WHITE PAIN, BLUE EXPERIENCE: WOMEN AND RSI

WHITE PAIN, BLUE EXPERIENCE: THE NORMALIZATION OF WOMEN'S REPETITIVE STRAIN INJURY

By

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ABSTRACT

This thesis is a study of women who have been diagnosed with repetitive strain injury (RSI). The purpose of the study was to give women a voice in their experience with the disease. Research has shown that women have often been omitted in occupational health and safety research. Therefore it was decided to interview women workers from two distinctly different workplaces. One group was located in the white collar sector. They performed essentially clerical duties in a library in Southern Ontario. The other group consisted of blue collar workers. They worked on an assembly line in a manufacturing plant. The women performed repetitive tasks which caused them crippling injuries with a great deal of pain. Most of the injuries affected their hands, arms and shoulders.

Their story is largely told in their own voices and reflects the perceptions of their suffering. The work-relatedness of their condition was more readily accepted by the assembly-line workers than by the clerical workers. One possible reason for this could be that the union in the library had placed less importance on occupational health and safety issues than the union in the manufacturing plant. Hence, the women in the library were caught between

competing medical discourses. Furthermore, both groups struggled with their identity as mother/wife and homemaker, since they were not able to perform many of their care-giving duties after their injury. This became a great source of stress for the sufferers. It also reflected their identity as they perceived it to be within the limits of patriarchy.

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are...Heather and you too Matt) who saw me through the experience and the many rough times. Your Master is here...the Doctor awaits!

I dedicate this thesis to:-

Myra Bovey

whose delightful humour keeps us laughing.

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Chapter 1

Introduction: Why Am I in Pain ?

> I was doing word processing, a lot of database work. As well as work with a little hand held computer with a big, heavy gun. People come and pile the books on the desk. And you might get four five hundred books in the course of an hour, books records and whatever. And you need to scan all the bar codes. And as they pile up high you need to sort of stack them so you're working at a really awkward angle. ... I was suddenly in a great deal of pain. I kept going: 'Why would this hurt? I haven't done anything'. I couldn't sit in the car. If I couldn't get my arm just in the right position it was agony. I was in chronic, constant pain. I couldn't figure out why I was in terrible pain. (interview #4, 1996).

> I was putting the screws in the black metal pieces with the gun. You had to have it in your hands for almost 8 hours a day. My hand was getting so numb I was dropping the gun many times. Then I started [to] have pain in my arm and elbow. I could not hold the gun the whole time. While [at work] I [do a lot of] gripping and pushing. It was the pushing that started the pain going up in the wrist more. The hand was getting worse so I went and had it [surgery] done. (interview #7, 1996).

This study seeks to fill a gap in the occupational health and safety literature by focusing attention on the problems and concerns of women workers with repetitive

strain injury (RSI). In order to accomplish this a sample of women from two distinctly different workplaces were selected and interviewed. In both workplaces the women perform repetitive tasks over extended periods of time. One workplace is a manufacturing plant - a blue collar sector workplace - where the women work on the line, while the other workplace is a library - a white collar sector workplace - where the women perform a number of different duties which involve the use of their hands.

The distinction between blue and white collar work is made based on the definitions used by Krahn and Lowe (1993:72), who note that blue collar work is traditionally associated with factory work, while white collar work includes clerical occupations. Based on the interview data, the women interviewed explained that they performed clerical duties in the library, while the women in the manufacturing plant worked on the assembly-line, which is traditional factory work. Hence, the researcher made the distinction between white collar and blue collar work. The thesis is thus divided along organizational lines in terms of the respective employers. The reason for this is that differences exist at the organizational level between the two workplaces. For instance the manufacturing plant has

medical facilities on the premises, while the library does not. Moreover, each workplace has a different union, each of them have separate approaches to workplace health and safety, placing different priorities on workplace issues, which influence the rank and file in their understanding of workplace hazards. Hence, workers working in the plant will experience the treatment of their injury differently than those workers in the library. In turn, such difference in treatment affects the way in which the workers perceive their injury as well as influences their discernment regarding their injury. Therefore, the concepts of white-collar versus blue-collar workers referred to in the thesis pertains to the notion of clerical versus industrial working class and not to their status. Indeed, the women in both workplaces would be considered to be members of the working class, in the marxist class perspective, since neither group of women own the means of production (Cuneo, 1990:204). Their concerns and problems were recorded, and comprise the preponderance of the data analyzed. The aim of the research was to allow the women workers to explain their perceptions, concerns, and experiences with repetitive strain injury. The primary research question asks how women workers' perceptions

reflect the normalization process[1] in the construction of repetitive strain injury - RSI - as a workplace health and safety problem.

