues that the ghettoization of women’s work can be an advantage for the study of women’s occupational health needs as one can focus on a narrow job title and industry and yet capture a large number of potentially at-risk women. This, she argues negates the potential for injuries to women to be considered as a biological problem,

… the careful assessment of exposures to hazards, combined with a complete analysis of the social factors that may contribute to the effects observed, should help us avoid the erroneous classification of health effects as gender specific, when, in fact, they are simply general occupational hazards to which women happen to be exposed (Stellman 1994: 824).

However, despite the growing amount of literature indicating the harm that women face at work, there continues to be a problem. Donna Mergler et al (1995: xi) argue that even feminist writers are reluctant to research women’s occupational health needs because they are aware that highlighting health issues may be taken as evidence that women are too weak to perform certain work. They state that this is the reason that issues such as the effects of occupational hazards on menstrual function are under-researched.

Women and the Double Day

In health research in general, most writers recognise that there is a complex relationship between work and non-work activities. As Michael Quinlan (1996: 414) states these activities are not all gender specific but there are a number of important ones that need to be taken into consideration when researching or
addressing women and occupational health. These include the increase time that women spend at work without the concomitant reduction in the time spent on domestic chores. Thus the balancing of work and family is particularly acute for women. Esther Greenglass (2002: 92) also notes that the workplace itself is a primary source of stress for women. Women are confronted with pay inequities, sexual discrimination and underutilisation of skills. Research into women and the double day has as its central question whether or not work is good for women. This field of questioning tends to ask whether employed women are healthier than women who stay at home (Lundberg 2002; Gutak 2001; Waldron 1983; Waldron 1991; Repetti, Matthews and Waldron 1989). Ingrid Waldron finds that women most at risk to their health are those in low socio-economic jobs which are repetitive and monotonous coupled with a high level of family responsibility. She also claims that employment appears to have a more adverse affect on the health of men than the health of women possibly due to the higher levels of exposure to chemicals that are experienced by men (Waldron 1983: 133; Waldron 1991: 35 see also Lundberg 2002).

Three major theoretical models have been used to discuss the relationship between workforce participation and health outcomes (for a more detailed account see, Frankenhaeuser, Lundberg and Chesney 1991). These include the health benefits model which concludes that the financial remuneration and the increase in social support are beneficial to women’s health. The second is the job stress model which claims that the stress of employment is harmful to women’s health. The third model, the role expansion model claims that multiple roles can be health enhancing through increased opportunities for rewards and satisfaction. Despite agreement
generally with the role expansion model, Jeanne Mager Stellman (1994: 821, 824) has argued,

Researchers in the field generally agree that multiple roles can be health enhancing when they are desired and desirable. But when multiple roles and responsibilities exert physical and social demands while providing little satisfaction or insufficient monetary or social rewards, the overload associated with multiple roles can be health diminishing (Stellman 1994: 821, 824).

It is not my intention to explore the issues that are raised above, but rather present an overview of what researchers identify as important factors when considering women’s occupational health. However, I would argue, as Lesley Doyal (1995: 155) does, that the key question should not be whether paid work in general is good or not for women, but which types of work are harmful or beneficial.

*Women and Reproductive Health at Work*

In reviewing the (scant) literature on women and occupational health, it is clear that reproductive health is one of the major concerns researched regarding women’s health at work. While there would be no disagreement that pregnancy and foetuses need to be protected from industrial toxins and harmful work practices, it is clear from the literature that reproductive protection is viewed very differently for women and men. One of the most researched industries (in Australia) considered to be harmful to foetal health is the lead industry (see for example Matthews 1993; Samuels 1995; Williams 1999). The research on the harmful effects of lead indicates that the concern is not women’s health but foetal health. If an industry is considered to be hazardous to the health of a foetus the most common policy is to exclude fertile women rather than the hazard. No significant investigation on the reproductive hazards of lead was carried out on male workers. Exclusion policies
have two major implications. Firstly, it reinforces sex segregation in the workforce and perpetrates the belief that women are secondary and marginal workers. Secondly, it has a negative impact on workplace safety in that the workplace is still hazardous and the impact that it may have on male workers is not investigated (Lindbohm and Taskinen 2000; Samuels 1995). This issue is further addressed in Chapter Five when I examine the influence that medical discourse has had on the investigation of women’s occupational health needs.

**Conclusion**

This chapter discussed historically how the development of a gendered occupational health and safety discourse in Australia influenced how occupational health and safety research could be conducted. Using a modernist conceptualisation of gender I showed how current practices within the workplace such as segregation of jobs by gender, unequal union participation and emphasis on male injuries within occupational health and safety research served to negate significant research outside the realm of women’s role as wife and mother. This enables, at least in part, an understanding of why many of the explanations surrounding RSI in the late 1980s and the early 1990s failed to consider gender as an analytical concept at all or when gender was considered explanations focused on women’s roles as mothers to understand the massive increases in compensation claims.

Furthermore, I highlighted how the protection era established medical discourse as the only discourse that could officially discuss occupational health and safety issues (that is, as opposed to workers and trade unionists). In the next chapter, I explore the implications of centralising medical discourse within occupational health and safety discourse for women workers and their health at work. I use a postmodernist
conceptualisation of gender to disrupt the knowledge claims made by some in the medical establishment who claimed that the RSI epidemic was an example of individual or mass hysteria. I will show that in the case of women, health professionals readily diagnose psychological instability when a clear cut diagnosis is not readily at hand.
CHAPTER FIVE

CENTRALISING WOMEN: WOMEN AND MEDICAL DISCOURSE

medicine has made the word “woman” a medical diagnosis…Being a woman is a disease just waiting to be treated…When a man experiences stress on the job, his supervisor tells him to take a vacation. A woman is told to see a doctor (Inlander 1994: 11-13).

Introduction

The aim of this chapter is to discuss the implications of privileging medical discourse within occupational health and safety discourse for women workers and their health at work. In particular, it will shed light on why the debates surrounding RSI took the form that they did and explore the ramifications for current research on RSI. As I discussed in Chapter Four, women entered occupational health and safety discourse via protection, which rendered women’s relationship to occupational health and safety discourse outside the workplace. Legislative decisions informed by dominant definitions of femininity and masculinity utilised and perpetuated a construction of woman that denied her the definition of worker at the same time as reinforcing her definition as mother and wife. The implication, as outlined in Chapter Four, is that research into women’s occupational health and safety needs at best focuses on women’s roles as wives and mothers, and at worst, is ignored. As was also discussed in Chapter Four, this narrow construction of woman was further consolidated in the protectionist era with the establishment of medical knowledge as the only legitimate voice to speak on occupational injury and disease. In this chapter, I argue that the entry of medical discourse solidified the gendering of
occupational health and safety discourse and bounded how women’s and men’s occupational health and safety needs could be discussed.

An examination of the research into RSI reveals the significance for women workers of the establishment of medical knowledge as the only official voice in occupational health and safety matters. As outlined in Chapter Two, RSI put women as workers onto the occupational health and safety map. I will argue in this chapter that within occupational health and safety discourse broader definitions of women were needed to discuss RSI because sufferers of RSI were clearly considered workers, yet RSI was not a reproductive issue. In order to account for the experience of RSI, this chapter will show how occupational health and safety discourse drew on medical discourse’s construction of women. In particular this chapter will examine the tendency for physicians and health care professionals to “default” toward psychogenic causal explanations particularly in cases where there is obscure aetiology (Richman, Jason, Taylor and Jahn 2000: 178), as is the case with RSI. While it cannot be argued that this phenomenon only affects women, as Judith Richman et al (2000: 178) argue “female illness is socially constructed as erroneously or disproportionately embracing psychiatric or socio-cultural contributors”.

This chapter will examine the power of medical discourse to construct an understanding of women and uses the work of Michel Foucault73 to frame the examination. In this first section I will briefly outline Foucault’s thoughts on power

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and discourse, which will enable me to discuss the role that medical discourse had in constructing women with RSI as suffering from a psychiatric disorder rather than a physical one, and in Chapter Six to discuss women’s acceptance and resistance to that definition.

Foucault (1979: 44) maintained that the rise of parliamentary institutions which accompanied new conceptions of political liberty resulted in a significant change in the dispersal of power in Western societies. In pre-parliamentary societies power was held in the hands of a monarch and wielded over an anonymous body of subjects whereas in modern societies power “circulate[s] through progressively finer channels, gaining access to individuals themselves, to their bodies, their gestures and all their daily actions” (Foucault 1980: 151). This raises three important points for my work. First, Foucault’s claim that power in modern societies is not located in one site such as the state, the ruling class (Marxism), or in the hands of elected representatives (democracy) (Mills 2004: 17), but rather that power has transformed from an “organ of repression” to one where power is dispersed and operates through relations of power upon the body (in Gordon 1980: 92, 236). These relations of power exist both inside and outside the state and are dispersed through a range of state apparatuses, as well as through organisations, bodies of knowledge (e.g. psychology, sociology and philosophy) and (expert) individuals such as doctors, social workers, psychologists, lawyers and educators. I will return to this point.

The second point is Foucault’s emphasis on the body as the site of political and ideological control, surveillance and regulation (Lupton 2003: 25). In contrast to traditional forms of rule where power was centralised (such as the state; the
monarchy, the father, the husband), and compliance was achieved through physical
assaults against the body; in the modern state, power seeks to transform the minds
of individuals rather than merely punishing or imprisoning their bodies (Bartky
1998: 40). Foucault argues that much more than political allegiance or
appropriation of the products of labour is required of a body in modern society.
Power is achieved through disciplining bodies. This new discipline produces what
Foucault terms “docile bodies” (Foucault 1979: 138). In this way, he sees power as
being productive rather than repressive as the disciplined body is moulded with
specific concerns, desires and beliefs.

This brings me to the third and main point. How is power at the micro level
achieved? According to Foucault modern modes of control depend on the
interrelationship between knowledge, power and truth. It is the link between how
knowledge, power and truth are produced and legitimised through established
institutions and the effects that this has on agency/subjectivity that is at the core of
my analysis. In essence, Foucault argues that through the body and its behaviours,
state apparatuses such as medicine, the educational system, psychiatry and the
law define the limits of behaviour and record activities, punishing those bodies
which violate the established boundaries, and thus rendering bodies productive
and politically and economically useful (Lupton 2003: 25).

State apparatuses draw their power from two main sources. The first is the claim to
scientific objectivity which allows them to assert expertise and make claims to
validity and truth. The second is the establishment of institutions, which enables the
legitimation and distribution of particular forms of knowledge (Mansfield 2000: 58).

74 This notion of power contradicts the hitherto taken-for-granted belief that power emanates from a
central source and as Jana Sawicki (1991: 98) states that “power at a micro-level of society suggests
that state-centred and economistic political strategies do not capture power where it is most
effective.”
I will discuss this in more detail below when I specifically examine medical power and knowledge. For Foucault, the relationship between power and knowledge is not a linear process. He did not see them as separate entities with power reliant on knowledge but interdependent,

We should not be content to say that power has need for such-and-such a discovery, such-and-such a form of knowledge, but we should add that the exercise of power itself creates and causes to emerge new objects of knowledge and accumulates new bodies of information...The exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power (Foucault 1980: 51-52).75

In other words, knowledge/power creates truths which are validated via claims of scientific objectivity and legitimated through established institutions. Central to this is Foucault’s notion of discourse. For Foucault, power, knowledge and truth are essentially what constitute discourse (Mills 2004: 15). Discourses can be regarded as an institutionalised way of thinking, a social boundary defining what can be said about a certain topic. In particular, discourse refers to knowledge and practices that are generally associated with a particular institution or group of institutions (Sunderland 2004: 6). They are not “something that exists in and of itself” but rather are “practices that systematically form the objects of which they speak” (Foucault 1972: 49). Furthermore, discourses vary in their authority as a result of the complex interplay of social, historical and political factors operating at a given time (Mills 2004; Lupton 2003). Contemporary authority is given to science. Investing a discourse with science, which Rom Harré et al (1999) coined “scientism”, gives that discourse a privileged status and the authority to speak. In this chapter I will explore in particular, medical discourse’s authority to speak about

75 Foucault actually referred to power and knowledge as pouvoir/savoir to indicate its interconnectedness.
women, but first, I will describe the effects that these privileged or dominant discourses have on individuals or populations.

These privileged discourses have effects and it is the effects on subjectivity/agency that I will now turn. In order to make sense of this, it is necessary to go back to my second point regarding the docile body which incorporates the belief that power is productive and that the body is the site of political and ideological control, surveillance and regulation. Foucault argued that our modern institutions such as the prison, the school and the hospital were sites where individuals became the object of knowledge through the power of experts to define (Cheek and Rudge 1996: 87). In particular, the discourses of truth and knowledge construct what we consider normal and abnormal behaviour (Mansfield 2000: 61). In order to induce individuals and populations to conform to these definitions/dominant discourses, Foucault used the metaphor of the Panopticon which he argued symbolises the form of surveillance that has been dominant since the 17th and 18th centuries. What was important for Foucault was not so much the actual surveillance but the potential for surveillance. Such potential ensures that individuals learn to monitor their behaviour thus constraining as well as producing certain forms of behaviour. This is what Foucault meant by the ‘docile body’ (1979: 138).

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76 According to Foucault, institutions are the sites where power is equipped with the ‘instruments’ or ‘techniques’ for ‘material intervention’ on the bodies of the governed (Foucault 1980: 96).

77 The Panopticon was Jeremy Bentham’s design for a model prison which was never built. It is a circular structure consisting of a tower at the centre with wide windows that open out. At the periphery, the structure is divided into cells each with two windows, one facing in and one facing out. People in the cell cannot communicate but are at all times visible from both the tower and other inmates thus “induc[ing] in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power… each becomes to himself his own jailer” (Foucault 1979: 201 in Bartky 1998: 27).
Self-surveillance is crucial here—not only do individuals discipline their own bodies to conform to what is considered normal—according to Foucault this disciplining also constitutes the very subjectivity of the subject. In Foucault’s words,

The individual is not to be conceived as a sort of elementary nucleus, a primitive atom, a multiple and inert material on which power comes to fasten or against which it happens to strike, and in so doing subdues or crushes individuals. In fact it is already one of the prime effects of power that certain bodies, certain gestures, certain discourses, certain desires, come to be identified and constituted as individuals. The individual, that is, is not the vis-à-vis of power; it is, I believe, one of its prime effects. The individual is an effect of power, and at the same time, or precisely to the extent to which it is that effect, it is the element of its articulation. The individual which power has constituted is at the same time its vehicle (Foucault 1980: 98).  

Foucault (1980: 118) goes on to say,

What makes power hold good, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network that runs through the whole social body, much more than as a negative instance whose function is repression (Foucault 1980: 118).

Therefore, what Foucault proposes is that discourses structure both our sense of reality as well as structuring our notion of our own identity (Mills 2004: 13). In contrast to the Marxist notion of ideology which views power as oppressive, Foucault’s notion of power entails an actively constructing self which can either acquiesce or contest. According to Foucault,

Discourses are not once and for all subservient to power or raised up against it, any more than silences are. We must make allowances for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a

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78 Individuality, therefore, is not the highest possibility of human life if only we could attune society to allow it expression. Instead, the individual is the thing social institutions need us to feel we are, so that we remain vulnerable to the truths they have contrived for their own efficiency...Instead, it is an anonymous and impersonal power that saturates the pettiest and quietest moments of our personal lives, pressing us with what we should be—at the height of its operation, even becoming us (Mansfield 2000: 62-63).
starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines it and exposes it, renders it fragile and makes it possible to thwart it (Foucault 1978: 100-101).

This part of Foucault’s theorizing is crucial to my thesis. His notion of power allows an understanding of why certain discourses gain the authority to speak, such as medical discourse, at the same time as acknowledging that because power is productive at the individual level and no power relation is one of total domination, resistance to dominant discourses and definitions is necessarily part of the definition of power (Mills 2004: 37). This resistance is evident in the stories of the injured poultry process workers where dominant definitions of femininity were used to explain the existence of RSI. I will elaborate on this in Chapter Six.

Using the framework developed above, this chapter will discuss how medical discourse came to have the power to define sufferers of RSI in a particular way. In order to do this it is necessary to discuss the complex interrelationship between medical discourse, occupational health and safety discourse and the role that gender played in that relationship. Two explanations help organise this discussion. The first explanation explores why medical discourse has become a powerful discourse in modern Western societies and how that power allowed medical discourse to not only define illness and disease but also other social realities. In particular, I will show how medical discourse came to have the authority to define women in certain ways, in particular sick women. The second explanation examines how these dominant definitions of women as espoused by medical discourse were readily taken up within occupational health and safety discourse to explain RSI, thus consolidating occupational health and safety as a gendered discourse.
The Emergence of Medicine as Discourse

As discussed above, Foucault’s explanations of the ways in which knowledge is produced, legitimised and maintained in sites such as prisons, hospitals and schools can help us understand how power is operationalised through knowledge and expertise. In this section, I will describe using a Foucaudian lens how medicine came to be a dominant discourse with the power to define.

The rise of modern medicine can be traced to the period of the Enlightenment. During this time, faith in the power of reason replaced faith in superstition in shaping human understanding. Accompanying the primacy given to reason was the belief that improved science and technology would enable societies to progress (Lupton 2003: 88; Risse 1992). Medical discourse initially claimed its expertise through defining itself as science. It replaced the subjective medical culture based on divine intervention and witchcraft which had existed prior with an objective understanding of the body and disease based on the then new practice of autopsy (Cheek and Rudge 1996: 87; Porter 1992: 103-114). Furthermore, improvements in medical technology such as the microscope enabled the identification of biological causes of disease. In an era where cholera, typhoid and diphtheria were rampant, this was very welcomed progress. The biomedical model of disease was born and medical expertise rested firmly in the hands of “medical men”79 and out of the lay person’s reach (Lupton 2003: 90; Jewson 1976: 232).

The initial power of medicine was established by the provision of scientific solutions to public health issues which emerged as a result of changing disease

79 Foucault referred to medical practitioners as medical men in *The Birth of the Clinic* (1973)
patterns due to industrialisation and urbanisation. This power was further consolidated with the growth of medical institutions such as hospitals and clinics with two main effects. The first was that the establishment of institutions enabled the legitimation and distribution of particular forms of knowledge. Doctors acquired enormous social prestige and influence because medicine focused on healing and well-being and it was considered as objective and rigorous modern scientific knowledge, privy to an elite few (Lupton 2003: 90; Turner 1995: 12). According to Foucault, the “clinical gaze” (medical power) enabled medical men to define bodies as deviant or normal, as hygienic or unhygienic, as controlled or needful of control (Foucault 1979: 54 in Lupton 2003: 25). However, for Foucault, medical power not only defined health and illness, but also defined reality (Turner 1995: 12).80 This brings me to the second and related point. The establishment of the modern hospital allowed individuals and populations to come under the control, discipline and regulation of medical experts through the panoptic system of surveillance. The surveillance, on the one hand, represented the individual as the object of knowledge and subject to the power of the various experts to define health in particular ways (Cheek and Rudge 1993 in Cheek and Rudge 1996: 87). On the other, the clinical gaze constituted the subject (Lupton 2003: 25; Turner 1995: 12). This brings me to the notion of the docile body.

According to Foucault, medical surveillance was the penultimate of surveillance “whereby the doctor investigates, questions, touches the exposed flesh of the patient, while the patient acquiesces, and confesses, with little knowledge of why the procedure is carried out” (Lupton 2003: 26). The knowledge/power that was

80 Medical experts replaced priests as the guardians of social reality (Turner 1995: 12).
Centralising Women: Women and Medical Discourse

derived from the surveillance of individuals and populations based on rationality and science and a quest to improve society has resulted in “increasing rationalisation, organisation and homogenisation of society in modern times” (Hoy 1986: 131). Medicine had moved from comparing a patient against him or herself to determining how far s/he deviated from the norm. The norms proffered by medicine supposedly developed neutrally and impartially as informed by scientific objectivity created “categories of the deviant subject which medical and psychiatric technologies of discipline were designed to eliminate” (Lupton 2003: 91). To illustrate simply, norms play a large part in our contemporary lives—normal weight, normal cholesterol levels, normal maternal instincts, normal male sexual drive. In contemporary society, uncritical acceptance of norms is apparent in that we “cannot or will not tolerate ideas and lifestyles which diverge too far from the ‘normal’ (as defined primarily by medicine)…In short, medicine is part of an extensive system of moral regulation of populations through the medical regimen” (Turner 1995: 13). To illustrate, homosexuality, alcoholism and opiate addiction once considered ‘bad’ habits became medicalised as ‘sick’. Similarly, in current times diverse issues such as childhood behaviour, weight loss and gain have come under the clinical gaze and subject to control by medical expertise.