The importance of the research reported here lies in its examination of a neglected area of social scientific research, namely occupational health and safety, in particular as it relates to women. To date research conducted on the occupational health and safety concerns of women has been insufficient. This research will aid in resolving this problem.

Another objective of the study is to overcome the bias of much of the current occupational health and safety literature toward excluding the very views, feelings and thoughts of those whom it purports to study (Messing, 1990a). Such an approach is necessary if we are to avoid a complete objectification of the worker and their injury. To this end a methodological approach and analysis are utilized which give full voice to the participants and their troubles.

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[1] During the process of normalizing injuries, individuals take steps in order to get their condition addressed, such as going to their doctor, specialist, and filing Workers' Compensation claims. The normalization process refers to the regulatory steps taken by individuals towards the normalization of their injury.

Why should we care about the troubles of these workers? Why should we be concerned about RSI as an occupational health and safety problem? A first reason is that RSI has only comparatively recently become a recognized condition (cf. Brisson et al., 1989; Tieger and Bernier, 1992). Given the newness of the condition, it is incumbent upon social researchers in the field of occupational health and safety to fully investigate the troubles and views of those afflicted. A further, perhaps more compelling, reason for caring is that evidence from occupational health studies as recently as 1994, reveals that RSI is a leading cause of workplace injury in North America (Korrick et al. 1994; Ashbury et al., n.d.). Such information provides an important reason to begin research into RSI. When large numbers of workers are being afflicted with a relatively new condition and there is an extremely limited amount of research regarding the condition, such conditions cry out for action. The social research community must provide information to patients, policy makers, unions, and business groups, who need to be informed about what the condition is, how to help those afflicted with it, and what steps to take (if any) to stop its occurrence.

The reasons articulated above provide a more than sufficient cause to investigate RSI as an occupational health and safety disease. However, in addition to that information, other research data support the view that women are more likely than men to develop RSI as a result of their paid labour employment activities (Meekosha and Jakubowicz, 1991). Given women's increasing role in the labour force, and the relative paucity of occupational health research on women, a study which focuses on how a new workplace disease such as RSI affects them is timely.

It would not be correct, however, to form the opinion that RSI as a work-related condition is without its detractors. In spite of the evidence provided above regarding RSI, it has not yet been accepted by the whole of the medical community as a recognizable ailment (Arksey, 1994; Diwaker and Stothard, 1995). Other disease conditions, which are not work-related, are being forwarded as possible reasons to account for the symptoms experienced by workers (cf. Littlejohn, 1989). The present study, therefore, will contribute to the academic debate over the condition known as RSI. Evidence from the data will be used to highlight the perception by the workers that their injury is in fact work-related. Where such evidence does

not exist, a speculative explanation based on the data will be provided.

I will argue, based on the data collected from the research interviews, that the women workers' injuries, in both workplaces, are being normalized.

The discussion will be organized in the following manner: Chapter Two will begin by covering the literature pertaining to women and occupational health. We will investigate some of the material which has focused on women specifically and in a manner which puts their concerns first. A more general critique of the literature is then offered, emphasizing the absence of women in many occupational health and safety studies, and possible reasons why, as well as ways to overcome the bias. Our discussion then turns to the literature on repetitive strain injury. The newness of the disease, the debate surrounding its nature, and the fact that women are more likely to develop the condition, are explained. The explanation of the necessity of utilizing concepts from feminist theory and Michel Foucault are covered in the remaining two sections. Feminist concepts such as patriarchal ideology and the double day of work, provide us with the context to explain how women workers can become so

wedded to their role and identity as mother/wife while also maintaining a full-time paid labour position. Foucault's concept of normalization (as an aspect of bio-power) is described in order to aid in our explanation of worker injury, and how injury becomes accepted as a normal part of working. Once workplace injury has been accepted as normal, the possible burden on capital to provide changes to work organization is weakened.

Chapter Three discusses the methodological approach taken and describes the sample selection. Chapter Four is an in-depth description of the data obtained from the white-collar library workplace. Framed within the context of the interview schedule, we look at the workplace job tasks and conditions as perceived by the women workers. This leads us into a discussion of what personal acts and experiences the women library workers followed in order to deal with their pain. The manner in which they perceived the treatment they received from the medical professionals, their employer, co-workers, and their family, will be elucidated. Our aim is to detail the pain and suffering as a result of their injury, how it has affected their paid and un-paid labour, and what they believe to be the cause of the injury. In spite of problems with their injury,

most of the library workers did not see the injury as solely work-related. Instead they viewed it either as some condition other than RSI, or that their domestic duties may have contributed to the injury. They did, however, stress the adverse effects that the injury had on their domestic lives.

Our discussion in Chapter Five concentrates on the description of the blue-collar women workers' perceptions. We begin by concentrating on the paid labour tasks which these women perform requiring repetitive motions and twisting of their bodies and arms. The focus then moves from their workplace perceptions to investigate the pain and discomfort suffered as a result of their injury. We look at the personal actions undertaken by these women in order to have their injuries dealt with. This leads into a consideration of their experiences surrounding the medical treatment both at the company and from their own family physicians. Our data reveal the effects that the injury has had: on the women themselves, in terms of their work life; on their treatment when seeking compensation; and on how their family life was affected by the injury. All of the women in the blue-collar sector attribute their injury to the paid work they perform. They identify the

injury as related to their repetitive paid labour. The women workers also discuss the detrimental effects that the injury has had on their un-paid labour and domestic life.

The information and data from the two workplaces are compared and analyzed in Chapter Six. We briefly describe some of the salient comparisons between the library and manufacturing plant. Following this we analyze the differences and similarities between the workplaces. Our investigation places emphasis on the theoretical concepts from feminism and Michel Foucault. It is observed that the workers hold strongly to their identity as mother/wife. However, because of their injury they perceive that they are unable to live-up to this role. It is contended that this is in keeping with the patriarchal ideology that assigns domestic labour to women, even when they have a double day of work (Gannagé, 1986; Luxton, 1986). In fact, the injury suffered by these women adds to the difficulty of mediating the role of domestic labourer and that of paid labourer, and furthers the stress and burden of their injury. Our analysis of the data from both workplaces also reveals that normalization of the injury occurs. Workers do accept injury as a normal part of paid labour. It is argued that this allows capital to avoid

having to change the manner in which production is organized. Since RSI is related to the manner in which work tasks are performed, then normalization makes it difficult to create resistance by workers.

Our observations and analysis will be brought together in Chapter Seven which is the conclusion. We will see how the various strands of data and information provide evidence for the conclusions reached in Chapter Five. Summarizing our argument, we will suggest some tentative positions: that workers need to be educated that injury is related to the paid employment; that it is not normal to be injured at work; that consideration must be given to the double day of work injured women must endure; that the necessity of investigating RSI and the occupational health and safety concerns of women is paramount; and finally, that the perceptions and view of workers must be integrated into occupational health and safety research.

Chapter 2

Don't Women Count?

Introduction

This chapter presents an outline of research dealing with women and occupational health. We begin with a presentation of studies which detail the problems women workers face in paid employment. A critique of much of the remaining research is offered, stressing the bias against the inclusion of workers' views and perceptions of occupational health and safety issues, as well as the exclusion of women as subjects for many research studies. Following from various criticisms of the present body of occupational health and safety research, it is suggested that we need to focus more research on problems affecting women's health in the paid work force. One such disease area, repetitive strain injury (RSI), is a fruitful area for investigation. Research pertaining to this disease is examined and it is found that there are still areas where the views and concerns of workers, and particularly women

workers, need to be studied. In order to begin such a study we need to utilize concepts which allow us to examine and explain the oppression of women and their bodies. An analysis of concepts from feminism and from Michel Foucault yield important insights. It is argued that the concepts of patriarchy and the double day of work, taken from feminist analysis, will enable us to account for the manner in which women workers experience their paid and unpaid work. The concept of 'normalization' will allow us to explain the way that workers under capitalism are examined, and become disciplined and regulated. The result is that injuries become normalized and accepted as part of the conditions of work. An application of these concepts to women workers with RSI is proposed.

Women and Occupational Health

Many studies have demonstrated the linkages between women's health and their paid employment (Walsh and Egdahl, 1980; Stellman, 1977; Tierny et al., 1990; Hricko and Brunt, 1976; Waldron, 1983; George, 1976). Recent research, for example, has shown the adverse health effects on women's reproductive capacities stemming from occupational hazards (Walsh and Egdahl, 1980; Stellman,

1977). As well, other studies have established the connection between an increased incidence of stress and associated physical ailments in women with paid employment (Stellman, 1977; Goldenberg and Waddell, 1990)[2]. Such research findings are important given that high levels of stress are associated with such physical ailments as rose angina, a potentially fatal heart disease (Haynes et al., 1987).