I argue however, that the normalising discourse of modern medicine is very different for men than women. We can see this through examining the history of how medicine has viewed women’s illness. This topic has been extensively covered in feminist health literature and while I cannot do it all justice, the purpose of this section is to discuss how medical discourse constructed a definition of woman as neurotic and women’s illness as psychosomatic or psychiatric. I do this to show the
historical links between science, medicine and the constitution of gender in order to understand how RSI came to be defined in the way that it was, and how sufferers of RSI were central to that definition. My reading of the literature draws on Foucault’s nexus of knowledge/power and subjectivity which allows the complexity of power issues to be discussed. I need to note here, however, that while I draw on Foucault’s notion of power, his extensive work on the history of sexuality and his concern to examine the relationships between certain medical discourses and the exercise of power in society does, for the most part, exclude women and gender. To that end, I concur with many feminist scholars that Foucault’s work produces a sexist discourse endemic within Western political theory (see for example McLaughlin 2003; Bartky 1998; Braidotti 1991; Morris 1979). Foucault fails to consider that men and women have a different relationship to the institutions of power resulting in practices that create gendered docile bodies (Bartky 1998: 27). Sandra Lee Bartky aptly points out the effect that this has on the recognition of practices that produce a female docile body,

Foucault tends to identify the imposition of discipline upon the body with the operation of specific institutions, for example, the school, the factory, the prison. To do this, however, is to overlook the extent to which discipline can be institutionally unbound as well as institutionally bound. The anonymity of disciplinary power and its wide dispersion have consequences that are crucial to a proper understanding of the subordination of women. The absence of a formal institutional structure and of authorities invested with the power to carry out institutional directives creates the impression that the production of femininity is either voluntary or natural (Bartky 1998: 36-37; italics in original)

For me, the importance of what Bartky is saying here is that while Foucault correctly recognised that certain institutions have disciplinary powers, it is important to note that there are discursive structures that are not linked to institutions. Discursive structures surrounding femininity and masculinity creating
female and male subjectivities are one such example. It is in this light that I will examine the representations of women within medical discourse.

**The Representations of Women within Medical Discourse**

Historically, representations of women within medical discourse have focused on women as the weak, incomplete versions of men, the source and carrier of disease and the cause of psychological damage to children; and the ‘Other’ (Ehrenreich and English 1974: 6; Turner 1995). Explanations for the deficiencies of the female body that have been proffered by the medical establishment since the Enlightenment centre either on the functions and attributes of the female reproductive organs or the instability of the female psyche. The centrality of the reproducing body and unstable mind has always been a constant in the explanations of women’s illness (and women); however, social, economic and political factors have produced shifting manifestations of this over time.

For several thousand years prior to the Enlightenment, male and female bodies were considered inherently the same, with “female genitals...considered the lesser, inverted homologues of male genitals” (Lupton 2003: 144). From the time of the Enlightenment onwards, there was a change in belief that women were not only the lesser of men but were in fact the opposite. According to Thomas Laqueur (1987: 27), science had ascertained that ovaries were the control centre of reproduction in female animals which in turn was interpreted as the “essence of femininity itself” for the human female. Thus the connection between women’s physiology and women’s psychology emerged. While medical knowledge from the late eighteenth

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81 There is vast amount of literature covering this topic. For a seminal text see, Ehrenreich and English (1978). See also Moscucci (1990).
century to the early nineteenth century recognised broader social and economic
determinants impacting on illness states, women’s illnesses were being more

The definition of woman as biology/nature was legitimated via the growth of the
speciality of gynaecology which established that men’s and women’s bodies had
different functions and reproduction was central to women’s natures and not men’s.
As many historians have noted, gynaecology emerged at a time when population
growth was needed and there was a desire to scientifically distinguish the two sexes
(see for example Lupton 2003; Theriot 1998; Moscucci 1990; Schiebinger 1989).
Medical research at the time focused on identifying sex differences in order to
explicate the inherent deficiencies in the female body. For example, women were
defined as intellectually inferior based on skull size and as natural child-rearers
based on pelvic size. As discussed in Chapter Four, pro-natalist ideologies centred
on the need to define women’s place in an industrialising society. Medical
discourses which were emerging at this time offered the ‘evidence’ that was needed
to keep women out of the public sphere. Claims were made that if a woman’s brain
developed too much, her uterus would atrophy and “we would have before us a
repulsive and useless hybrid” (Moebius quoted in Ehrenreich and English 1974: 28).

This had a two-fold effect. First, it established the belief that science rather than
philosophy or theology held the key to “penetrate the dark secrets of femininity”
providing conclusive evidence of the difference between the sexes, thus
‘scientifically’ demonstrating that women were more suited to the domestic role
(Moscucci 1990: 15). Knowledge regarding women’s bodies was influenced by the
ability of gynaecologists to see women’s bodies via the speculum initially and later through surgery which allowed an anatomical representation of women’s complaints (Showalter 1997: 129-131). Nancy Theriot (1996: 129) argues that it is of little surprise that men who were devoted to explaining women’s otherness would see all of their complaints as stemming from their ovaries or their uteruses. According to I.S. Stone (1891: 873 in Theriot 1996: 128), it is “logical that disease of the organs peculiar to women, which so much more than the corresponding organs in men, have to do with her physical and mental condition, may cause physical derangement”. In a more clear connection between women’s reproductive biology and illness, Horatio Storer, a Boston gynaecologist writing in 1864 states that,

[woman’s] possession of an inner mechanism, a central force, around which all her other systems and functions turn, and to which they are in reality, to a certain extent, but subsidiary…[is] so subtle and so easily disarranged by even slight external causes, that the real wonder is not that so many women are invalid, but that any are well (1864: 199-200 in Theriot 1996: 129)

It was not only menstruation and pregnancy that were treated as illnesses during the nineteenth and early twentieth centuries. Any complaints—physiological or psychological—made by female patients such as headaches, indigestion or sore throats were regarded as resulting from ovarian or uterine disorders (Ehrenreich and English 1974: 29). The medicalisation82 of menstruation and pregnancy suffered by women made all women potential patients, subject to surveillance by the medical profession. More central for my thesis, however, is the connection that was made between reproduction and women’s mental status which implied that all women were mentally ill on the sole basis that they were women and that their mental

82 Medicalisation refers to three main processes. The first is the medical control of normal human processes such as pregnancy, menstruation and menopause. Second, is the defining of bodily occurrences as medical problems that have not hitherto been thought of as such; and the third is overly aggressive medical treatment of normal bodily functions (Richman et al 2000: 177; Riessman 1998: 47-48).
health issues could be addressed using physiological cures. Furthermore, certain categories of mental illness, most notably hysteria, were considered to be a condition that was only suffered by women. The history of hysteria is a prime example of how medical discourse took on then current definitions of gender to shape an understanding of an illness state and in turn create a medicalised female subjectivity.

**Medical Constructions of Gender: The Hysterical Woman**

Hysteria is derived from the Greek word for uterus and the condition was attributed “to the wandering of the uterus to different parts of a woman’s body, causing a variety of symptoms and erratic behaviour” (Bachmann 1990: 41). By the time of the Enlightenment, the notion of the wandering uterus was no longer accepted; however, hysteria was still considered to be caused by a malfunctioning womb and hence a condition unique to women (Turner 1995: 91; Lupton 2003: 147). The practice of treating hysteria with hysterectomies attests to the medical view that psychological phenomena in women had a physical causal basis. Furthermore, the rest cure which was prescribed not only for women with hysteria but also for women suffering with hypochondria, neurasthenics or physical complaints is evidence of medical discourse buying into and thus perpetuating the definition of woman as weak and in needing of protection. The rest cure involved being confined to bed, resisting any mental or physical stimulation and being administered with regular vaginal douches and rectal enemas. According to Ellen Bassuk (1986), patients were also subjected to a moral re-education by medical practitioners

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83 Of interest, other words from Latin or Greek include *Pudendum* or *Pudenda*: also known as vulva from the Latin *Pudere*, “to be ashamed of”; and *Estogen*: from the Greek *oistros*: “insane desire” (from Munch 2004: 104).
teaching the patient patience, resignation, logical argument and management of emotions.\textsuperscript{84}

However, the view that hysteria and other manifestations of women’s insanity were directly linked to women’s reproduction was not universally accepted by all specialties within the medical profession or by women themselves. Nancy Theriot’s (1996) study of women’s voices in nineteenth century medical discourse argued that while the gynaecological perspective was dominant there was a “spirited discourse among alienists\textsuperscript{85} and neurologists [which] articulated a very different set of assumptions about the nature of women’s mental illness and nervousness and a very different framework for understanding gender” (Theriot 1996: 130). While these specialists were not unified in their view, alienists and neurologists argued that both women and men suffered from mental illness and that sociological or environmental factors were responsible for its onset. Arguments were forwarded which suggested that women’s gender role in society may be implicated in the onset of mental ill-health in women. According to two physicians of the time,

\begin{quote}
The entailments of marriage—anxiety concerning the material welfare of mate and offspring, incompatibility of partners, dread and depression attending sickness and death, the assumption of marital and material obligations, etc—are contributing to the occurrence of this neurosis (Joseph Collins and Carlin Phillips 1899: 413 in Theriot 1996: 132)
\end{quote}

The neurologists and alienists refuted the gynaecological theory based on ‘scientific evidence’ of the connection between women’s reproductive organs and the functioning of the rest of her system and a new dominant discourse emerged which

\textsuperscript{84} Many feminist scholars also argue that hysteria was a way that women could express their anger and frustration in an acceptable manner and the rest cure allowed women to retreat from their responsibilities (see Ehrenreich 1974: 39-41 and Bassuk 1986: 147-148). I will discuss this later when I examine resistance within discourses.

\textsuperscript{85} Alienist was the original word for psychiatrist.
explicated mental illness as being located in the nervous system. While, most of these specialists argued against the belief that mental illness, including hysteria, was only suffered by women, they did propose that women had “finer tuned” nervous systems than men so that any physical or situational problem encountered by women would more likely result in a nervous breakdown (Theriot 1996: 131). This of course indicates that while the neurologists and alienists argued against a gynaecological theory of mental illness, they still operated within the gendered discourses of the time. Gynaecologists, neurologists and alienists alike argued that women’s reproductive organs dictated their social roles and therefore women should limit their activities and aspirations. In a telling review of an article regarding the building of the human brain the author was praised for arguing,  

so forcibly, so overpoweringly, so thoroughly logically against the claims of some women to corporeal and mental identity with man (in Theriot 1996: 132)\textsuperscript{86}  

This brings me back to the point that discourses can be institutionally bound as well as institutionally unbound and calls into question Foucault’s notion of the discontinuity of discourse. While there was a major move from the belief that the uterus causes hysteria to the belief that environmental and social causes impact on the nervous system causing mental ill health, there was little to no movement in the constructions of gender that informed the new dominant discourse. Women’s more “finely tuned” nervous system meant that women were inherently more prone to psychological responses such as depression and hysteria when confronted with life’s difficulties (Theriot 1996: 133). Thus a medicalised female subjectivity was created based on clinical evidence produced by medical science. According to Nancy

Theriot (1996) this was significant because the move from the uterus to the nerves was a move from a visible (and clinically refutable) view of ill health to one that was based on the invisible femininity of the nervous system (and therefore not clinically refutable). The notion of the hysterical female controlled by her reproduction was systematised and given legitimacy via emerging psychoanalytic theories developed most prominently by Sigmund Freud and according to Jan Goldstein (1987: 324) became “a wastepaper basket of medicine where one throws otherwise unemployed symptoms”, which resulted in many more women being labelled as hysterics (see also Ratcliff 2002: 153).

It is important to note, however, that the labelling of women as hysterics was not merely a clear example of the medical profession’s dominance of women, but also an example of women’s resistance to the difficult biological and social pressures in their lives. According to Barbara Ehrenreich and Deidre English (1974: 39-41), women used the hysterical fit as the only acceptable way to express resentment of their day to day lives, and the rest cure as a means to escape from their day to day responsibilities. However, hysterical women provided the ‘proof” that women needed to be confined under the surveillance of both their significant male others and the medical profession. Rebelliousness was interpreted as symptomatic of a disease which needed to (and could be) treated and cured.

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87 Nancy Theriot argues that the gynaecological discourse was shaped by male and female physicians as well as women themselves, however the new neurological/psychiatric theory of invisible femininity was insulated from the voices of women patients and immune to clinical evidence (Theriot 1996: 147).
The more women became hysterical, the more doctors became punitive towards the disease; and at the same time, they began to see the disease everywhere themselves until they were diagnosing every independent act by a woman, especially a women’s rights action, as hysterical (Ehrenreich and English 1974: 42 in Lupton 2003: 149)

It is also important to note that the nineteenth century definition of the hysterical woman was confined to upper class women. It was only the privileged women who were defined as weak, fragile and dependent, and encouraged to retire to bed when menstruating. Working class women were required to work long hours in factories with no recognition of any of their reproductive needs (Lupton 2003: 148). As Deborah Lupton (2003) argues, this demonstrates the socially constructed nature of illness. It also means that working class women did not have access to this definition to be able to resist it. I will elaborate on this point in Chapter Six when I discuss working class women’s resistance to RSI being labelled as a health issue, and their insistence that occupational injury was purely an industrial relations matter.

The historical legacy of the construction of women’s ill health and women as ill continues to be evident. There is a wealth of current feminist literature demonstrating that contemporary medical practice continues to view women as being unduly tied to their wombs and/or their nerves—in 20\textsuperscript{th}/21\textsuperscript{st} century parlance, hormones and emotions. Judith Richman et al (2000: 177-179) offer four main aspects of this legacy. These include the medicalisation of otherwise normal bodily occurrences; the psychologisation of legitimate medical illnesses, the inequitable allocation of medical resources, and highly asymmetric medical power relations (see also Riessman 1998: 47-48). In the next section I will examine these four aspects in light of the historical and current literature on RSI as well as the current literature on
psychiatric illness. I do this to highlight the ease with which occupational health and safety discourse took up medical discourse’s construction of woman to understand RSI as well as to highlight why the centralising of medical discourse in occupational health and safety discourse has a significantly different impact on women’s and men’s occupational health and safety needs.

The first aspect, medicalisation, as discussed historically above refers to the medical control of normal human processes through their definition as medical problems and the subsequent requisite medical treatment (Roach Anleu 2006). In contemporary society, the construction of the syndrome “women’s problems” results in medical treatment being prescribed for conditions which many women consider natural (Roach Anleu 2006: 360-363; Lorber 1997: 10). The medicalisation of pregnancy is a clear example of this and has been well documented in feminist literature (see for example Lorber 1997; Markens 1996). Furthermore, the transformation of symptoms individually experienced at different points of women’s reproductive cycle into physiological and psychological syndromes clearly illustrates the continuing power of medical discourse to define women as being controlled by their reproduction. Examples include now labelled medical conditions such as premenstrual tension (see for example Kaufert 1988), menopause (see for example Lorber and Moore 2002; Lupton 1996, Lupton 2003) including the use of HRT treatments (see for example Murtagh and Hepworth 2003) and bonding experiences (see for example Oakley 1984). As Judith Lorber (1997: 10) argues, not all women experience cramps or tension as problematic, “but if these occurrences are routinely labeled as illnesses by the medical profession, then all women will often be considered “sick” or not able to function normally.”
The second (and most significant for this thesis) aspect of the legacy for women is the psychologisation of legitimate medical illnesses. Contentions that current diseases such as chronic fatigue syndrome (see for example Richman et al 2000; Clarke 2000; Jason et al 1997), multiple sclerosis (see for example Johnson 2007; Murray 1995), and my own research into RSI (see Chapter Two and Six; also see Reid, Ewan and Lowy 1991) can be explained as primarily psychiatric/psychological in nature is evidence of this. Similarly, research into conditions such as heart disease show that women receive significantly less treatment than men due to chest pain in women often being attributed to hormonal imbalances, stress or psychiatric disorders (see for example Goudsmit 1994; Popay and Groves 2000; Ratcliff 2002; Stacey et al 1993; Walters 1993). In a telling quote, Patricia Kaufert (1999: 124) found in an analysis of a major population health text: *Why are Some People Healthy and Others Not?*,

A careful search of the text turned up an occasional sentence on male/female differences in mortality, but most passages dealing with women considered them in relation to their reproductive or mothering roles…By the conclusion of the review, my impression was that, insofar as women were represented, it was as mothers, or as depressed, or as depressed mothers, or otherwise as bodies mysteriously slow to die of heart disease⁸⁸

As in the case of the late 19th and early 20th century hysterical woman, contemporary conditions that cannot be definitively diagnosed by organic medicine have been diagnosed as largely psychiatric or psychogenic in nature with links to women’s biological and social reproductive roles. Similar arguments that were

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⁸⁸ While outside the scope of this thesis, it is worth noting, that the training of medical personnel also perpetuates the construction of woman as controlled by their hormones and emotions. Some views that have been reported from medical schools include that “women’s illnesses are always assumed psychosomatic unless proved otherwise”; “women are hysterical, nagging mothers and their problems are trivial”; and “mothers are seen as complaining and older women as demanding and bitchy” (Goudsmit 1994: 10)
made by Joseph Collins and Carlin Phillips in 1899 (see above) have been made in relation to women suffering from chronic fatigue syndrome, where the social and cultural expectations of women force them into the sick role. A study regarding chronic fatigue syndrome argued that,

“Liberated” by feminism to enter previously all male occupations, women in the 1970s found themselves exhorted to “have it all” by combining a demanding career with a rich and fulfilling family life. This meant juggling a number of incompatible identities (Ware and Kleinman 1992: 554; my emphasis).

In a similar vein, research in the late 1980s into RSI corroborates the gender-linked nature of illness. Janice Reid et al (1991: 610) found in their research that medical professionals drew readily on the construction of woman as reproducer and as psychologically challenged. They argued that this was evident in the construction of RSI sufferers’ pain as the “outcome of thwarted urges or neglected duties of the peculiarly female kind”.

The women [sufferers of RSI] were especially vulnerable to such pejorative labels because of the social and medical perceptions that, as women, they were less reliable and stable and less likely to be physically injured (verses psychologically affected) than men. Comments by professionals about their maternal instincts, the supposed therapeutic virtues of getting pregnant, their duty to stay at home and be good mothers, and their attitudes to children and housework were ample evidence to those women that their symptoms were not taken seriously, their work outside the home was trivialised and that the speakers had no idea of the financial hardship the loss of a salary could mean (Reid, Ewan and Lowy 1991: 610).

The psychologisation of legitimate medical illnesses is supported by contemporary psychiatric discourse which identifies a predominance of women with psychiatric disorders. Of particular interest to this thesis is the claim that women are disproportionately represented as suffering from individual or collective hysteria, now commonly referred to as somatoform disorder, conversion disorder or hysterical neurosis, conversion type (Bartholomew 2000:154). The next section in this chapter will explore what Joan Busfield (2002) calls the gendered landscape of
psychiatric disorder, which will give some insight into how current psychiatric discourse understands and defines psychiatric disorders and will explain the connection of certain disorders to men and women. Drawing largely on the work of Joan Busfield (2002) I examine how modern psychiatry “defines and frames the terrain of psychiatric disorder and, consequently, structures the observed gender differences” in order to read the current literature on individual and collective hysteria, and RSI.

Joan Busfield (2002: 146) distinguishes psychiatric disorder into three main types which include disorders of thought, disorders of emotion and disorders of behaviour. According to epidemiological data the gender distribution of these categories differ, with the distribution being more or less equal for disorders of thought, and unequal for emotion and behaviour. Disorders of thought include the more severe psychiatric conditions such as schizophrenia and various types of dementia including Alzheimer’s. Disorders of emotion comprise depression, anxiety states and phobias and have a female predominance. Disorders of behaviour consist of behaviour and personality disorders including substance abuse disorders. This group has a male predominance.

**Contemporary Medical Discourse at Work**

In order to understand the gendered variation in these disorders, Joan Busfield (2002: 147-148) identifies six main mechanisms to explain these differences. She has divided these mechanisms into two groups of three. The first group accepts as

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89 Joan Busfield (2002: 146) states clearly that her typology of disorders does not correspond exactly to current psychiatric classifications however she argues that it has important analytical value in understanding the gendered differences in psychiatric disorder.
given the boundaries of specific psychiatric disorders and the second three mechanisms suggest that the processes involved in the identification of psychiatric disorders results in the differences. The first three mechanisms consider first, differential exposure to the causes of a psychiatric disorder such as higher levels of depression in women as a result of their social situation; second, different vulnerability either biological or social; and third, different expression of an underlying psychological disturbance. The difference in expression is shaped by social expectations and can account for women internalising problems and becoming depressed and men externalising and becoming violent.

The second set of three mechanisms highlight the socially constructed nature of psychiatric illness. In this group of mechanisms, gender differences in a given psychiatric disorder may be the result of biased gendered assumptions. This results in firstly, the misdiagnoses of symptoms; secondly, the construction of what is considered the problem, for example, certain conduct is viewed as criminal in a man but as the result of a psychiatric illness in a woman; and thirdly, biased gender assumptions influence what is considered to be a psychiatric disorder. In the words of Joan Busfield,

Gender can intersect with the way in which certain problems are framed as psychiatric problems and others as problems of deviance and morality, or with the way in which some phenomenon is seen as problematic or not, as when sexual violence, which is more common in men than in women, is treated as normal or a matter of bad behaviour rather than as indicative of psychological pathology (Busfield 2002: 148).

The reasons for the propensity of women to suffer from emotional disturbances are explained readily by the first three mechanisms, that is, that women are more exposed and more vulnerable to situations that can trigger depression or anxiety and that constructions of femininity allow women to express their emotions, be it
sadness, fear or anxiety. This is in direct contrast to the construction of masculinity which discourages the expression of these emotions.

Shaping Gender Norms: The Power of Psychiatry

However, it is the analysis of the second group of mechanisms that is more central to the point I am developing here. Joan Busfield (2002: 156) argues that the definition of emotion within psychiatric discourse is very narrow. Only the emotions of sadness, fear and anxiety associated with women have been pathologised into disorders of depression, phobia and anxiety states. On the other hand, emotions linked closer to men such as anger, jealousy and hate are considered symptoms and are not pathologised as psychiatric. Rather, it is the behaviours such as violence which stem from these emotions that are considered problematic and are interpreted as bad, immoral and/or delinquent. Diagnosing the emotions of sadness, fear and anxiety as depression, phobias and anxiety states and the emotions of anger, jealousy and hate as socially unacceptable conduct puts women squarely in the psychiatric frame and men outside it.

It is also important to note that emotional disorders are not only confined to women individually but also collectively. The literature on “mass” or “epidemic” hysteria without exception emphasises the disproportionate numbers of women or girls who suffer from it (see for example Bartholomew 2001; Malleson 2002; Shorter 1997). Andrew Malleson (2002: 330-331) in his study on whiplash and other “fashionable illnesses” does not question the existence of these “somatoform disorders”, but questions why it is that women are overrepresented. He concludes that,
Women take to patienthood more easily than do men. They make two-thirds of all visits to conventional physicians; and women (especially with college education) are more likely than men to consult alternative practitioners (Malleson 2002: 330)

Of importance to this thesis is that he uses the 1980s “epidemic” of RSI in Australia to support his argument that it is women’s exposure, vulnerability and expression (to use Joan Busfield’s framework) that accounts for the predominance of women with psychiatric pathology,

Sometimes the judicious use of a fashionable illness is the only practical way to juggle competing obligations. Titbits of statistical evidence indicate that women use the fashionable illnesses in this way. RSI increased in frequency in Australian mothers just before schools broke up for summer vacation. The same happened in fruit pickers as the picking season drew to a close (Malleson 2002: 331)

In a similar vein, Yolande Lucire (2003) reiterates her arguments that she proposed in the late 1980s (see Chapter Two). She argues that RSI was a “newly defined hysterical belief” that occupational tasks could cause injuries (2003: 20) and concludes as Andrew Malleson (2002) does in his study that,

…RSI is more likely to be related to life events, stressors and conflicts than to any identified aspects of tasks or occupations…the opportunities to malinger were inexhaustible. I chose to ignore them in favour of testing the hypothesis that the claimant had not suffered an injury but was experiencing a disorder caused by her beliefs and desires. In a strict causation model, or in any litigation that demanded any standard at all, hysteria and malingering are not compensable as injuries as neither can possibly be caused by a physical event. Being given a diagnosis of physical injury, where none exists, provides an opportunity for action. Opportunities are not causes.\(^9^0\)

It is outside the scope of this thesis and indeed my expertise to debate the adequacy of the diagnoses of psychiatric disorders in women, except to note that both these arguments draw only on the first three mechanisms outlined in Joan Busfield’s framework. Furthermore it must be said that it would be naïve to suggest that all

\(^9^0\)For similar psychosocial and psychiatric explanations see also Szabo and King (2000); Keyserling (2000a); Keyserling (2000b); Awerbnch (2004), Hadler (1999); Reilly (1995).
female workers who make a claim for compensation for an RSI injury are genuine. However, to assume that this is always the case when a female worker presents with long-term wrist and arm problems would be erroneous. My concern rather is to show how centralising medical discourse within occupational health and safety discourse has had different implications for male and female workers. In particular, I want to show how occupational health and safety discourse draws on psychological/psychiatric theory to explain occupational injury and disease. This is important because, as many occupational health and safety commentators argue, the focus of injury prevention within occupational health and safety discourse places the problem directly with the individual worker (see for example Eakin 2005; Bohle and Quinlan 2000; Nichols 1997). Individualist theories of injury causation draw heavily on psychological theories, which in light of the argument presented in this chapter, impacts very differently on male and female workers.

For male workers, the emphasis on individual theories of injury causation has resulted in the belief that occupational injuries and diseases are caused by ignorance, carelessness, machismo and apathy. These four assumptions are clearly documented in the Robens Report (1972) which forms the ideological, philosophical and practical basis for contemporary occupational health and safety legislation in all Australian states. This emphasis on “bad” behaviour resulting in injuries is succinctly shown in a statement from an enquiry into the high rates of injuries in a chemical plant which argued that the injury levels were associated with “social maladjustment” including,

- sociopathic attitudes and past behaviours, delinquency and law-breaking,
- marital and family strife, disregard for other people, immaturity, emphasis on exaggerated masculinity (for males), hostility and anger, irresponsibility, superficial social relationships, self-centredness, problem drinking, aggressive
Centralising Women: Women and Medical Discourse

attitudes, physical violence, impulsivity, and authority problems (Hansen 1989:82-83; 85 in Nichols 1997: 65)

These psychological symptoms attest to current psychiatric discourse which views men’s mental health problems (with the notable exception of disorders of thought) as behavioural. Therefore, strategies to deal with this include incentive payments, increased supervision and education and training. Understandably, many occupational health and safety experts argue adamantly against this conceptualisation of injury causation which works very much in favour of capital and ignores the political, economic and legal pressures on workplace health and safety (Peterson and Mayhew 2005; Bohle and Quinlan 2000; Nichols 1997: 66-67). Workplace injury and disease, they argue, can better be explained through sociological and political economy approaches and psychology has a very limited role to play.

However, the history of RSI in Australia shows that for women workers psychological explanations for injury are not so readily dismissed. While most commentators dispute the psychiatric explanations suggested by Yolande Lucire (above),

91 current readings on RSI show that psychosocial/psycho-cultural explanations are readily used (see for example ASCC 2006b; Bohle and Quinlan 2000; Keyserling 2000b; Strazdins and Bammer 2004; Awerbuch 2004, Hadler 1999; Yassi 1997; Worksafe 1994; Tyrer 1999). The psychosocial/psycho-cultural explanations query why some women suffer from RSI while others working in the

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91 This is not necessarily the case outside of academia. I was informed by a rehabilitation co-ordinator that at a meeting regarding compensation claims for RSI type injuries, industry representatives and insurance company representatives came with Yolonde Lucire’s book tucked under their arms (pers comm. 21.6.05). In another instance I was told by an HR advisor for a large consulting firm that stress and bullying were now the “new RSI…and women were at the forefront of the claims” (pers comm.5.9.06)
same industry do not. Many refer back to the “epidemic” of the 1980s and conclude that certain women are psychologically predisposed to turn muscular pain into a long-term injury. Factors influencing this include anger and stress stemming from the workplace, the home or both. As was the case of the hysterical woman in the early 1900s, most authors sympathise with women’s lack of control and autonomy at work, their lack of access to a unionised workforce coupled with their roles as wives and mothers, which demand that they take on the main responsibilities of children and home. Importantly, these authors do not dispute the existence of an actual injury, as is the case with Yolande Lucire’s 2003 stance. However, it is clear that there is an unquestioned acceptance of women’s propensity to psychological illness based on exposure, vulnerability and expression.

Having said this, it would be a mistake to see this as the whole picture. The psychologisation of RSI is only one aspect, albeit a prominent one, of the discursive framework surrounding the recognition of an occupational health and safety issue suffered primarily by women workers. This brings me to the material implications of the construction of women’s ill health and women as ill: the inequitable allocation of medical and financial resources pertaining to the treatment and research needs of men and women. This aspect was dealt with in some detail in Chapter Four and therefore only needs reiterating. As I argued in Chapter Four occupational health and safety research and intervention have rarely addressed women. This stems from the belief that women work in soft occupations and are rarely injured at work. It is also the result of using the male body as the norm for medical and occupational health research, excluding women from clinical trials and research funding (Liamputtong and Dwyer 2003; Messing et al 2003; Doyal 2000,
The neglect to research women’s occupational health needs results in the claim that women do not suffer from occupational harm (Mergler 1987; Messing 1998). Thus when an occupational injury such as RSI emerged which affected mainly women workers, it is not surprising that it created the controversy that it did. Compounding the fact that it was women who were presenting with an occupational injury was the fact that it was one with obscure aetiology.

It is in the failure of science to reveal real tangible evidence that Foucault’s argument regarding the power of medical discourse to define what symptoms can be designated as a disease and which ones cannot, based on rational, objective medical science becomes useful. Foucault’s insight into asymmetric power relations helps forward my argument that when medical discourse interacts with gender, it creates a gendered medical discourse which results in significant differences in how a disease entity such as RSI which does not present with a clear organic basis is defined. I argue that the inability of medical science to find an organic basis for RSI resulted in the adopting of psychiatric and psychological explanations readily available within medical discourse to explain women’s ill-health. The adoption of this default position was readily accepted by those who stood to lose the most from the massive increases in injury claims, that is, employers, insurance companies and the government. As Lucire Yolande (2003: 20) stated “hysteria and malingering are not compensable as injuries.” Therefore, I would argue that the emergence of RSI forced a broadening of the definition of woman from reproducer and mother and wife as espoused by occupational health and safety discourse to one that recognises woman as worker. However, as can be seen with the history of RSI, this was not
necessarily beneficial to women who found themselves being primarily defined by their psyches.

Conclusion

This chapter has demonstrated that the entry of medical discourse into occupational health and safety discourse had a major impact on how women’s occupational health and safety needs are recognised and met. Using Michel Foucault’s notions of power and discourse and key feminist writers I showed how the medical institution had the power to define women and illness in certain ways. This enables an understanding of why psychiatric and psychosocial explanations were readily offered and accepted when large numbers of women made claims for RSI. With medical discourse firmly enshrined within occupational health and safety discourse as the only legitimate voice to speak about injuries, women’s biology and psyches continue to be at the forefront when research is conducted on women’s occupational health and safety. Nevertheless, according to Foucault, power in modern societies is not one of total domination and is in fact productive at the individual level allowing for resistance to dominant discourses and definitions. It is to this individual level that I will now turn, when I present the injured poultry process workers’ stories of their RSI injuries.
CHAPTER SIX

CLASHING NARRATIVES: INTERPRETING

CONTEMPORARY EXPERIENCES OF RSI

(Helen) 92 They’ve got to think what they’re doing. I mean they can’t expect us ta, to work in there as we do, and as hard as we do and not get hurt, it’s ridiculous, I mean we’re not robots…they get maintenance in there every half an hour to fix the machines, I mean the machines can’t keep up with it and they expect us to, it’s ridiculous.

Introduction

The aim of this chapter is to tell the stories of twenty-five poultry process workers who have experienced or are experiencing an RSI type injury. These stories will allow an exploration of the discourses surrounding the experience of RSI for contemporary blue collar women workers. This chapter will continue to explore gender as analytical concept within the RSI debate. With the exception of the first four interviewees, the participants were self-selected from a poultry processing plant in Queensland. The occupational health and safety nurse advised the workers of the research project and asked for volunteers. The first four participants were told that they had to take part in the research. This situation was corrected and the final 21 women workers were self selected. The women workers ranged in age from 24 to 58 and had worked at this plant for periods from 8 months to 16 years. The interviews took place during work hours off the floor in a separate building from other workers and management. Each interview lasted between one and two hours and each interviewee was interviewed once. I asked each interviewee questions regarding length of service and injuries sustained and then allowed the interviewees

92 All participants were given pseudonyms.
to determine the focus of the discussion that followed. The initial plan was to conduct interviews until saturation as guided by the principles of grounded theory (see Glazer and Strauss 1967). However, following an incident at the plant which resulted in a serious injury to one of the women workers, I was advised by management that I would have to conclude my interviews. The data that I had collected by that time was sufficient to carry out the research. Therefore, there was no need to change the direction of the project because of this incident.

I begin the chapter with a description of a poultry processing plant to enable the reader to get a sense of the factory, the workers, the work organisation and the work. To protect the identity of the plant where the interviews took place, this description is a conglomerate of a number of plants, which includes the factories where I worked as a workplace health and safety coordinator as well as the factory where the interviews were conducted. I tell one injured poultry process worker’s story of her injury experience which was consistent with many of the stories that were told to me as well as with my experience in the industry.

An autobiographical reading allows me to explore stories and my responses to women’s experiences from a number of perspectives. Central to this chapter, and indeed this thesis, is the divergence around gender as a useful tool for exploring RSI. The tension between the women and me regarding the usefulness of gender to explain their experiences is used as a point of reference. The workers disagreed with me on two important issues. First, while they agreed that gender had a role to play in their experiences as workers, they were adamant that when discussing their injuries, being male or female made no difference to how they were treated by the
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medical profession or management. The second point, which is interlinked with the first, is the workers’ rejection that RSI is a health issue. The injured women workers would only speak about RSI as an industrial relations issue and claimed that doctors (even incompetent ones) played no role in the lack of recognition or the lack of appropriate treatment for their injuries. This stance from the workers seriously questioned my position that centralising medical discourse within occupational health and safety discourse was the key to understanding women’s occupational health and safety concerns. This led to the problem of how to present this research.

Michelle Fine et al (2000: 120) speak about this as a “triple representational problem”. First this work asks how do we as researchers collating and interpreting the narratives present our voices. Second, how do we interpret our interviewee’s interpretations of their experiences particularly those that contradict one’s own? And third, how do we interpret the “others” who are being spoken about such as supervisors, doctors, management and union representatives. According to Michelle Fine et al (2000: 120) we need to figure out “how to represent and contextualise our narrators, ourselves, and the people about whom they speak.” This chapter is an attempt to grapple with these tensions and to help this process I present the women’s and my voice as an active dialogue. Before doing this, I will discuss the women’s work environment.

The Factory Floor: The Work and Research Environment

Physically, poultry processing plants are noisy cold, wet and smelly. Noise emanates from the machinery operating a large number of conveyor belts crisscrossing the factory at between waist and chest height as well as rattling
overhead carrying de-feathered and guttered chooks. The constant throng of the conveyer belts is punctured by the thud of the bagging machines as whole chooks are forced into plastic bags often too small to accommodate. The high-powered saws used to cut whole chicken into pieces adds to the throng of noise, which is constantly above the 80db stipulated by the *Workplace Health and Safety Regulation* (1997) as the highest level of noise that a worker can be exposed to over an eight hour period before requiring hearing protection. For food safety and hygiene reasons, the factory is maintained at low temperatures and hosed out on a regular basis making the whole environment wet, cold and humid.

Stationary rows of workers donned in large white plastic aprons, knee-length rubber-soled galoshes, hair nets, hard hats, ear muffs or plugs and gloves attend the conveyer belts. On one line, workers hang chilled chickens about shoulder height on the shackles by one or two legs, which require a forceful bilateral thumb movement. On another line, workers pick up two chickens at a time each weighing anywhere between one to three kilos and hang each chicken by one leg. On another, workers force up to eight different sizes of chickens into bags, which only come in three sizes. These bagged chickens are then transported to the packing room via a conveyer belt and packed into boxes twelve a piece. The boxes are stapled using an industrial sized stapling gun spring-loaded for ease of use. The bagging of chickens is either done by hand or with the use of the bagging machines. In the boning room, workers stand in front of a slow moving conveyer belt and each worker is responsible for one cut. For example, the first worker on the line slices down the breast bone, the second, cuts off the left wing, the third, the right wing and down the line until there is just the carcass remaining. Each worker is using a boning knife
that has been sharpened to such an extent that a minimum of force is required to make each cut to the bone. Knives are continually sharpened throughout the day and workers in the boning room must wear steel mesh gloves.

Away from the conveyer belts, there are pockets of workers that are responsible for certain cuts of meat. In the saw section, workers using high-powered saws cut whole chicken into pieces. On the lovely legs table, workers pull off the skin of the de-hocked legs on steel cones which are mounted on the edge of a work bench. On the quality control table, workers check boneless cuts for remaining pieces of bone. Each job in the processing plant requires repetitive movements using mainly the hands, wrists, elbows and shoulders as well as requiring workers to remain stationary for the most part of their shifts. Hence, job rotation either down the line (as in the boning rooms) or between the bagging machines and the saws does little to relieve the tension placed on the muscles and tendons of the hands, wrists and shoulders or on the legs and back from standing on the spot for long periods of time in the cold.

A usual workday for process workers starts at 6 00am and finishes at 2 30pm. One of the factories processed from 6am until 10pm. The majority of workers are casual and permenacy is offered to workers based on seniority. Some factories offer permanent part-time positions. Workers can lose their seniority status for breaches of conduct, such as continually being late for start up, from meal breaks or from rest pauses. Rest pauses are 5-7minute breaks every two hours to allow workers to recover from the physical demands of the job. All the jobs in all the factories were strictly divided by gender. However, which job was considered male and which
was considered female differed from factory to factory. For example some boning rooms were exclusively male and some exclusively female as were the saw sections. All packing rooms were female and distribution was male. Stationary jobs such as hanging was mixed, but considered to be a female job. Men helped out in high peak periods. Jobs requiring movement around the factory such as cleaning (hosing floors and belts) and pushing tubs of chickens to different parts of the factory were carried out by male workers. As will be shown below, there was a strong justification offered in each plant by workers, management and the medical profession as to why it was imperative that certain jobs were carried out by women or men. On the whole, however, the majority of workers on the floor in all factories were women. Furthermore, as is the case in most workplaces regarding job segregation and crowding, positions off the floor in middle and senior management were primarily held by men.

The main injuries that were sustained by the participant women workers were representative of the industry. They comprised wrist injuries including carpal tunnel syndrome, tendonitis, tenosynovitis and deQuervain’s disease; lateral and medical epicondylitis of the elbow and tendonitis of the shoulder. The women also spoke of constant sore backs and foot pain. This is consistent with the literature on injuries sustained in process workers. Below is Judy’s story of one of her wrist injuries. Judy’s story is typical of a number of the stories that were told to me and it highlights the path that many workers with RSI injuries have to travel.
Judy’s Story

At the time of interview, Judy had been a process worker at the factory for almost six years. She was a permanent employee and had sustained many injuries including,

(Judy) Ah, let’s see I’ve had carpal tunnel, tendonitis, a broken finger, pains in both shoulders, back and elbow, and the odd tendon in the heel when you have stretched too far, and that’s basically it.

(Me) How serious were these injuries?

(Judy) Some, no problems. Others a bit more serious like my wrist…

(Me) Can you tell me about your wrist injury? Just from when you did it and then what happened.

(Judy) My left hand has had three operations and I’m in the middle of having it re-assessed and having my right hand done.

(Me) When did you first report it?

(Judy) About 18 months after I started working

(Me) You mean 18 months after it started hurting?

(Judy) No. It didn’t hurt. It was tingling at night. It took for ages to rub ’em and get them back together.

(Me) Did you know that there was a connection between those symptoms and work?

(Judy) Just what the girls tell ya. Your hands tends ta…takes time for ya body to get used to the work, so you tend to just kind of ignore a lot of it until it gets to the stage when you see the sister and say well…I’m having a lot of trouble sleeping at night, my hands going to sleep at night, my arms going to sleep at night, like they are actually dead, they’re a dead weight. And um, they say, oh yeah, OK we’ll see how it goes for a while and then you’re continually going up there [to first aid] saying na, no improvement and they say oh well get the doctor and have a look.
(Me) How long was that process?

(Judy) Probably about three months. Before I saw a doctor and was put on a light duty program. And things didn’t settle down and so they sent me to a specialist and have nerve conduction studies done. This happens to a lot of the girls. They are getting told by the nurse, “yeah, don’t worry about it…your hands will get better” and then 18 months down the track they’re still having lots of problems and then when they finally get surgery, it’s too late the surgery doesn’t repair what’s wrong.

(Me) You are about to go for surgery now on your right hand, yes? Are you on light duties now?

(Judy) No. I am on full duties. I refuse to go on light.

(Me) Why?

(Judy) I have not long gone back on full duties and it’s, whether I’m on light duties or full duties it’s not going to make much difference to the hand because it’s at night when it goes to sleep, and it’s not aggravatin’ me durin’ work hours. So it’s just like when you rest ya arm that’s when all the problems start and when it aches I just go and get a rub with Voltaren or something the…wherever it’s sore and hopefully that’ll ease the pain and I’ll carry on working. But if you go on light duties for too long you get nothin’ but complaints from all the other workers. And then ya ya leadin’ hands and your um, supervisors, more so ya supervisors start givin’ you a bit of a bum’s rush and not pleased with you because you can’t do the work that they want you to do, and all that sort of stuff. So a couple of times I’ve had a blow up with a supervisor.

(Me) What about the union? Do you get a lot of support from there?

(Judy) I don’t have much faith in the unions. Actually they’re just piss. In cohorts with management. The unions don’t seem to do much for us…all they want to talk about is the red meat industry and the white meat is pushed aside…more interested in the meatworks.

(Me) I am presuming that you are covered by workers’ compensation. What about WorkCover, what was your experience with them?

(Judy) Well, sort of. I have had two appointments with specialists re: whether I should have an operation or not [on the right hand]. Their first opinion is that
I should get another job. It’s easy to say, but nobody’s going to touch you when you’ve got problems with your hands again, you can’t get a job anywhere else, it’s too hard. And second, then it’s physio, and they decide should we talk about physio. It takes about a three to six month period. And WorkCover has decided to hang everything off at the moment and I’ve got to go and see their specialist to see whether he recommends that I should go and see my specialist and all this sort of stuff so I’m, I’m in the middle of a pickle. You see they’re holding up the works and the longer they hold the works up the worse the hand’s going to get. And I said to my doctor, I said well, why should I go on light duties when they’re holding everything up on me? I said I’d miss out on overtime and all that and I’m a single wage earner. I’ve got to feed my kids and pay my mortgage, so…I’m not going to miss out on all that.

(Me) What is the hold-up with WorkCover?

(Judy) They are waiting for a report on the case before they accept the claim or not, even though it was a pre-existing case. Because I’ve got limited movement they’re claiming that it’s arthritis, not work. Not work!!?? Shit, they know that they are a 60% injury rate company, so they need to work on how to rehabilitate these people [injured workers] not make matters worse. It’s a very scary thing. I mean, there’s, you’d probably find 20% of the girls in there probably never had a problem with their hands and you’d be lucky to get that many.

(Me) What about management? What sort of strategies do they have in place to deal with this large amount of injuries?

(Judy) Ya tensing your body constantly which is causing more problems in the muscles and your tendons, so it’s just, they’ve got to start looking at these things and listening to people to find out where the problems are. And they just don’t. Management, you can go up there and talk to them ’til you’re blue in the face and they go yeah, yeah, yeah. You walk out the door and they’ve forgotten everything you said. That’s a big issue at the moment. The big deal at the moment is to get the injury time down, get the light duty people numbers down, and all this sort of stuff. It, it is always thrown at us. This week we’ve done so well, we’ve only had ten light duty people and so on and so on. And, it’s always constantly thrown in your face. And I just turned around and said to ’em one day, I said well you’re lucky the whole bloody factory’s not on light duties and they said why and I said the way you are pushing us. I said if they’re not going to have nervous breakdowns or an accident or someone’s going to punch someone else out or something like that. I said you’re just pushing people too hard. I said we are just an accident waiting to happen, this place.

(Me) A couple of the injured workers have said that they are leaving because the company has nothing here for them to do? Have you considered another job?
(Judy) I can’t survive on a single parent’s pension and no-one else will employ me with the injuries I’ve had to my hands. You just kind of get fed up with all the crap that goes on in the place. Like I said to someone, you’re treated like shit. You’re kicked around the place like a piece of bloody dung. And I said people just get sick of it and they go on about absenteeism and I said and why wouldn’t people take time off, I said they need a break. They get sick of being treated like crap.

Judy’s story is a common story told by many of the workers and one which is depressingly similar to those reported in the literature in the 1980s and 1990s at the peak of the RSI ‘epidemic’ (see for example Bammer, 1986; Meekosha and Jakubowicz 1986; Ewan, Lowy and Reid 1991; Reid, Ewan, Lowy, 1991; Arksey 1998), and raises many of the main issues discussed in preceding chapters. In light of my reading of the RSI debate, the next section will present my reading of Judy’s story using the two major discourses, occupational health and safety discourse and medical discourse. In order to make sense of the data, and to highlight the points of contradiction, I will analyse Judy’s experience of injury firstly in light of occupational health and safety discourse and secondly in terms of medical discourse. The reading utilising occupational health and safety discourse will examine the reporting and evaluation of symptoms, on-site treatment, and injured workers encounters with management, the union and WorkCover. In this section I will also explore the workers’ views on the role that gender plays in the acquisition, recognition and treatment of their injuries through asking about different attitudes and treatment between injured male and female workers to ascertain if and how they differ from my own. I will apply a power relations perspective to examine access to and appropriateness of medical treatment for the women suffering from RSI injuries. The RSI debate centred on questions of legitimacy via the medical profession with a consensus reached that psycho-social factors were significant features in aetiology thereby discrediting its legitimacy as a purely organic illness.

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In this section, I will explore whether this belief still impacts on how RSI is currently diagnosed in the poultry processing industry via the workers’ accounts of their encounters with the medical profession.

**Modernist Occupational Health and Safety Issues**

*Reporting and Evaluation of Symptoms*

One of the most prominent similarities between Judy’s and other injured workers’ stories as well as those reported in the literature was the sheer number of injuries, pain and discomfort suffered by workers in repetitive industries and the delay in and/or the lack of both the reporting of and treatment of symptoms. In a vivid account, Nina speaks about the pain associated with her wrist injuries,

(Nina) Oh the pain, there is a constant ache, the dull, the dull, the thud, and if you pick something up the sharp pain. My hands are so bad at some times that you can’t even touch them. I am nearly in tears at times ’cause they’re so sore. Like childbirth, you can try to explain it but you’ll never know what it’s like unless you’ve been through it.

Nina, like Judy had had surgery on both her wrists, but was still having problems. Peta spoke about the disability associated with her shoulder injury which was at the time of interview still causing her problems although her workers’ compensation claim had been closed,

(Peta) I just have to live with the fact that my shoulder is buggered. I can’t zip up my pants at the back. Can’t stretch to hang washing on the line, have you tried to get a teenager to help with chores like that? I can’t even mash potatoes for tea.

When asked what could be done to prevent the chronicity of the injuries, many of the workers’ responses entailed the need for early reporting. This response was in line with current medical views on managing RSI in the workplace and was also clearly a company policy,
(Cathy) They tell you to report injuries straight away. There are signs all over the place. There is always someone up there [in first aid] to report to.

However, when I asked whether workers followed the policy of early reporting it was clear that many injuries went unreported. The workers identified three main reasons for the lack of early reporting of injuries. The first as articulated below by Margaret was a common response. Because many of the workers experience symptoms from very early in their careers as poultry process workers, there is a belief that with time, “it’ll get better” or as Judy commented above that it just takes time for your body to get used to the work,

(Margaret) You can’t force people to report. Maybe there are some who are too scared because they might get into trouble or these sorts of things. But most people just think that it’ll get better, they can’t be bothered reporting it.

A more common response was based on the lack of staff to cover workers to go to first aid to fill out incident reports,

(Cathy) They tell you to report injuries straight away, but what are you gonna do, we haven’t got spare girls there normally, so you haven’t got time to go up to first aid cause whose gonna do your job?

The third reason suggested by Therese and Karen below suggested that there was a lack of concern displayed by the first aid and nursing staff regarding the symptoms,

(Therese) A lot of non-reporting goes on. What’s the use? They’ll only think or at least say that it’s old age. Or that you need an operation.

(Karen) A lot of people don’t report because nothing gets done. A lot of people think that you are just bludging going to see the nurse.

Suzanne offers an explanation which allows an understanding of the difficulties placed on the workers to continually report symptoms or injuries that are not improving and/or progressive, particularly where there is no follow through with the report,
(Suzanne) A lot of the time you can put a report in and it doesn’t get followed up…most of the time you feel a sharp pain and you shake it off, it goes away and then you shake it off again and it comes back etc etc. So, I mean you got a report in, but you don’t keep going up to the office and saying, I hurt me wrist doing this today and I hurt my hand doin’ that today. Now you don’t go into those reporting everyday of what actually happened. You’ve got a report; you know that I’ve got a problem with it, I’ve had problems with it or somethin’ like that and then that’s it until it really blows up and gets really sore and swollen and whatever and then you go and say that I got a problem with my arm.

In contrast to the lack of follow through on an injury report is the inadequate or inappropriate initial treatment of injuries by the on-site medical staff including the first aid and nursing staff. I have separated out the first aid and nursing staff from the on-site doctor, physio and WorkCover specialists because based on the workers’ stories there was a clear demarcation between the different roles in the recognition and evaluation of injury symptoms. The workers’ readings of their experiences with the occupational health and safety nurse (Penny) were much more contextualised within the broader workings of the factory than were their readings of their experiences with the doctor. This is probably because the occupational health and safety nurse holds a very different position to the doctor in that she is a company employee as opposed to being an outside consultant “being paid a hundred bucks an hour to give out pills” (Donna). In the first instance workers had to report injuries to the first aid worker on duty. If s/he felt that further treatment was warranted the nurse was informed who would then decide on whether the worker would go on light duties or would see the doctor or the physio. Moreover, all the workers were under the impression that the nurse was the one who decided whether a workers’ compensation claim could be made and it was well known that one of her primary responsibilities was to keep workers’ compensation premiums down. Peta’s and Helen’s comments below articulate how most of the workers viewed Penny’s role in relation to injury reporting and symptom evaluation,
Clashing Narratives: Interpreting Contemporary Experiences of RSI

(Peta) She [Penny] is more interested in her numbers. Oh look, we’ve had no lost time injuries this month. Oh look, we’ve only got two people on light duties. It doesn’t matter how you got on light duties or how you got off. She likes to keep her numbers down; she is more interested in that.

(Helen) When I got hurt, I thought there is no way that I am going to stay here when there are five girls doing twenty girls jobs, there is no way that I can handle that. So I went and saw Penny [the nurse] and she just said let’s see how it goes, I’ll come and check on you later. I was really annoyed when she didn’t and when I went and saw her she says “oh sorry”. I was nearly in tears because I was in so much pain; I could hardly move my shoulder. And then she says “oh are you all right?” I couldn’t cry because there were a lot of people around and I thought there’s no way I’m crying for this cow and she asked me if I would like to go home and I said no I want something done about my shoulder please. Stick me somewhere for the afternoon. If you go home early it’s like why the fuck did you go home early? Ra ra ra from everybody. It jacked me off that she fobbed me off and then all of a sudden expected me to go home and not get paid nothing because she was the one that made the mistake, I mean, like I said I did this when I was casual, I couldn’t afford to take time off. It was, you know, do so many hours a week and maybe I’ll have the extra bit of money to go out or something, but most of the time it was, you know, I’ve got 20 bucks to play with this week, you know after paying the bills…

(Me) But, you would have gone home on workers’ comp?

(Helen) No, she didn’t say that, just go home and it’ll be all right.

Tracy clarifies what many of the workers said regarding the requirement to go through the company doctor if a worker expects to be eligible for workers’ compensation,

(Tracy) Someone I know went to their own doctor and the nurse got really, really angry with her, and said to her, her exact words were, you want to seriously consider your position here. So now she won’t tell her own doctor. I mean this girl had been on light duties for so long, she was so desperate, because she has got tennis elbow and as well she’s done, has needles and all that stuff and so she went to her own doctor and that was the response…

When I asked the workers their thoughts on why Penny seemed to ignore their reports, many commented that she did not believe that the workers were injured,

(Karen) Well a friend of mine who went upstairs and saw the nurse and said I’ve got a…my back is sore, and she’d already been to the hospital, and they’d said it’s wear and tear, but she’s been here like 11 or 12 years, so you know where your wear and tear comes from, and the nurse said, but did you do it here? She said yeah, and it’s wear and tear, like I didn’t fall over, you know what I mean. And the nurse just didn’t get it or didn’t want to get it, so she
just walked out and that was the end of it. She just puts up with it all the time…

(Leslie) I wanted to stay on light duties but was told that I couldn’t. Later Penny [the nurse] came down and asked how I was feeling and I said my arm’s killing me and I can’t do it and she goes, “oh that’s all right” and walked off. And I thought, no it’s not all right. And I tracked her down ten minutes later and said I want to see you about going home. She said we’ll find you something else to do and the supervisor said that there was nothing she had for me and sent me home. I saw the nurse and she said what are you doing and I said Gayle [the supervisor] sent me home and Penny said that there has to be something that you can do. I said no. The impression she gives, is that you are only playing with your injury whether it is a real injury or not.

In one of the interviews it was revealed that Penny only had psychiatric training,

(Bronwyn) The nurse has no training at all, the only training that she has had is psychiatric training…so what can she do?

Given that I had only been given access to the plant because management had thought that I was a psychologist and hoped that I could devise a psychological test “to weed out potential problems before they start” (Risk Manager, Plant B). I thought that this was an invaluable piece of information that I could work from to explore my argument that RSI injuries continue to be considered as originating in a psychiatric condition. When I asked the workers whether they felt that this was significant, the response was,

(Bronwyn) No. The only problem is that she knows nothing about anatomy and physiology. She would be a lot more useful if she had general training.

93 I only found this out after I had conducted the first four interviews and was told by the participants that they were told that they had to come and speak to me. When I informed the Risk Manager that participation had to be voluntary, he suggested that I would probably only get the workers that wanted to complain about the company and had a grudge because “the company and WorkCover were calling their bluff and I wouldn’t get a balanced view of what the work was really like in there. It is hard, but we need some sort of test that will weed out the problems before they start”. I raised this issue of self selection in Chapter One (see also Strazdins and Bammer 2004). However, there were little to no inconsistencies in the stories of the first four participants. The only inconsistency was that one of the workers, Cathy, had never had an RSI injury to her wrists, hands or shoulders. However, she did have a WorkCover history for a knee injury following a fall, removal of bones under fingernails and a back injury. As will be seen later on, Cathy was only one of two workers who questioned the legitimacy of RSI.
While I was inclined to conclude that the management wanted to view the women’s injuries as psychiatrically-based, the women continued to respond negatively as I attempted to ascertain whether Penny was handing out psychiatric diagnosis to women suffering from RSI. Furthermore, the strong association made with her and management, rather than her and the doctor meant that I had to re-think my stance on the role of medicine in the recognition and treatment of RSI injuries. This was one of the points in my research where it was clear that there were two discourses surrounding the recognition of RSI in the industry. Where I had considered that medicine played a more prominent role in the lack of recognition and treatment, the workers clearly articulated that this was not the case. I will return to this point later when I examine the women’s encounter with the on-site doctor. For the workers, the diagnosis was not the problem. The problem lay in the lack of adequate treatment by the company, that is, the occupational health and safety nurse, not with the medical profession.

On-site Treatment

As Judy relayed in her story above, before she saw the doctor she was put on a light duty programme. The light duty programme was the only treatment available to the workers other than the “occasional rubs from the first aiders” (Jane) and surgery. For many of the workers, light duties was simply a way that the company could keep their lost time injuries down thus “saving them bucks on their workers’ comp premiums” (Jane). According to many of the workers, the light duty programme was haphazard and poorly organised (Kirsten). Also, as with Judy, refusing to go on light duties was a common occurrence in the factory. There were three main reasons put forth as to why this was. First, many of the workers claimed that this was because there was little difference between the light and the heavy work on the
injury as Judy stated above. Helen, like many of the workers, felt that she was on a one-way progression towards an operation and no amount of light duties was going to fix that,

(Helen) I don’t want to fill out an incident report because it’ll be fine tomorrow. If it continues I’d fill out an incident report. I still wake up with pins and needles but it is not as bad as when I first started. I know when it gets to the next stage I’d be the first one up there, but at the moment, they’d probably stick me on light duties for a couple of months for it to settle down and I’ve been told by the doctor it’ll just keep coming back until it gets as bad as it can, basically, and then you’re supposed to have an operation or something. So I just leave it.

(Me) And you are happy to do that? Rather than go on light duties?

(Helen) Definitely. The only reason why I put up with my shoulder is because it was no better on light duties and it was still giving me grief when I went home and I said well Sue [first aid worker], we’ll have a go at normal duties and I said if it’s worse than it is now, then I’ll go back to light duties. It’s no worse than when I was on light duties.

(Me) And it doesn’t concern you that you are developing a chronic injury?

(Helen) Yes it does. But there is nothing that I can do with my wrists until it gets major. I know that you must think that I am an idiot but because of the grief in there that you get, I mean, um, after I did my shoulder they sent me into the ticket room and you sit down and you count tickets all day and like people come in with orders and stuff and it’s like what are you doin’ here and I’m like, Sue [first aider] wanted me to go home and I’m like I can’t because I am casual and I saw the doctor and he didn’t suggest that I go off.

The second reason was purely financial. There was a cap of hours for workers on light duties and they were unable to do overtime as there was no light work on the overtime shift,

(Leslie) I said to my doctor, why should I go on light duties when it’s not going to make any difference? I said I’d miss out on overtime and all that, and I am a single wage earner. I’ve got to feed my kids and pay my mortgage …so I am not going to miss out on all that. This is why a lot of us don’t want to go onto light duties. They really need the money. And there’s the feeling that you might get sacked if you go on light duties. If my injury gets worse I wouldn’t say anything, I’d just let it go, for the hours and that, because like you are bringing home good money. I’m just greedy. I want money.
The sentiments expressed by Leslie and Karen raise a couple of very important issues. First, there is the need for women to justify their need for overtime money. Leslie is a sole parent and yet states here that wanting to do overtime is simply a matter of greed. This highlights the difficulty of women to define themselves primarily as a breadwinner/worker, particularly once they are injured. This point will be developed below when the workers discuss their views on their colleagues’ injuries. Second, the comment that you can get sacked if you go on light duties and cannot do overtime is a concern expressed by a number of workers. Most workers know that this is not the case, as Tracy and Suzanne articulate,

(Tracy) It’s not the fear of getting sacked…because you can’t get the sack because it’s legit you know, you’re legit, you know you’re not going to get the sack, so that’s not stopping you…

(Suzanne) It’s not the case that you can get sacked. But the word gets around to the newer people that if they have the tingles in the fingers not to go on light duties because they will get the sack. So they hold off and don’t say anything until it’s too late.

Nevertheless, “getting the sack” it is often forwarded as a justification for holding onto injuries and taking on overtime,

(Phillipa) I know of some girls that have been asked to leave, they’ve been told that they won’t get better…your only choice is to go on full duties or leave.

Interestingly, the more that the workers spoke about overtime, the more it became clear that working overtime was not a matter of choice.

(Me) Do you have to work overtime? Can you choose to go home?
(Karen) No. Only if you fake that you are sick. And I suppose a few people do that. A few people use their kids as, as an excuse. Like, I’ve just rung home and my daughter’s had an accident, I’ve got to go and they’ll be off. It’s a bit annoying when they know you don’t have kids but…

(Leilie) We get mothers in here that have to ring the babysitters every hour to say that they don’t know when they’ll get home. They could make it easier on everyone if the workers knew what time approximately the work will finish.

The third reason stated by workers was the stigma attached to being on light duties. There were two main reasons that workers on light duties were targeted. First, they were seen to (and saw themselves) as letting their co-workers down, as articulated by Jacqui, Kirsten and Tracy,

(Jacqui) I won’t go on light duties because they’ll think I’m a wimp, that I can’t handle the job.

(Kirsten) I don’t know if you [me] saw the hot and spicy section. Quite often I’ll go over there and I am the only able-bodied one on, and so that means that others would pack out and bag, because they don’t lift and that means because I am the only one I’ve got to carry the heavy tubs over, over, over, and by the end of the day you get a bit sour. You get pretty, well I don’t know, if I live to lift another tub…you know you get pretty sour. And everyone will do it so yeah….

(Tracy) I was feeling pretty sore, but we were so rushed that I was caught up with doing it, don’t want to let your mate down…you know, so you just keep going and going, and I thought well I just got to get through the day, so I, I’ll just keep going, and you just push and push until it was that bad that I couldn’t even lift my own daughter, and I couldn’t hold the liners like this [indicated hand position required] and eventually I had to own up that I was hurt, and then you hate doing that because then you felt like a leper.

The second reason was that their injuries were not considered to be real, and that workers on light duties are “bunging it on”,

(Helen) You know you go in there [the factory floor], you have your hand strapped for any reason and everybody’s just looking at you…and I went for five and I took my gloves off and I turned around and every girl that was sitting down was just staring at my hands like, and in their head would have been the thought she’s been on light duties for her hands, her shoulder and now her hands again, you know she’s original. They think that I am bunging it on. They think I am an excellent actor, yes. I should get an Oscar apparently.
(Me) But aren’t these workers injured too?

(Helen) Yeah, yeah, they are, but what happens is that they bitch about the girls that are on light duties and when it happens to them, they’re serious. Everyone else is bludging, but when they get hurt it’s, you know, it’s fair dinkum. It’s oh, the bloody bludgers, they come in here and expect to get a full wage and work half the job and you know…

In a slightly different vein, Nina argued that it was only workers, who had never experienced an injury that questioned the legitimacy of workers claiming to be hurting,

(Nina) People that have never had an injury are those who tend not to believe you. Yeah, that’s right, yes because they’ve never had to experience that pain, the constant ache, the dull, dull, the thud, and if you pick something up the sharp pain… I mean they’ve never experienced it, so they’ve, they don’t know what you mean. They think, oh yeah, you are just playing on it. They think well I’ve been here for so many years and I’ve never had any problem, so what’s your problem? You might have got a little bit of aches and pains from being here and now you’re playing on it. And which is not right. And which is not true. Because they can’t actually see the mark, the area that’s hurt they don’t relate to it. So and that’s where you get a lot of bitchiness.

What Helen and Nina are saying here has been identified in much occupational health and safety research as evidence that co-workers’ disbelief in the credibility of injuries is a reason for the lack of reporting or refusing to go on light duties until the injury is at a stage where there is no choice to either report and get treated or leave. Coupled with the disbelief displayed by Penny, the occupational health and safety nurse, it was clear that credibility was a major issue for women suffering from RSI. This was consistent with the literature on RSI as presented in the previous chapters and I wanted to examine why it was that injured workers (even those who had harboured the same injuries) didn’t believe that their colleagues were injured. One of the main issues for credibility is the lack of an identifiable lesion by the medical profession called into question whether or not an injury existed at all. The following quotes confirm that some of the workers attested to this. Cathy (the only
worker who had not sustained an RSI injury) out rightly denied that RSI injuries existed and Therese needed a diagnosis to be convinced that a worker had an injury,

(Cathy) There is no such thing as a muscle strain…the birds are small and therefore you can’t strain anything…it is just sore from exercise that you haven’t done…If you have been hit by a bird then that’s different.

(Therese) Depends on your injury, you know, um, like if you can see it, if ya can’t then I am not so sure about it. If you have a diagnosis then it is OK.

While most of the workers disagreed with Cathy’s and Therese’s stance on the existence of injuries, they were more than aware that it was a powerful belief on the factory floor (see Margaret’s, Peta’s and Helen’s comments below) and that it had serious ramifications for treatment, as Bronwyn’s and Jo-Anne’s comments demonstrate,

(Margaret) I have been lucky, maybe because mine was an accident, not just like a repetitive strain

(Peta) The minute someone is on light duties now, you see everyone going “tsk, oh, what’s wrong with her or what’s wrong with him?” you know, and ’cause they can’t see any visible injury they think, oh, not much wrong. You need a scar for people to accept light duties…People thought I was bunging it on. When I had to go for an operation I had more belief. I have a scar.

(Helen) When I got my ultrasound for my shoulder, um, I was actually disappointed that there wasn’t anything wrong because I wanted that piece of paper so that I could walk in there and as soon as someone says anything to me I would of, I would of just gone, “look at this, there is something wrong with me and now just leave me alone”.

(Bronwyn) The main problem is that it is the invisible injuries. The girl who had an accident, she went off on lost time, there was no question but it is invisible injuries, that don’t get looked after, even if they could be more serious.

(Jo-Anne) No, I don’t think anyone believed me at all. Like they saw me when I pulled my back because they saw me grab the tub and I just stopped…but with my hand no-one believed me.
On-site Medical Treatment

I wanted to situate the women’s experience of not being believed within a) the dominant medical discourse which, readily defines women’s ill health that does not have a diagnosable lesion as psychiatric or psychological or b) within occupational health and safety discourse, which ignores women’s complaints, unless reproductive in nature, by using standards developed for male workers to address all occupational health and safety issues (see Chapter Four). While it was quite clear that the co-workers and the occupational health and safety nurse did not believe that the injured women were suffering from genuine injuries, when it came to on-site medical treatment however, most of the workers claimed that there was no problem with them being believed by the company doctor,

(Vivien) Yeah, yeah, no problem. They never query your injury. Always get treatment, anti-inflammatories and light duties if you want it. Never suggests going on WorkCover though. Never heard him say that. And the nurse is pretty good. Sue [one of the first aid workers] is the best….if it wasn’t for her, I am not sure what most of the workers, you know those that are hurt would do.

While the workers said that there was no problem with being believed by the medical staff at the plant, the adequacy of the treatment was poor. When I suggested that perhaps their injuries were not taken seriously, the responses were,

(Judy) No. He just doesn’t care. The doctor diagnoses you by looking at the wall. He says “just do light duties for a week and go back to work”

(Kirsten) No…but, I’ll come to the doctor here and he will sit like you [indicates where I am sitting] and you will say, I’ve got a sore shoulder, he’ll go, oh have you, I think I’ll just give you some anti-inflammatories. There was not even a feel where it’s hurting, he does not touch you, I don’t know if he’s been up on litigation, I don’t know, but he doesn’t have any contact with you. Rather than feeling it and saying oh yes, look I think you should go to the
physio or…anti-inflammatories is his answer. So I go to my own doctor and she gets me some proper treatment.

(Karen) Yeah, maybe…sometimes the doctor here doesn’t take the injuries seriously…just take the medication and it will fix up. If only everything was so simple like that…they only take it seriously if you have to go for an operation or something like that.

(Jacqui) The doctor told me not to use my sore arm, which of course is impossible. I am a sastec worker and I use two arms to push the boxes down. The doctor didn’t put me on light duties because he considers the job that I am doing is light. I think that I should of gone on light duties and said so, but he didn’t agree.

(Me) Did he believe that you have an injury?

(Jacqui) Yes. There was no problem with that. He just considers my job to be light.

(Peta) They just stick us on light duties [as opposed to lost time] trying to get away with it. They think, oh the girls, they’ll be right, stick them on a light duties job. They do believe us, but production is first.

For most of the workers that were interviewed the lack of care from the doctor was readily dismissed as an individual personality issue and despite my repeated attempts to encourage the workers to see (and say) that his poor treatment was clearly more than just laxity on his part, it was close to impossible to get the workers to elaborate any more than what is quoted above, other than to emphasise his uselessness as a medical practitioner. For example when I asked Tracy,

(Me) So do you think that he believes you straight up or just he doesn’t care?

(Tracy) I don’t know, I mean, that’s hard to say whether he just believes us, or whether he just doesn’t care. Probably doesn’t care. Because it is hard to believe a bunch of people that you don’t know straight up, isn’t it? Probably doesn’t care.
Despite the lack of a clear confirmation from the women workers, I felt sure that what I was hearing from the workers was a clear example of an unequal power relationship between a male medical practitioner and a sick (injured) female patient. Furthermore, these women confirmed to me that the belief that women were considered to only work in soft or “light” work continued to hold sway. In short, I read these quotes as supporting the claim that sufferers of RSI were still vulnerable in the hands of the medical profession and, although my argument that RSI was readily diagnosed as having a psychiatric basis was looking tenuous, I wanted to explore whether gender was at the core of their experiences. Given the women’s openness to speak to me and the richness of their comments, I came into this part of the interviews with confidence. The confidence in part stemmed from the fact that the stories that I had heard so far were very similar to those that had already been reported in the literature and I felt sure that I could overlay my feminist theoretical framework on and through their words.

In order to get a more comprehensive picture of the workers’ experiences of RSI, I asked them about their encounters with the union, WorkCover and specifically about differences in attitude and treatment on the factory floor between injured male and female workers. I was also interested in exploring their off-site treatment experiences with their own doctors and other treating health professionals. These areas were all identified in the literature as interlinking factors impacting on a gendered experience at work.

*Encounters with the Union*

The union which covers the poultry processing industry is The Australasian Meat Industry Employees’ Union (AMIEU). It represents all workers in Queensland
working in all areas of meat slaughtering, processing, and storage in both the white and red meat industries. Each plant has union representatives and as would be expected there were contrasting opinions about the effectiveness of the union. According to Jane the union is very visible and quite active in advocating for workers’ rights,

(Jane) As far as I know, everyone knows who the union reps are and can go and talk to them about anything that they want. Don’t know how much good it does in the long run, but they try and yeah, they’re there if you need ’em.

In contrast, Nina claims that,

(Nina) I went through the union delegates here to no avail. [Head Office] helped out. The union on the floor is divided. Many of the workers think that it is a waste of time and money. There are union delegates and a union president. The union president does not do anything. We don’t even know who the union delegates are. A lot of people don’t even realise that there are union reps on the floor…not that it would make any difference.

One point which all the workers seemed to agree on (see Judy’s story above) was the lack of attention given to the white meat industry compared to the red meat industry,

(Jacqui) I’ve left the union because they just do what the company wants them to do, not what the workers want. Same old, same old. People argue and nothing gets done. We are so far away from what they pay at the red meat industry.

(Vivien) Well, the unions are strong to a point. And I’d like to stop there. But I do feel that the unions could do a bit more and they should get behind the girls ’cause the girls are paying $220 a year. And they’re not being heard. It’s being stopped. It gets to a certain level and is stopped. They only care about the red meat industry. You know there are instances where the white meat industry gives money to the red meat workers to strike. But not visa versa. They think what have we got to strike about?

I had heard this same line directly from the union delegates at a seminar day that I had been invited to attend by the AMIEU. When discussing my research project with a number of the union delegates and representatives from both the red and
white meat industries, I was told that what I was doing was “really interesting but when you finish with the chickens you should have a look at where the real problems are”. When I suggested that the workers in the poultry industry sustained significant injuries, it was suggested to me that “maybe you should employ blokes then if the girls can’t handle it”. Many commentators argue that the lack of unionisation of women workers is one of the reasons that their work demands are not met. However, this evidence suggests that even when the women are organised their needs are trivialised or ignored. The needs of the poultry process workers were always discussed in relation to the red meat workers (male norm) and because the red meat industry handles large cattle, the “chicken” workers were easily dismissed. However, this attitude was not only restricted to union officials. While the women workers clearly articulated that the AMIEU should take the injuries sustained in the white meat industry seriously, they argued that it did not require the same level of commitment as in the red meat industry. For example, Helen, who had sustained a significant wrist injury and was seriously contemplating leaving the industry because of it, commented that,

(Helen) The poultry industry is easy. It is much easier for the women. Men do all the hard work in the red meat industry.

Furthermore, Bronwyn commented that it was appropriate for the union to address the greater needs of the red meat industry and that if the union was not addressing the needs of the white meat industry that it was not the fault of the union, but a problem of the women workers themselves,

(Bronwyn) It is understandable that the meat industry tends to have a very different attitude towards injury. For instance, it is more acceptable for a man doing a big job to be on compo because he is on a bigger job than it is for a woman. I don’t think that the [women] workers are being honest enough. They just work for the money and then when they are hurt they complain that the union does not help them out. Possibly because the white meat industry has predominantly more women…and women are not that interested in getting
involved in politics, they aren’t aggressive enough to be able to change the company.

These comments from Bronwyn raise at least two important points. The first is the issue of the women’s right to workers’ compensation, and the second is women’s integrity and right to paid employment and union representation. One interpretation of this passage is to read it as the women internalising the dominant definition of themselves as being marginal workers who work in soft occupations and do not possess political know-how. When I asked Jane to expand on her thoughts regarding the lack of strong union support for the poultry processing industry she stated,

(Jane) As I said before, I think that the union here is good. The only reason that it may not work well is because it is trying to deal, I mean work with a bunch of whingers. You know what women are like, like when I got hurt, there was no problem with them… And the boys they get it harder.

(Me) You mean here or the boys in the red meat industry?

(Jane) Both. It is much harder for them to get compo. They get the harder time and yet do the more hard work, the lifting and the rest. Most of ’em are young now, but, but they will be needing to think about supporting families, you know what happens if they can’t work?

The rejection that the union was discriminating between the red and white meat industries purely on gender grounds was another major stumbling block that I came to. As I will show below, when I spoke to the women regarding their encounters with WorkCover and asked them about the different attitudes on the factory floor towards male and female workers, similar views were presented. That is, while the women spoke openly about problems that they encountered, gender (at least for women) was discounted as playing a role in that experience.
Encounters with WorkCover

The stories around the experiences with WorkCover forced me to further re-consider my position on gender. As I will show below, the stories that the women told me supported much that has been reported in the literature regarding women’s experience with workers’ compensation. In particular, their stories indicated that obtaining compensation for injuries was not an easy path to go down, many claims were rejected, and the workers were very aware of the implications for future employment should they have a WorkCover history. Because of this, many of the workers intentionally chose not to put in a WorkCover claim,

(Therese) I have heard that a lot out there don’t get covered. My last injury was knocked back because I saw my own doctor. No-one here likes the doctor and so they choose not to go through WorkCover and go to their own doctor. If it [an injury] happened again, I wouldn’t go through WorkCover again.

Despite it not being accurate, many of the workers spoke about the inability to make a WorkCover claim through their own GPs and the medical staff on site appeared not to discount it. Even workers that had the necessary paperwork from their own doctors were told they could not submit it for compensation. However, as discussed above, for the workers on the whole, the choice not to use the company doctor was because of his poor treatment, and not a decision based on making a workers’ compensation claim. Decisions regarding whether to make a claim or not were based either on prior experience with WorkCover or the fear of becoming unemployable,

(Karen) WorkCover follows you around so I’d stay off as much as possible, and therefore go through Medicare. I don’t think that I would actually push anything to WorkCover anymore. Seriously because they give such a shit time and I don’t want that over the top of me every time I went for another job, you know, you’ve been on WorkCover, na, we don’t want ya. You already had the injury. Na, we don’t want ya.
For those workers who did attempt to put a claim through WorkCover, their stories were very similar to those presented in Judy’s story at the beginning of the chapter. Their stories spoke of not being believed that they were injured, not being believed that it was work-related and being advised to leave the industry because they obviously could not cope with the work that was required of them (see Judy’s story above). Nina’s story is one that I heard a lot at the plant and one that has been reported frequently in the literature,

(Nina) The people at Workcover asked me, how can you explain your injury?...I got the impression that they wanted, um, a time and a day when ya, where you actually did it, and it wasn’t and I’m thinking, well, I can’t give you an exact date, I said because it was over a period of time. And then it’s, oh why didn’t you report it?...And I’m thinking, well you don’t think about it straight away and um, I said to them so, and I had to explain more and they asked me about my hobbies that I do at home and everything like that and I’m thinking well, I don’t do horse riding or anything like that, and I don’t go um, steering ropes or anything like that. I am a housewife with three small children and my relaxation is walking, reading and um, fishing. Oh! How do you go fishing?; how do you um go when you go fishing? I said I try and go at least once a month. I said we got our own boat. Oh do you? How do you go about that? I said well what do you mean how do I go about that. Who pulls the anchor up? And I said well I used to ‘til I hurt my hand. And I said but my husband does it, I said he puts it in the water and he puts it out of the water. So it more or less felt that I was being discriminated about my own personal life and stuff. I mean some of these ladies have got horses and that and they get the third degree and they know they probably won’t get WorkCover. One lady quit work because she hurt her back here and um, she was only fairly new, and she actually quit because she hurt her back here but WorkCover said that she did it at home with the horses. And she knew and we all knew that she didn’t do it at home.

In a similar incident, Jacqui’s injury was regarded not as work-related but as a possible sports injury,

(Jacqui) WorkCover often does not believe you. I went in once and they didn’t believe that the type of job that I was doing would result in a tennis elbow. They kept asking what sport I played.

Given the statistics regarding rejection rates for women (discussed in Chapter One), I would expect that women would have a much harder time than men in being
believed by WorkCover and that reasons for rejecting women’s claims would also
differ. However, in contrast to what I expected to hear and what had been reported
in the literature during the RSI epidemic, the claims were not rejected on the basis
of women’s thwarted needs to be at home and look after children, but on the basis of
sporting pursuits, which was more in line with rejected claims for male workers
(pers. comm.. WorkCover Qld). Emma commented that,

(Emma) Every time I have an interview with WorkCover they ask, what are
your hobbies outside work? They try to find fault outside of the workplace.

Furthermore, when I asked the workers if they felt either that they were given a hard
time by WorkCover because they were women or that their encounters with
WorkCover were more negative than their male colleagues most workers
commented that men’s experience was much worse. Even Nina, whose story was
told at length above, commented that,

(Nina) Men that I know that have been on WorkCover get more of a run
around than we do. They get injured and can’t work and still have to prove
that they did it at work.

In a similar vein, Bronwyn’s comment above that “it is more acceptable for a man
to be on compo” and Jane’s that “the men get the harder time, yet do the harder
work”, supported Nina’s position that men have an inalienable right to workers’
compensation, which she didn’t afford to herself or her female colleagues. Again,
as I commented above, this may be the result of internalising constructions of
gender, which defines men primarily as worker and their work as potentially
harmful. This was further reinforced when I asked one of the first aid officers, Sue,
what were the more serious injuries sustained in the plant. She replied that,
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(Sue) We have had only one major injury here. One of the boners sustained a stab injury, which affected one of his nerves in his hand. He was right after a while, but was off work for a month and required intensive physio.

All workers spoke highly of this first aid officer commenting that she was able to recognise when injuries required medical treatment. Furthermore, she was an advocate for decreasing light duties for injured workers and instead allowing them to go off on lost time. She was previously a process worker herself who had sustained a shoulder injury, which took several years to heal. For a good part of the year, she was unable to dress herself without pain. She still cannot lift her elbow above shoulder height. Following her rehabilitation, she was re-trained to take on one of the first aid officer positions. When I spoke to her, she was very sympathetic to the injured women workers. When I queried the severity of this injury compared to the many wrist, shoulder and elbow injuries that I had been told about she said that,

(Sue) Yes, I agree with you. But as you know the men do the hard work, the lifting and working with knives. I know that the women get hurt, but it is not the same…

This comment was in direct contradiction with what I had been told by the workers regarding the gendered division of labour in the plant. Unless the workers were talking about the work of injured workers, the overall opinion was that the women’s work was much harder than the men’s. This contradiction in the construction of work is an important point that I will return to later. For now, I want to briefly discuss how the workers viewed the gendered segregation of the plant.

Gendered Segregation of the Poultry Processing Plant

Within the factory there was a strict segregation of jobs by gender as was the norm in all the poultry processing plants that I have dealt with. What is relevant here is the justification given for the need of segregation of some for some of the jobs, as
well as the observation that the jobs, which were exclusively male, included all the mobile jobs and/or the jobs that were done by a small number of workers. That is, the large boning rooms employing up to 100 boners employed women and the smaller boning rooms where there were only six to ten boners employed men. In the plant where the boners were female I was told that this was necessary because,

women are better with their hands and are more careful. Also, women do what they are told, you know, they’re easier to control (pers. comm. Risk Manager, Plant A)

In contrast, where the boners were male, most of the workers accepted that that was the way it should be. They argued that the women could learn to bone if they wanted to,

(Jacqui) But most of the girls don’t want to try, I think because the girls are concerned that they’ll chop their fingers off. The boys are much better with knives and stuff.

While most of the workers agreed that women were not suited to boning or sawing, they could not understand why the men could not help out in other parts of the factory, particularly with the hanging jobs. Hanging is one of the harder jobs in the factory and is considered to be responsible for many of the wrist and shoulder injuries in the plant. In all plants that I have been involved in, this job has been exclusively done by women. When I asked the workers for a possible explanation for why men don’t hang, as this would enable more rotation of jobs, Suzanne’s very sarcastic response was that,

(Suzanne) Women are more fussy about their work. They take more care. And that is your answer. They take more care (very sarcastic). You are a second-class person. No one cares. Just get and do your job and don’t whinge.

All of the women that I spoke to agreed that the women did the harder jobs. “The girls do the harder work” (Therese). “The men don’t work. We do the harder
work” (Donna). They claimed that while jobs were segregated, “the girls often helped the men, but the men refuse to do our jobs” (Therese). I asked Therese if this caused any resentment and she simply responded that “no, that’s just the way it is”. Leslie commented that,

(Lele) We are made to rely on them, even though we really don’t need to. For example, getting stuffing. Sometimes, you are asked, what are you doing that for, that’s a guy’s job. And I say, what does it matter, they’re busy…not. They don’t do anything.

Emma went further and commented that the work that the men carried out was so undemanding that they shouldn’t even get injured,

(Emma) There’s no surprise that the girls are the ones with all the problems. The boys don’t do nothin’ to hurt themselves. I tell you what, some of the jobs they do, I reckon, you know, could be used as an alternate job [light duties]. Like walking about with a little broom picking up, um, you know, they go along cleaning the floor,

and Phillipa claimed that,

(Phillipa) Guys that get injuries, well, it’s usually because they are bloody horsin’ around the place more than anything else. Not many of ‘em get it from lifting too much heavy, heavy gear or anything like that. And the supervisors and stuff, they just let ’em do it.

(Me) I gather from what you’ve said that the supervisors would not treat you the same if you were mucking around and getting injured.

(Phillipa) You wish. The attitude here is discriminatory. Anyone would think we were still in the middle ‘40s. Na, if, to most of them we’re just whinging women. Just havin’ a bitch. Even though they do nothin’ to get injured they get away with it.

Karen confirmed that management was at times very dismissive of the women particularly following an injury,

(Karen) They don’t take you seriously at times. When I fell down a drain, I got told why don’t you watch where you’re going? And when I got hit by a chook, you shouldn’t put your head in the way of the chooks. Shit, you can’t win around here. And when I went in with my wrists strapped, well it’s, here is the fuckin’ invalid.
(Me) Is it the same attitude when the men get injured?

(Karen) Na, they look after their own. When the boys or men get injured, it’s taken more seriously. I mean, they get sent straight up to the nurses. It’s the way it should be. But no, sometimes they get a hard time too because they are supposed to be tough and most of ’em aren’t.

Given the comments regarding the division of labour, I was surprised with the responses above regarding the interpretation of access to workers’ compensation for injured male workers. So far the women had clearly articulated that they were subject to major problems at work, that is, the number of injuries, the severity of injuries and the lack of adequate treatment from health professionals. Moreover, the attitude of the union, the supervisors and WorkCover impacted negatively on the experience of injury for these women. They disagreed with my interpretation of their situation, that their injuries were being ignored and trivialised because they were women via the power of medical discourse to define them as weak and neurotic and via occupational health and safety discourse to judge them against a male norm. For the poultry process workers, RSI was clearly an industrial relations issue and the only solution to making the poultry processing plant safe was for management to change work practices. Their experience of injury was no different from their male colleagues and if anything, the men had a harder time. The main solutions suggested by most of the participants involved putting on more staff, improving rotation and slowing down the belt. The workers recognised that there was a need for better treatment, but this was from the company, not the medical profession. This was evident in their views that it was the occupational health and safety nurse that needed to change her practices such as reviewing the light duties
programme, following through with reported injuries and being more diligent with getting injured workers to medical care.

In contrast, despite the overall view that the company doctor was incompetent, the workers did not have a problem with him. If they felt that they needed more appropriate medical treatment they would go to their own GPs. According to the workers, the medical profession had little to no impact on the recognition and appropriate treatment for RSI. Furthermore, for the women workers, gender, like the medical profession did not influence the experience of injury, despite their acknowledgement that gender at some level impacted on their experience of work. They articulated how the division of labour resulted in women doing the heavier work, the AMIEU was more concerned with the male-dominated red meat industry and the attitude of supervisors and management was discriminatory at times, One interpretation could be that the women were suffering from a “false consciousness” in a Marxian sense. However, utilising the feminist understandings allowed me to move away from an analysis of the poultry process workers’ stories of injury as the narratives of victims, and recognise that while the women workers obviously worked within boundaries that defined them as female they were aware of what those boundaries entailed. This became evident when analysing the women’s interpretation of their colleagues’ injuries. When discussing their colleagues’ injuries, constructions of RSI as an illegitimate disease entity and constructions of RSI sufferers as weak, as malingerers and as bad wives and mothers surfaced. I argue that the women actively disengaged with any debate around gender or around health because arguing that these held the key to addressing the large numbers of
injuries in the poultry processing industry necessitated strategies that questioned their standing as workers with rights to demand access to better working conditions and workers’ compensation once they were injured.

In the next section, I will recount the stories as they are told by colleagues of injured workers. It is important to keep in mind that all the participants in the research, bar one (Cathy), had sustained an RSI during their time as poultry process workers. These narratives allow a deeper explanation of the discourses surrounding the experience of RSI, and allow an understanding of how the women workers engage in constructing their own subjectivity through acquiescing at times and contesting at other times the gendered roles that they have been assigned (Mills 2004). I will explore this in more detail at the end of this chapter.

**Postmodernist Understandings of Gender**

*Constructions of Gender and Injury Experiences*

As I demonstrated earlier in the chapter, many of the workers questioned the legitimacy of RSI and the credibility of the women who claimed to be suffering from a work-related RSI. When asked for their opinions as to why they felt so many workers were reporting injuries, two main reasons were offered. The first reason was that the women were weak, and the second was that they were fabricating the injury. In direct contrast with how the workers had described the pain associated with RSI injuries, Nicola, Georgina and Donna argued that many of the workers just could not handle the bit of pain that is associated with the job,

(Nicola) It’s not that you don’t get sore and that, you just work with it. You see, I can take pain. It’s [not sure where] always sore, but I can work with it. That’s how I wonder how a lot of these with their sore fingers…I reckon it was better before all these light duties came in.
Clashing Narratives: Interpreting Contemporary Experiences of RSI

(Me) What happened then?

(Nicola) You just went on compo…and if you were too long they just put you off. In those days, in those days you worked, I heard that the supervisors said to work your way through it and you did work your way through it. Older people and injuries—understandable; the newer people…have no sympathy for them.

(Georgina) Some people are just stupid; they just don’t watch what they are doing. You may get sore from the big birds…we call them the big bastards…but you’ve just got to keep going.

(Donna) You know some, some of them are genuine, but some it’s just a little pain; you know, they can’t put up with a little bit of pain here and a little bit of pain there. You know they don’t want to work, you see, just put it this way, they don’t want to work hard. That’s why.

While the credibility of women reporting “pain” was not questioned, it was clear from these comments that in order to legitimate oneself as an injured worker, one had to differentiate between normal fatigue and an injury. The women did this by constructing an injured worker as one “who can take pain” in contrast to a weak woman “who can’t put up with a little bit of pain here and a little bit of pain there”. In making this differentiation, the workers articulated acquiescence with the discursive construction of woman as weak when discussing their colleagues’ injuries and at the same time, contested this construction to legitimate their own claims to being an injured worker. For example, when Jacqui is referring to herself and recounting her experience of injury, she claims,

(Jacqui) I’m not a whinger; I’ll wait ’til the last minute before I see the doctor. But if you have hurt a muscle you’re mad not to report it. That is of course, if you need to.

(Me) Do you think that there are a lot of people reporting injuries that are not really injured?

(Jacqui) Yeah. I think so. Like, it could be that your hands are sore but not really sore and any slight little pain and they go up and report it.
(Me) Isn’t that what they are told to do?

(Jacqui) Yes. They are being told to do that. But you know what your limitations are. So if you just get a little pain you can put up with it. Some girls in there can’t. Some nights when you’ve got pins and needles and everything, that’s when you can’t really, some girls just go off for, I think a chat.

Jacqui’s belief that “some girls just go off for a chat” raises the second and more iniquitous argument forwarded by the women regarding the large number of reported injuries. As I established above, being believed was a major issue on the factory floor. I was surprised at how many of the women workers held this belief about their colleagues, given that all, bar one, were suffering or had suffered from similar injuries. The workers clearly articulated that many of the workers simply fabricated their injuries,

(Peta) There’ve been cases of workers abusing the system. Seen out riding horses and throwing around bails of hay and can’t lift 5 kilograms at work. They’re the ones that made it difficult for everyone.

(Jo-Anne) Some people carry on with an injury. Like there was a worker who was on light duties and went off two days before she became permanent and then back on light duties. They know they can get away with it.

(Leslie) A lot of people use and abuse light duties; take advantage of it to do nothing.

(Donna) Some of them, others, you know get it [their injuries] from outside work and when they work, work here, they claim it here. That’s not fair, but it’s true.

I was interested in finding out why the women thought that their colleagues would falsely claim to be injured. Three main reasons were put forward. First, injured workers were considered lazy and saw light duties as a way to “take advantage of it to do nothing” (Leslie). This was sparked off by witnessing other workers gaining from claiming that they were injured. Second, they were protesting against the
company; and third, they wanted to sue the company for financial gain. These reasons aligned very closely with arguments that were presented at the height of the RSI debate in the late eighties and the early nineties where accusations of malingering, compensation neurosis and hysterical contagion were at the forefront of the explanations for the large numbers of RSI claims. For example, when I asked Vivien, who worked part time as a first aid worker and part time as a process worker whether she was seeing many workers who she thought were “putting on injuries” she answered “no, if there are, it would only be a small percentage” (Vivien). However, she then went on to say,

(Varient) There is so much on television these days; therefore it is easy to make up signs and symptoms. I know we get girls up here from time to time, but I can’t say they’re not hurting, I can’t say they haven’t got an injury. But I would say that some people cope with pain better than others and some, well some see their friends taking it easy and think, well I’m hurting like they are, I shouldn’t have to do all the heavy work.

Similarly, Margaret claimed that some of the girls are led to believe that their aches and pains are the result of an injury by their co-workers and they use it as an excuse to skive off work and get back at the supervisors,

(Margaret) [When I went up for a rub] I couldn’t believe the amount of people coming in and out. They were in and out. Yeah, I was surprised that they whinge about the slightest little aches, you know, it’s not that I don’t want to believe them, but it’s not fair on us workers that are really hurting or on us that have to carry them just because they’re pissed off with the supervisors or what not and want to skive off of work. You know, I think that they just egg each other on. Like, there are a lot more now than say a year ago. Not sure why, maybe the bigger kill, maybe the change in supervisors.

94 This argument was a common one among management and aligns with Lucire Yolande’s comment that “the powerless and dependent….and those who otherwise cannot express their righteous rage at their supervisors, employers and spouses, resort to…their exquisitely symbolic pain and incapacity as a mode of communication of their distress (See Chapter 2; Lucire 1986: 325 for the original quote). The CEO of Plant A simply stated that “there is no point to your research, they are simply protest injuries”.

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Even the workers who had had operations for their injuries and were returning to work via a light duties programme were at times considered to be malingering. When Karen was commenting about how the company expects too much from the girls who were hurting she claimed,

(Karen) I’ve seen a lot of girls on the floor this morning and they really should not be here, they should go off, but they won’t. They just think/say production, production, production. It’s just production before humans.

(Me) Sorry I’m a bit confused. Who won’t go off, the girls or the company won’t allow them to go off on a lost time injury?

(Karen) The company understandably wants to get its production out. But some of these girls that have had operations, when I had my operation I wanted to get better, get back. A lot of these girls that have had these operations are not too keen to get back to work.

(Me) Some of the workers are saying that they are coming back too early from their operations and that they have not had time to heal properly.

(Karen) Well, don’t get me started on those. Not being rude, but some of the girls just play on their operation. Some are drama queens, oh look at me, I’ve had an operation and like, love the attention and others well, like they want to make [name of company] pay. I hate having to carry these people on light duties when there is nothing wrong with them, especially when you’re flat out, and they just won’t put in the effort.

As was the case with Jacqui above, Karen’s reading of her colleagues’ injuries compared to her own articulated a clear demarcation between the construction of herself as injured, that is, as an honest and hard working worker; compared with the dishonest women who are just out “to get back at the company and make a profit doing it” (Jane),

(Karen) I, when I was injured, well, I couldn’t work. And there are times when if you can’t work, you can’t work. But that’s only when the pain is so bad. I believe in doing my work, doing my fair share. It’s workers like me that get injured because we’re, we have to carry all those bitches who don’t want to work, you know who are like little fairies going ha ha ha, I’m sore.
In a slightly different vein, the third reason expressed by many of the workers was the desire for compensation. The argument presented by Bronwyn is very similar to those proposed by the proponents of the compensation neurosis thesis at the height of the RSI debate,

(Bronwyn) I’ll give you one example, one girl who was doing male work and she was exceptionally good at the task, and then she did sustain a long term injury. She was offered alternate work in the plant…she was offered a number of jobs a number of times and refused of course, she was going down in status and of course going down in money. It eventually went to court, common law court, because she was unable to continue with work and eventually got a huge payout which I felt was somewhat unfair to the industry because they were in a real bind because they couldn’t sack her because the work was unsuited to her current status because that would incur all sorts of union activity….they did pay out, she, this girl got a house and possibly a car. Between her going away and the court case was five or six years and as soon as she got the money she was able to do whatever she wanted.

Clearly, these reasons aligned closely with those that were presented at the height of the RSI debate in the late 1980s and the early 1990s. According to the injured workers’ colleagues, the women who were presenting with symptoms of RSI were considered to be either physically or emotionally unable to cope with the work required of them in the poultry industry. However, while there were allusions to hysterical contagion as in Margaret’s comment that “they just egg each other on” and Vivien’s belief that workers are “just taking it easy” in reaction to their friends’ behaviour, and accusations of compensation neurosis as in Bronwyn’s articulation of the worker who retired comfortably on a pay-out after she refused alternative work, the construction of the injured worker as hysterical woman was largely absent from the narratives.

In particular, there was no indication that the large numbers of injuries were considered to be an example of mass hysteria. It was becoming very clear that there was a significant inconsistency with what had been reported in the literature in the
1980s and the 1990s and what the experience of RSI was for poultry process workers at the turn of the 21st century. My argument that the power of medical discourse to define women as neurotic resulted in incorrect diagnoses and lack of appropriate treatment was not substantiated by the women that I had interviewed. If the credibility of the injury was questioned on the basis of neurosis it “comes from within the women workers themselves” as Bronwyn stated. She then goes on to say,

(Bronwyn) That is not a work thing; there is nothing that the company can do about that. The doctors and the company do their best to do the right thing by the girls, like what I said before about that live bay worker [see quote immediately above]. She was offered alternative work but didn’t take it on. There is a problem [at this factory] because there are so many incentives for the girls to stay even if they are injured. The doctor is here this morning trying to put some sense into about six of the workers that they should not be in this industry and that they should look for work elsewhere. But the girls won’t listen. How can the company improve if these girls won’t consider stepping down? The ethos then is to go on compo rather than step down.

From Bronwyn’s comments here it was clear that while the construction of woman as hysterical was not visible, the construction of woman as worker became very tenuous once a woman became injured. Bronwyn’s conviction that the “girls should just step down” was one that was echoed by many of the women when I asked what should be done with workers who sustain a long-term injury. It was in the treatment and the rehabilitation of long-term injuries where the opinions of the treating medical professionals and the “other” injured workers concurred and the construction of woman as primarily wife and mother became prominent. This was most obvious in many of the women’s and doctors’ convictions that long-term injured workers should look for employment elsewhere or leave the workforce altogether. While I do not dismiss the plausibility of this as a reasonable medical plan of action for chronically injured workers, the lack of any discussion around workers’ compensation, rehabilitation or retraining coupled with the unproblematic
assumptions that women do not need an independent income nor are entitled to disability payouts raises doubts as to women’s position as full industrial citizens. As can be seen from my conversation with Nicola below, dealing with chronic injuries focused on what the women themselves should do and not on what the industry or company needed to do to clean up the hazardous workplace. Furthermore, it is clear from this conversation that chronically injured workers were no longer classified as worker but as woman,

(Me) What strategies do you think [the company] could put in place to deal with the large number of workers that are chronically injured or have been on light duties for a long length of time?

(Nicola) I…I believe that if you are married and if you, you know, have another income coming in and if you can’t do the job, you know, there is a time and a place, there’ll be a time and a place for me when I can’t work anymore. And I’ll have to leave and that’s what I reckon that they should do.

(Me) But these women need to work, and it is the work that has injured them, shouldn’t the company take some of the responsibility?

(Nicola) Some people take on too much. They depend on two wages and you can’t, you shouldn’t depend on two wages, you should only depend on your husband’s, in case something like this happens. I’ve got to put up with it, I’ve got one wage and I’ve got to live on it.

(Me) A lot of women are in your situation. They are the sole wage earners for the family…

(Nicola) They take on too much, and then when they go on, when something goes wrong they’re in a panic.

The dismissal of the need to earn money, even from a sole wage earner was an argument presented by many of the workers. Women’s decisions to take on light duties even when injured were often construed as “being greedy” (Leslie). These stories moved the discussion of injury causation from an issue of work organisation to one which questioned women’s ability to manage their domestic and work lives.
According to many of the workers, becoming injured was a clear indication that women could not cope with work and the only reason they did was for financial gain. For example, Kirsten and Jo-Anne state that,

(Kirsten) Injuries are difficult to control because the girls out there are wanting or demanding to work longer than they should.

(Jo-Anne) And for a lot of these girls, it comes down to, do you like the work or do you like the money that is paid for that particular work that you are doing. I’d say it isn’t the work.

When I suggested to some of the workers that maybe this was not an issue of women’s right to employment, but rather should be looked at in terms of what the company should or could do, Therese responded,

(Therese) Well yes and no. But, once they are injured they keep working until they get the money and then they retire on the money and that is what they aim to do. Some people, I, there was a girl and I tried to, and so did some of the other workers to consider her long term health rather than a few extra dollars. But she wouldn’t she felt that she was at a place of work and that she wasn’t going to lose that.

(Me) I would have thought that that was fair enough. To me, one of the big problems is that the industry is not recognised as the heavy industry that it is.

(Therese) To me it is, it is. But if you ask these girls they say that it is not too bad. But they don’t think. I don’t know, the dollar sign to me seems to be getting more important these days for the girls. They want this and they want that and they know the only way they are going to get it is to work for it.

These narratives are clearly based on the assumption that women do not need to work and when they do it is simply for pin money. This assumption was further reinforced when women’s role as wife and mother was used as a justification for why women should not continue to work. For example, Vivien and Leslie argued,

(Vivien) I had two children and I accepted that I had to look after them. My children were in bed. They did their homework. I got my husband off, etc, etc, etc. I was always there for my children…I was missing through the night
but there was rarely anything that my husband had to attend to. These girls that sort of work through the day, they want day work and therefore that’s all they can get. These ladies have to take childcare, they have no option, they have to take one that opens at 6. It’s all because there is something that they need and they know that they can work and get it. The cost in the long run is high. The older mums helped out the kids more and the younger mums thought they’d go to work.

(Leslie) I mean some children go into childcare at half past six here and even earlier if they can get them in. Well then those mothers are tired. Then half past six until about midday or ten past six until twenty to three. Then they go and pick up those children. These children are probably, could be sick, tired or something else. It’s a lot. It really is a lot to ask of the kids.

Interestingly, Leslie continued immediately on with “another problem down there are the badly placed switches. Someone is really going to hurt themselves one day.”

Denying the definition of women as worker was not an issue at the plant until a woman was injured, and this move in the construction of able-bodied worker to injured woman was not lost on the workers. Tracy clearly articulates the consequences of sustaining a long-term injury,

(Tracy) I used to cry all the time because I just didn’t fit in and because like I said I’ve been here for years and got on well with everyone and all of a sudden I just didn’t fit in, that’s hard on your head. Because you classify yourself as a worker and all of a sudden your workers, you know, your workmates don’t think you’re a worker, that’s pretty hard to cope with. And like I said even though I have been off light duties for a while now, and someone says that to me, they thought that I would be here forever and do nothing like I always do, you know what I mean. So you just...even once you’re back you still don’t ever lose it. Yeah, everyone hates ya, treats you so bad and you just feel, it is so hard to find the words. I’ve cried many a day coming to work because its bad enough being in pain but the fact that no-one ever believes you, even your workmates don’t believe you. And I’ve had pictures, the ultra sound thing, and reading it with a letter from the doctor, so I could have well ripped it out and shown anyone but it didn’t matter.

The shift in definition from worker to injured woman was also evident in the stories of the long-term injured and their doctors. Phillippa was one of the workers who
the doctor was “trying to put some sense into” (see Bronwyn above). According to

Phillippa,

(Phillipa) I was told that I didn’t have tennis elbow but he [the doctor] didn’t
examine me. So ’um I was actually told this morning that I should look for
other work ’cause I am obviously not suited to this type of work here. There is
no talk of re-training. That’s easy for him to say. I have actually been looking
for something else, but where am I going to get another job with my injuries?
You know I was a machinist for 17 years.

Another worker was told,

(Jane) He just told me to go and get another job and when I said that they are
laying off all over the place, that it is not that easy he said well don’t you have
a husband. I thought he was gonna’ say a pretty little thing like you, but be
didn’t but that’s what he meant, like didn’t he, like why else would he of asked
me if I had a husband? This fuckin’ company, treat you like shit and then
when you can’t work like a dog anymore they send you off home.

(Me) Are you currently on a workers’ comp claim?

(Jane) Huh. What a joke. He told me that I didn’t have an injury and that this
industry is just too heavy for me, maybe I should go and get an easier job. But
here pays well, and I need the money.

(Me) Does the doctor make the decision whether you stay or go?

(Jane) As far as I know, yeah. Anyway, if he says I’m not injured, they won’t
let me stay on light duties and there’s no way I could handle full duties with
the pain like it is, so I guess, yes, I’d just have to go. He’s just a company
lackey, he just says what they want to hear.

Jane’s story highlights the complexity of the discourses surrounding the recognition
and treatment of RSI. As was the case in the 1980s and the 1990s, women’s
physical, social and psychological ability to cope with the demands of the
workplace is at the forefront of understanding contemporary experiences of RSI. A
key difference, however, is the role that medical discourse plays in that
understanding. In my reading of the RSI debate, I ascertained that medical
discourse’s power to define women as neurotic was central to understanding why so
many women’s injuries were not being acknowledged. However, from the interviews that I conducted it was clear that this was not a core part of the experience of not being believed and receiving adequate treatment for contemporary workers. Injured women were not being labeled neurotic nor were they being told that they thought that they were injured because their “maternal instinct made [them] want to stay home”. As was the case in the 1980s and the 1990s they were being told that they were not suited to the industry because they were either physically not capable of carrying out the tasks demanded of them, or that they were malingering as a protest against the company or simply because they were lazy. Similarly, the workers’ roles as wives and mothers were unquestionably drawn upon when dealing with chronic injuries where women were simply advised to leave the industry once they were injured. Workers who pursued claims were considered undeserving. For the women, who were not wives and mothers, their greed for income and their weak bodies were considered the source of their injuries. In both instances, women, once they were injured were not considered to be workers. That is, discussions around compensation, rehabilitation, re-training and disability payouts were absent from all conversations regarding treatment for long term injuries.

Furthermore, these narratives demonstrate the changing discourses surrounding gender. In the 1980s and the 1990s, medical discourse’s power to define women as psychologically frail was taken up by occupational health and safety discourse to dismiss the large number of claims being made by women workers. By the turn of the 21st century, medical discourse’s power to define women as neurotic was waning; however, discursive constructions of femininity continue to define women
as weak and as primarily wives and mothers. While there was a major shift in the belief that RSI was the result of women’s psychological frailty, constructions of femininity still inform how women’s occupational health and safety needs can be addressed.

This is not to suggest, however, that women are powerless in all of this. While many of the narratives presented in this chapter demonstrate acquiescence with the dominant constructions of gender from both the medical profession and the workers themselves, sites of negotiation and contestation were apparent. This was most apparent when women actively disengaged with any debate around gender or around health in order to be able to negotiate better outcomes for their injuries.

*Negotiating Outcomes: Subjectivity and Resistance*

I would like to return to Judy’s story presented at the beginning of the chapter when I asked her when she first reported her wrist injury. Rather than responding from the time that she first felt pain (as I would have expected), she dated her injury back to the time that she started working. This response was very common from many of the women. After hearing it a couple of times I asked Therese why she stated that her injury was twelve months old rather than the three months since she said that the tingling started,

(Therese) From the day you step in here your body starts to deteriorate…and anyway how would you know when it started...it goes over a period of time…the doctors don’t know and anyway can’t do nothin’ about it. It’s not up to them anyway, the arseholes that run this company need to…you know, don’t they have a duty of care?
Similarly, Kirsten and Emma argued that the doctors were not responsible and that the company simply used them to get rid of the workers, who could not keep up with production,

(Kirsten) I think that [Company’s name] just wants the surgeons to fix us up and then send us on our way…means that they don’t need to look at themselves eh? And if the surgeons can’t fix us, the doctors just tell us to find other work. Where do they expect us to go?

(Emma) We’re just seen as a bunch of whingers …you know can’t take a bit of pain. Great excuse, they will just have to get over it and you know it is up to them to fix the problem not us.

Helen draws attention to the role she feels the doctor and company play in the recognition and treatment of injuries, and argues that the company is more than aware that the women need the work which is why they do not need to clean up the workplace,

(Helen) You know most of us can’t leave, either because we are single or our hubby’s don’t make that much either, or we are on our own with kids. I think that they know that, and that is why they treat us like shit. If they really want to get rid of us, they just send us to the doctor who tells us we’re not suited.

From Helen’s comment it is very clear why the women workers steered clear of any discussion of their injuries being related to their health. She continues,

(Helen) No, I tell you what, that is what they think. They want the doctors to act, actually they expect the doctors to tell them what they, this is the truth and that is that we are just a bunch of wingers, a bunch of bitches that should just shut up. If we can’t stand the heat we should get outta the kitchen…you know what I mean?... They’ve got to think what they’re doing. I mean they can’t expect us to, to work in there as we do, and as hard as we do and not get hurt, it’s ridiculous, I mean we’re not robots…they get maintenance in there every half an hour to fix the machines, I mean the machines can’t keep up with it and they expect us to, it’s ridiculous. And the doctor will come up some balony like we aren’t suited to the industry. Come up with some balony like that we’re not strong enough!!!
Conclusion

Understanding how the women negotiated their injuries allows an insight into the changing discourses surrounding gender. I would argue that the stories presented here clearly demonstrate how occupational health and safety discourse has incorporated medical discourse’s view of women and uses it to ignore the injuries that are sustained within the poultry processing industry. However, medicine’s definition of women as neurotic is not significant here, but constructions of women as wife and mother and as weak compared to men were still consistently drawn on to explain the large numbers of injuries found at the plant. As was the case in the RSI debate of the 1980s and the 1990s and in the history of women and medicine definitions of gender as espoused by medical discourse continue to be powerful in determining social reality. In the words of Tracy,

(Tracy) You know we’re stuck between a rock and a hard place once the pain won’t stop. Management just ignores us and sends us to the doctors and the doctors just tell us to go home or get another job!

This brings me back to the over arching question of the thesis regarding how to conceptualise gender within occupational health and safety research to obtain a meaningful understanding of women’s health concerns at work. In order to fully understand the impact that gender has on the experience of injury, an eclectic approach that draws on both modernist and postmodernist forms of inquiry is necessary. This allows us to name gender as the problem as well as allowing us to deconstruct the binary divisions of gender which only allows a narrow understanding of women’s health compared to men’s. This is the discussion developed in the next chapter.
CHAPTER SEVEN

ENGENDERING OCCUPATIONAL HEALTH AND SAFETY

Gender is so deeply embedded in our lives because it is a social institution. It creates structure and stability, seeps into the practices of many social roles, has a long history, and is virtually unquestioned. Institutionalized patterns of acting and thinking are learned so early and reinforced that they seem impervious to change (Lorber 2006: 471)

(Tracy) You know we’re stuck between a rock and a hard place once the pain won’t stop. Management just ignores us and sends us to the doctors and the doctors just tell us to go home or get another job!

Introduction

The aim of this discussion is to return to the central question of the thesis: is gender a useful analytical category in understanding the lived experiences of contemporary poultry process workers currently suffering from RSI. In addressing this question, I will revisit the discussions around RSI drawing on the injured poultry process workers’ insights to offer an alternative reading of this significant occupational concern for women. I maintain that gender is indeed a necessary category with which to analyse the lived experience of both women and men. If we do not grapple with the complexities of gender, we will fail to fully realise the effect that gender has on the health of women and men at work. As demonstrated by the women’s stories and their lived experiences of RSI, this failure has very practical and material ramifications for women sustaining injuries in the poultry processing industry.
Incorporating gender into occupational health and safety research is not a simple task. I contend that in order to make gender a meaningful analytical category it needs to be re-conceptualised in light of insights offered by postmodernism. Specifically, the notion of patriarchy, that is the dominance of men and masculinity over women and femininity needs to be broadened to include not only patriarchy as structure but also patriarchy as discourse. By this I mean that we need to move beyond the binary division of gender embedded in occupational health and safety discourse and medical discourse because it can only offer a narrow understanding of women’s experience, that is, experiences that can be compared to those of men.

To move beyond the binary divisions we need to draw on postmodernist insights and make visible the hegemonic discourses that shape men’s and women’s lives. If not, we will be unable to meaningfully research difference in occupational health and safety. As Deborah Lupton (2003: 174) asserts, postmodernist perspectives provide an opportunity for alternative ways of thinking and speaking that avoid taken-for-granted assumptions and stereotypes. For both male and female workers, this means deconstructing the binary opposites of man/worker/strong/protector and woman/mother/weak/protected, and challenging the constitution of the norm as male. Modernisms framework of binary divisions positions the male as norm in occupational health and safety research, that is, the “normal body” and/or the “normal worker”. This limits recognition of women’s experiences to aspects that can be perceived as the same as, or different from, the male norm. Thus research investigating women’s relationship to the work process that relies on this framework will continue to result in the marginalisation of women. Both the occupational health and safety discourse and medical discourse constituting the RSI debate drew
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on the modernist framework. The result was that women were either ignored in discussions about RSI and a focus was placed on the changing work processes in industrial capitalism, or they were the centre of analysis and their biological, social and perceived psychological differences to men became the focus of the research.

There are some benefits for women in ignoring difference. According to Allison Hepler (2000: 5) ignoring difference allows women to combat the institutionalised inequality and compete with men in the workplace. However, she argues that defining women by male norms simply allows women equal rights to a hazardous workplace and given that women are ignored in research, this equates with invisibility. Furthermore, this means that the workplace itself remains hazardous. On the other hand, centralising difference allows an examination of women’s biological and social differences to men; however, this has been used to justify ‘protecting’ women out of certain jobs. Specifically, as with the case of RSI, when women’s occupational health and safety needs have been recognised, their biological and social reproductive functions and psyches have been at the centre of research.

This brings me to some central thesis theoretical considerations. My research and research experiences indicate that to meaningfully understand women’s occupational health and safety needs we need to move beyond the same/difference questions in relation to men (Bacchi 1990, Eveline and Bacchi 2005). Questioning the binary oppositions undermines universal assumptions about men and women, such as men are rational, women irrational and allows us to question the taken-for-granted understandings we hold about gender. However, this also undermines
patriarchy as a concept and raises the question of whether we can speak about women (or men) as a group. I contend as does Annette Scambler (1998: 101), that the deconstruction of the categories of men and women negates the “underlying realit[y]…[that] many complex and gendered social structures survive…deconstruction”. In other words, in order to understand the experiences of men and women we must not reject causality and reference to structures. In the words of Annette Scambler (1998: 197), what is needed is:

a strong modernism, reinforced by the insights of discourse analysis, [which] offers both an appreciation of difference and a structural theory of a patriarchy which is pervasive but chameleon-like in its effects.

Drawing on both modernist and postmodernist constructions of gender allows an understanding of both the gendered structures and the hegemonic discourses that surround occupational injury for both men and women. In the next sections I highlight what RSI looks like using both modernist “patriarchy as structure” and postmodernist “patriarchy as discourse” methods of inquiry. Using both methods of inquiry allows me to use the modernist category of gender and speak about women as a group without reference to men as a group, thus undermining the binary logic which situates gender categories as normal and natural. At the same time, it allows me to explore the gendered discourses that influence the experience of RSI for women workers. Examining RSI in this way will highlight the gendered material structures that require change to improve women’s health at work and the discursive structures in which gender is done (West and Zimmerman 2003). Understanding how we “do gender” in material structures and discourses allows an understanding of how gender is produced and reproduced and enables us to consider how we would like it produced or created in a different way (DiPalma and Ferguson 2006).
Modernism: Patriarchy as Structure

A modernist perspective allows gender to be named as the problem. This recognition acknowledges that gender shapes women’s and men’s opportunities in life and that the major social institutions of control such as medicine treat women and men differently (Lorber and Moore 2002; Lorber and Farrell 1991; Chapter Three). Using a modernist conceptualisation of gender allows researchers to take into account the experiences of work and injury of women as a group and/or men as a group and to ask how did it come to be this way and how could it be done differently. As Karen Messing et al (2003) argue, in order to fully understand women’s (and men’s) occupational health, we need to know what the job assignments and occupational exposures are for each group of workers. Furthermore, we need to understand differences in responses to exposures using both sex and gender as analytical categories. For me, the importance of this is not to compare men to women or vice versa but to recognise the impact that gendered structures have on all of our lives.

In the case of RSI, using gender as a modernist analytical category allowed me to move away from the question of why there are more women than men making claims for RSI to what it is about women’s work experience that results in such a large number of RSI injuries. To do this an examination of the gendered structures that surround the experience of injury for women at work was needed. For example, job segregation and crowding, lack of access to union representation, lack of access to workers’ compensation and rehabilitation, lack of access to appropriate on-site medical treatment for injuries and policy and legislation all impact on injured poultry process workers’ ability to have their injuries acknowledged and
appropriately treated. I will briefly revisit each of these in turn to show how women as a group have specific concerns at work that impact on their experience of injury.

The gendered segregation of the workplace means that women are exposed to a particular set of hazards. Women tend to be crowded into a small number of jobs. Many of these jobs are lower status, sedentary and involve repetitive work and static load which are all attributes known to carry a high risk of RSI (Strazdins and Bammer 2004: 998; Messing et al 2003). Women’s propensity to suffer from RSI therefore can be understood by their exposure to certain hazards that result in RSI injuries. The women workers who I spoke to clearly linked the type of work that they did with their injuries,

(Therese) From the day you step in here your body starts to deteriorate…

(Judy) they know that they are a 60% injury rate company… I mean, there’s, you’d probably find 20% of the girls in there probably never had a problem with their hands and you’d be lucky to get that many.

This higher exposure to RSI risk is compounded by the demands made of women in the domestic sphere. Employed married women report spending on average 20.8 hours on domestic tasks each week (Blau et al 2002: 57). Ulf Lundberg and Marianne Frankenhaeuser (1999) suggest that the ‘time poverty’ experienced by women results in the inability to take time for leisure, relaxation and exercise which impairs recovery from musculoskeletal disorders (MSD/RSI). This was borne out in the interviews with Tracy stating,

(Tracy) You know I start here often at six and then, you know, I finish about three and the kids are home and they need this and they need that and you know I’m not the only one. Most of us never get the chance to wipe our bums or pick our noses, if you know what I mean…so whether you’re sore or not, it makes no difference.
Another gendered structure that impacts on the poultry process workers’ experience of injury is the lack of attention paid to the white meat industry by the union. In contrast to the literature which argues that women do not have access to good occupational health and safety because they tend to be employed in non-unionised industries or are employed in part-time or precarious employment (Ratcliff 2002), the women in this study were members of a strong union, the AMIEU (The Australasian Meat Industry Employees Union). However, this did not translate into strong representation for the women workers suffering from RSI. It was clear in many of the women’s accounts that it was because they were in a female dominated industry that the AMIEU ignored their concerns,

(Vivien) Well, the unions are strong to a point. And I’d like to stop there. But I do feel that the unions could do a bit more and they should get behind the girls, ’cause the girls are paying $220 a year. And they’re not being heard….They [the union] think what have we got to strike about?

Another important aspect that impacted on the ability for the poultry process workers in this study to have their injuries recognised was access to treatment, rehabilitation and compensation. Women spoke about not being believed and about not being offered workers’ compensation, rehabilitation or training,

(Jacqui) WorkCover often does not believe you. I went in once and they didn’t believe that the type of job that I was doing would result in a tennis elbow.

(Phillipa) I was told that I didn’t have tennis elbow but he [the doctor] didn’t examine me. So ’um I was actually told this morning that I should look for other work ’cause I am obviously not suited to this type of work here. There is no talk of re-training. That’s easy for him to say.

Furthermore, there were many claims that were being rejected,

(Therese) I have heard that a lot [claims] out there don’t get covered. My last injury was knocked back because I saw my own doctor.

More recent research confirms that women continue to have their claims rejected.

Katherine Lippel’s (2003) Canadian study indicates that women’s claims continue
to be rejected. A 2006 World Health Organisation (WHO) report claims that in Sweden 77.2% of women’s work-related compensation claims are rejected (Messing and Östlin 2006: 14). The constant and consistent rejection of claims indicates that women’s experience of injury continues to go unrecognised.

As highlighted by Jacqui, Phillipa and Therese claims being rejected was clearly based on not being believed which continues to be a core concern for women suffering from RSI. Furthermore, the belief that women’s work is light was articulated by Jacqui when she was attempting to negotiate light duties with the on-site doctor,

(Jacqui) The doctor didn’t put me on light duties because he considers the job that I am doing light. I think that I should of gone on light duties and said so, but he didn’t agree.

The belief that women only work in light occupations can be traced to the establishment of contemporary occupational health and safety discourse in Australia. Women’s entry into occupational health and safety discourse in Australia was via a protectionist discourse which results in the belief that women are protected from the harms of the workplace and therefore do not get hurt at work. Legislative decisions regarding women’s health at work were informed by dominant definitions of femininity which defined women as weak, as capable of doing repetitive work, and as primarily wives and mothers. Significantly, women did not enter occupational health and safety discourse as workers. This not only had a major impact on how women’s occupational health and safety can be researched, it also constrained the types of work that were considered suitable for women.
This understanding of the gendered structures that surround women’s experience at work is a necessary first step to make women’s occupational health and safety needs visible. Modernist understandings offer an interpretation of the reality of women’s lives at work and allow alternative realities to be envisaged. However, I would argue that care needs to be taken not to fall into the trap of simply comparing women’s experience to men’s.

To illustrate, the disbelief by the unions, WorkCover, management and the medical profession that the women were subjected to hazardous working conditions needs to be addressed. However, if this requirement is couched in terms that compares male and female workers, for example comparing the experiences of women in the white meat industry to men in the red meat industry, the poultry process workers’ needs will continued to be ignored. Framing research around “women (men) are hurt too” will not be of benefit to women or men. Statements such as this reflect the binary logic that situates the category ‘woman’ as dependent on the category ‘man’, but are not useful in understanding the real life experiences of women working in the poultry processing industry (see Chapter Three). This was evident in the discussions surrounding RSI in the 1980s and 1990s and currently, where modernist conceptualisations of gender were used to discredit RSI as an occupational injury and sufferers of RSI as either neurotic or weak.

This is where a postmodernist conceptualisation of gender can provide richness and depth to the discussions surrounding RSI. Questioning how certain knowledges and truths come to be legitimated and what effects these truths have at the level of material structures and at the level of subjectivity deepens and expands our
understanding of certain phenomena (Zaleweski 2000). The modernist reading of RSI as an occupational injury for women can be supplemented by postmodernist insights to understand how gendered discourses shape our understanding of RSI and sufferers of RSI. Furthermore, the voices of the injured poultry process workers can reveal how these hegemonic discourses are currently played out in contemporary experiences of RSI, thus providing valuable insights into the ongoing debate.

Before I look at how a discursive reading builds on the modernist reading, I would like to revisit some of the basic tenets of postmodernist thought that have been used in this analysis.

Postmodernism: Patriarchy as Discourse

Foucault’s notion of discourse demonstrates how powerful institutions such as medicine have the power to define what is normal and what is not. In contrast to the Marxist notion of ideology where power is conceived as “duping” individuals into conceptual systems not in their interests (Mills 2004: 27), Foucault’s notion of discourse allows an understanding of how individuals actively participate in the creation of their own subjectivity. That is, according to Foucault, power is not something that we have or accumulate but it is “a multiplicity of effects through which being and identity is situated and known” (Gatens 1996: 149). This productive view of power necessarily entails room for contestation and negotiation of dominant thought. In the next section, I will draw on these three core aspects of Foucault’s thought to offer an additional reading of RSI.

Medical discourse produces, legitimises and maintains knowledge surrounding occupational injuries and disease as well as other social phenomena. It also allows occupational health and safety discourse to produce, legitimise and perpetuate
knowledge about injured women workers. In particular both medical and occupational health and safety discourses draw on patriarchal discourses to generate understandings of gender. While Foucault’s thought is invaluable in understanding the productive capacity of discursive structures, he focused only on discursive structures linked to institutions thus ignoring those surrounding masculinity and femininity. Combining discourse to modernist structuralist ideas such as patriarchy can provide new insights. Making the hegemonic discourse of patriarchy visible allows an understanding of how our institutions draw on and perpetuate understandings of gender. It also allows an understanding of how patriarchy continues to produce a range of different effects at the individual level, in particular male and female subjectivities.

Foucault’s notion of knowledge/power sees individuals actively working out their subject positions and roles in the process of negotiating discursive constraints. This insight, coupled with Candice West and Don Zimmerman’s (2003) notion of “doing gender” allows us to move away from reading the women’s stories as the narratives of passive victims to one where the women were active in the construction of themselves as injured workers requiring attention.

Foucault also shows that discourses are not stable and fixed but are fluid and contingent. This fluidity and discourses working can be seen in the tensions between the women’s understanding of their injuries and my interpretation of their injuries and experiences. The tension was based on our different readings of the role that gender played in our understanding of RSI. This tension highlights how discourses surrounding gender are fluid and contingent. For example this can be
seen in the waning of the power of medical discourse to define sufferers of RSI as neurotic and the epidemic of RSI as an example of mass hysteria as was the case in the 1980s and 1990s. However, gendered discourses remain powerful and exploring the gendered nature of discourses can be useful in furthering our understanding of occupational injury.

In Chapter Four I argued that women entered occupational health and safety discourse via protection. Women workers were considered to be protected from the hazards of industry and their roles as wives and mothers were central to any occupational concern. Medicine became the only official voice that could speak about occupational health and safety (Williams 1997). The entry of medicine as the only official voice that can speak about injury and disease at work has a very different impact depending on whether the injured worker is a man or a woman. Insights from postmodernism offer an explanation.

As Michel Foucault (1973) argued, medical discourse has the power to define not only what constitutes illness and disease, but it also has the power to define other social realities. Gender is one such reality. The intersection between medicine and gender has resulted in women being labelled neurotic when presenting with an injury that had an obscure aetiology. According to Dorothy Broom (1995: 103),

Definitions of health and illness, and the actual practices involved in recruiting and training medical personnel and delivering medical care are shaped by ideas about gender, ideas about the ‘natures’ of women and men, and by the norms and patterns of social life that structure relations between the sexes. Through these processes, medicine becomes not a gender-neutral applied science, but an institutional part of the gender order which is at once influenced by, and in turn influences the ideologies and lived experiences of femininity and masculinity. It also has the unintended consequences for the experience and management of health and illness.
Because medicine was unable to find an organic basis for RSI, an alternative account was required to explain the large numbers of workers claiming to be suffering from this injury. Drawing on medical discourse’s construction of women as weak, able to do repetitive work and hysterical, occupational health and safety discourse was able to dismiss RSI as a genuine occupational injury, and rather put it down to women’s psychiatric or psychological problems linked to their biological and social reproductive roles. Diagnosing women with psychiatric illness when the aetiology is obscure continues to be evident in current conditions such as chronic fatigue syndrome and multiple sclerosis (Richman et al 2000).

While RSI had the potential to put women within occupational health and safety discourse because a broader definition of woman was needed other than mother and reproducer, the introduction of medical discourse as the expert discourse within occupational health and safety precluded this. As Dorothy Broom contends above, medicine draws on constructions of gender to understand illness and disease and then via its power as an institution perpetrates those constructions. Those who stood to lose the most from the massive increases in RSI injury claims, that is, employers, insurance companies and the government readily accepted the hegemonic discourse of women as neurotic.

However, my interview data showed constructions of women as neurotic were only visible via some comments from management. For example a risk manager from one of the plants where I did not get access stated that what was needed to curb the large numbers of injuries in the poultry processing industry was for the injured women to see “a psychiatrist to set some of these whingers back on track” (pers.
comm. Risk Manager Plant A). The women themselves denied that they were being defined as neurotic or that their injuries were not being taken seriously by the doctors. I will return to this point below when I discuss the injured women workers actively constructing their identities as workers through contesting a health definition of RSI (as opposed to a work definition). For now, I would like to revisit the injured women workers’ narratives to make visible the patriarchal discourses surrounding contemporary experiences of RSI.

In the case of RSI, making the hegemonic discourses of patriarchy visible allows an understanding that patriarchy continues to produce a range of effects at the individual level. This was clear in the injured women’s narratives when dominant definitions of woman came to the fore when speaking about women’s relationship to work. The first quote questions the need for women to work and the second questions the right for mothers to work,

(Therese) I don’t know, the dollar sign to me seems to be getting more important these days for the girls. They want this and they want that and they know the only way they are going to get it is to work for it.

(Vivien) I had two children and I accepted that I had to look after them. My children were in bed. They did their homework. I got my husband off, etc, etc, etc. I was always there for my children...I was missing through the night but there was rarely anything that my husband had to attend to. These girls that sort of work through the day, they want day work and therefore that’s all they can get. These ladies have to take childcare, they have no option, they have to take one that opens at 6. It’s all because there is something that they need and they know that they can work and get it. The cost in the long run is high.

The hegemonic discourses surrounding gender were also visible when the women workers spoke about their male colleagues,

(Jane) As I said before I think that the union here is good. The only reason that it may not work well is because it is trying to deal, I mean work with a bunch of whingers. You know what women are like… And the boys they get it harder. It is much harder for them to get compo. They get the harder time and yet do the more hard work, the lifting and the rest. Most of ‘em are young now,
but, but they will be needing to think about supporting families, you know what happens if they can’t work?

(Sue) But as you know the men do the hard work, the lifting and working with knives. I know that the women get hurt, but it is not the same…

Furthermore they were clear from the treating doctors and management when injured women workers were not offered compensation, rehabilitation or re-training,

(Phillipa) I was told that I didn’t have tennis elbow but he [the doctor] didn’t examine me. So ’um I was actually told this morning that I should look for other work ’cause I am obviously not suited to this type of work here. There is no talk of re-training. That’s easy for him to say.

The women’s insights here help to explicate the gendered dynamics of power in contemporary society. At one level, it could be argued that they were suffering from a “false consciousness” in the Marxian sense. Therese, Vivian and Jane clearly acquiesce with the dominant definitions of woman as mother/protected at work and men as worker/hurt at work and Phillipa demonstrates the doctor’s power to maintain and legitimise current understandings of RSI and sufferers of RSI. This brings me to another core aspect of Foucault’s work, his notion of knowledge/power. Foucault argued that power in modern societies was not repressive but productive. That is, subjects engage in their own constitution, acquiescing with or contesting the roles or definitions that are placed on them (Foucault 1979; and see Mills 2004). As demonstrated in the stories of the workers I interviewed, it is through the active disruption of the gendered constructions of women as weak and as wife and mother that they were able to negotiate their identities as injured workers. Helen very astutely argues why drawing on the definition of RSI as a health issue would not be of benefit to women attempting to get their injuries recognised,

(Helen) You know most of us can’t leave, either because we are single or our hubby’s don’t make that much either or we are on our own with kids. I think
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that they know that and that is why they treat us like shit. If they really want to get rid of us, they just send us to the doctor who tells us we’re not suited.

Furthermore, Therese clearly shows the benefit of negating medicine’s role in addressing the number of injuries sustained at the plant. According to her, because doctors cannot accurately diagnose RSI and hence do not know how to treat it, the company itself should be responsible for dealing with the injuries that they are responsible for,

(Therese) From the day you step in here your body starts to deteriorate…and anyway how would you know when it started…it goes over a period of time…the doctors don’t know and anyway can’t do nothin’ about it. It’s not up to them anyway, the arseholes that run this company need to…you know, don’t they have a duty of care?

Injured women workers also actively disengaged with any discussion around RSI as a health issue as this negated their ability to define themselves as workers, as Tracy clearly articulates,

(Tracy) I used to cry all the time because I just didn’t fit in and because like I said I’ve been here for years and got on well with everyone and all of a sudden I just didn’t fit in, that’s hard on your head. Because you classify yourself as a worker and all of a sudden your workers, you know, your workmates don’t think you’re a worker, that’s pretty hard to cope with.

Reading RSI through this postmodernist lens yields a deeper understanding of how the hegemonic discourses of patriarchy continue to impact on the experience of RSI for contemporary poultry process workers. Using Foucault’s notion of knowledge/power allows us to see how constructions of woman inhibit RSI being recognised by management, doctors, workers’ compensation authorities and some of the injured poultry process workers. Seeing the ways that the women contested the dominant discourses surrounding gender illuminated how these discourses impact on injury recognition. In particular it enables us to recognise the importance that gender still plays in the experience of occupational injury for contemporary poultry
process workers. However, while the dominant discourse of gender continues to be significant in our understanding of RSI, it is not stable. The tension between my reading of RSI and the readings proffered by the injured poultry process workers demonstrate the changing shifts in discourses surrounding gender.

The gendered discourses surrounding RSI in the 1980s and the 1990s constructed women as neurotic and possessing maternal instincts that compelled them to want to stay home. By the turn of the 21st century, this definition of woman though evident was not significant in the understanding of RSI for contemporary poultry process workers. However, discursive constructions of femininity continued to define women as weak and as primarily wives and mothers, which was evident when the rights of women to employment were severely curtailed once a woman sustained a long term injury. This highlights the importance of maintaining gender as an analytical category in understanding the experiences of RSI. However, it also cautions us not to use gender as a stable and fixed category which constrains our analysis to simplified comparison between women and femininity and men and masculinity.

**Conclusion**

This discussion has demonstrated the importance of engendering occupational health and safety to ensure an adequate reading of women’s occupational health in general and RSI in particular. Using both modernist and postmodernist methods of inquiry allows analysis to move beyond the simple comparison between men and women in which men are the standard by which everything else is judged. As I have demonstrated throughout the thesis, analysis such as this negates a clear picture of women’s occupational health and safety concerns. This undermining of
gender categories allows us to research and consider women as a subject group at the same time as questioning the taken-for-granted understandings we hold about gender.
CONCLUDING REMARKS

Theoretical concepts bear a necessary relationship to the ‘real world’. They grow from it and feed into it. Theoretical conversations are therefore about what needs to change and what can change (Eveline and Bacchi 2005: 509).

This thesis offers a different reading of one of women’s most significant workplace injuries, RSI. While there is a wealth of research into RSI and a small but growing interest in understanding women’s occupational health and safety concerns, there is a gap in our understanding of how gender impacts on the experience of occupational injury for women workers. My thesis has addressed this gap in knowledge through grappling with the complexity and utility of using gender as an analytical category in understanding both the historical and contemporary experiences of RSI for women workers. In doing so, it offers new insights into this debilitating injury and demonstrates the significance and importance of engendering occupational health and safety to meaningfully understand women’s and men’s experience of occupational injury.

Engendering occupational health and safety forces us to think differently about how we read and do occupational health and safety research. Traditional occupational health and safety research ignores issues of gender or equates gender with women. This modernist conceptualisation of gender results in research that simply compares female workers to male workers. This has resulted in women’s occupational health and safety needs being considered at best as only pertaining to reproductive issues, and at worst, as non-existent, trivial or stemming from some assumed female deficiency. For engendering to be meaningful, the conceptualisation of gender
Concluding Remarks

needs to move beyond the simple biological and social comparisons between men and women.

This is where my thesis makes a contribution to occupational health and safety research. Broadening the conceptualisation of gender to not only include gender as a modernist biological and social construct, but also to include gender as a postmodernist discursive construct yields a deeper and richer exploration of the material and discursive structures surrounding the historical and contemporary experience of RSI for women workers. Drawing on both modernist and postmodernist conceptualisations of gender my thesis “chart[ed] the shifts that [took] place in the machinery of thinking” (Mills 2004: 54) in relation to women and work, women and medicine and women and occupational injury. Charting the shifts in thinking about women and work, and women and injury enabled me to ‘understand’ and to ‘disrupt’ the knowledge claims that have been made about women’s occupational health and safety concerns in general, and RSI in particular, from both an historical and contemporary perspective.

Using Michel Foucault’s notion of power/knowledge I was able to question the knowledge claims made at the height of the RSI debate and to ascertain how that was played out in the contemporary experiences of injured poultry process workers. Of particular importance it allowed an understanding of why certain ‘truths’ about RSI and about women become dominant. Furthermore, it made visible those with the authority to speak, and it shed light on the fluidity of the discursive constructs that shape our lives. In particular, the thesis highlights the changing discourses
surrounding gender that shape the lives of male and female workers in very different ways.

Tackling the complexities of using gender as an analytical category raises important issues that were addressed in this thesis. It raises the issue of the meaning that gender has in our lives. In the West, many would argue that gender is no longer of any consequence given women’s equality with men before the law, women’s often higher educational qualifications, as well as equal opportunity and sexual discrimination legislation protecting women’s rights at work. There is also a “public rhetoric” that we have reached equal rights and equal responsibility for family support, childcare and household maintenance (Lorber 2006: 470), despite this rarely translating into practice. This rejection of the importance of gender in shaping our experiences was openly stated by the poultry process workers. Many feminists also propose for analytical and strategic reasons, that gender is no longer useful for understanding our experiences. I disagree.

Gender continues to significantly impact on our life opportunities, on how we identify ourselves and behave and on how social and economic organisations organise and operate and therefore requires attention. Gender is not simply played out in material structures, that is, the realities that we can see, such as unequal wage distributions and employment opportunities and/or expectations that women are primary carers for children and older relatives. The material social world has very real consequences for women and men and therefore requires truth claims to be made. However, we also need to incorporate an understanding of the ways in which hegemonic discourses are produced through the intersection of institutional and
organisational processes and the multiple sites of power/knowledge that inform and shape experience. In essence, I argue that we need to move beyond considering gender as merely something that describes our social reality, and to recognise the binary divisions that create our gendered experiences, our gendered institutions and our gendered knowledges.

Via the narratives of the injured poultry process workers I demonstrated how hegemonic discourses frame understandings of illness and disease and also gender. Their stories illuminated how they “did gender” within the dominant constructions of injured women workers as weak and undeserving. In other words, they acquiesced to those constructions, but at the same time, their resistance to those constructions allows us to see how gender can be done differently. That is, in refusing the binary framework, the women were able to negotiate an understanding of themselves as injured worker rather than injured women. The women workers actively disengaged with any discussion around gender as entering into this discussion raised questions as to their standing as workers with rights to demand better access to occupational health care.

**Suggestions for Future Research**

The insights gained from this thesis reveal the potential that a broad conceptualisation of gender has for future occupational health and safety research. Understanding that gender is integral to our experiences at both a material and discursive level has implications for research into both men’s and women’s occupational health concerns. In particular, occupational health and safety research that examines the gendered constructions of disease and workers will expand our
understandings of occupational injury. Men are gendered beings as well and research that considers discursive constructions of masculinity has the potential to yield important insights into the massive amounts of traumatic and serious occupational injuries and diseases sustained by male workers.

Furthermore, research that can accommodate an understanding of power relations and gender can offer a new perspective to injuries and work practices in our globalised economy. Many developing nations depend on manufacturing to boost their economies and these factories largely depend on the labour of women. Research using a gender lens may reveal important power relations that impact on the experience of work, the experience of gender and the experience of development. Research such as this is important because it will negate superficial research which focuses only on the economic relationships between countries and reveal the multiple sites of power and relations of domination within these relationships.

**A Final Word**

To conclude, I suggest the need for more research that grapples with the complexities surrounding and constituting gender. This has the potential to yield valuable information regarding how gender continues to structure our experiences at an individual, organisational and societal level. Over the last two decades, gender has slipped off the research agenda. While we pay lip service to it by including “women” into many of our research projects, gender is not researched meaningfully outside feminist texts. Until we reinstate gender as a category of analysis, our
research will reflect dominant modes of thinking which negate alternative understandings and thus limit our potential to make meaningful change in our lives.
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MEMORANDUM

To: Dr Cordia Chu  
School of Public Health  
Nathan Campus

Cc: Ms Benedette Seber

Subject: Ethical Approval of Research Protocol

From: Secretary,  
Human Research Ethics Committee

File:  
Date: 15 August 2000

1.0 I refer to your request for ethical approval of the research protocol entitled "Investigating Occupational Health and Safety of Female Poultry Process Workers". The approval number for this protocol is PBH/01/00/REC). Please quote it in any future correspondence with this office concerning this project.

2.0 The Chair of the Human Research Ethics Committee has expressly approved the protocol for the period 9 August 2000 to 31 January 2002.

3.0 Would you please note that the following standard conditions apply:

   • Variation to Project
     Approval is strictly limited to the research proposal as submitted in your application. Consequently, any variations or modifications that you might wish to make to your project must be put before the Committee for further consideration and approval. If the proposed changes are significant, you will need to submit a new application for approval of the revised project.

   • Progress and Final Report
     You are required to submit a progress report on an annual basis and a final report on conclusion of the project. I will remind you that the report is due closer to the time of submission.

   • Continuation of Project
     Please advise the Committee if this project does not proceed (on the grounds of insufficient funding, for example). Should you require an extension of your period of approval, please submit a written request for the Committee's consideration outlining your reasons, together with a progress report. Please advise the Committee immediately of any unforeseen events that might affect continued ethical acceptability of the project. Similarly, please notify the Committee, immediately, in the event of any adverse effects on subjects.

4.0 Should you have any queries in relation to this approval or if you require additional information, please do not hesitate to contact me on extension 6618 or by e-mail (M.Cochrane@mailbox.gu.edu.au).

Thank you.

Michele Cochrane  
Secretary  
Human Research Ethics Committee