Women's health is adversely affected by activities outside of the paid labour market as well. Evidence suggests that the risk of accidents may be approximately equal for homemakers and women in the labour force (Krute and Burdette, 1978). Rosenberg (1986: 37) contends "that a rigid sexual division of labor in the household contributes to significant health and safety hazards for women who work in the home". These hazards affect all women, those who are in the paid labour force and those who are not. As well, existing occupational health problems and injuries can be compounded by activities in the home. Tierny et al. (1990), demonstrate the perils of the double

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[2] For instance Goldenberg and Waddell (1990:541) assert that a heavy workload is a significant contributor to high levels of stress in women.

day of work (paid and un-paid) that confront employed women. They note that the combined workload of household labour tasks in addition to paid employment tasks leads to increased levels of insomnia and fatigue in women. Furthermore, this double day of work leads to raised stress levels due to the heavier workload and hence heightens the potential for developing associated physical ailments.

Other studies suggest that the occupational health and safety views and problems of women have been trivialized (Reid et al., 1991). That is, despite the occupational health concerns voiced by women, many researchers have simply attributed any such health problems to 'mass hysteria', 'mass psychogenic illness' or, 'occupational neurosis', rather than to the working conditions (Reid et al., 1991). Ready-made psychological categories are used as explanations of physiological effects (Voiss, 1995). As a result, women's occupational health concerns are viewed as unimportant and their observations marginalized (Messing et al., 1995). For example, women who perform jobs in air-tight workplaces such as large office buildings contend that they suffer occupational health problems because of the poor air quality (Yassi et al., 1989; Messing, 1990b). However,

such symptoms may be incorrectly viewed by researchers as resulting from collective stress reaction from fast, repetitive work under rigid supervision, when in fact the symptoms are a result of air pollution problems (Yassi et al., 1989).

The views of women are often discounted by the medical profession. Sanford and Donovan (1984), recount a study that investigated the manner in which doctors treated male and female patients who reported the same physical symptoms. They discovered that the doctors in the study tended to take the men's reports more seriously than they did the women's. Moreover, "[t]he doctors were more likely to dismiss the women's symptoms as evidence of hypochondria" (Sanford and Donovan, 1984:249), or attribute their symptoms to a psychological condition. The authors state that "[d]octors traditionally have been taught that women are ... given to hysteria and hypochondria" (Ibid.:248). Furthermore, they note that doctors are taught that all medical problems which women experience "have their roots in mental illness (it's all in your head) or in a pathological inability to adjust to 'the feminine role'" (Ibid.:248). In other words, traditional stereotypical labels are used to devalue the subjective

experiences of women, and, by extension, women workers.

An important reason why women's occupational health and safety problems have not been examined is that "[h]istorically, researchers in occupational health and safety have studied male workers, a practice established before the influx of women into the paid labour force" (Skillen, 1995: 153). Messing (1991, 1994) and Walters (1993), similarly note that it has frequently been the practice to exclude women as subjects from occupational health and safety studies. In fact, Messing (1994:11) argues that "[o]ccupational health intervention and research has [only] concentrated on men's jobs [and] occupational health and safety concepts have been derived from examin[ing them]". For example, a research project to study cancer in a fertilizer plant excluded women from its sample (Messing,1994). The plant employed a total of 3400 workers of which 173 workers were female. However, these women were not included in the study since they did not constitute a large enough group - only about five percent of the study population. Methodologically this may seem sound except for the fact that the researchers <u>did</u> include in the study 38 males who <u>did not</u> work in the plant - but did work for the company. Clearly these males were not

considered too small a population to be included in the study (Messing,1994). Indeed, upon further investigation, Messing (1994) discovered another cancer study conducted at an earlier period in Canada that also had not included women. When she inquired into the absence of women in the study the reply she received was that it was "a cost benefit analysis; women don't get many occupational cancers" (Ibid.).

Can the occupational health and safety concerns of women be addressed now, without waiting for newer studies? Some maintain that the findings of many research studies which focus upon males can be applied to women. However, Messing (1994) and Vezina and Courville (1992), argue that this is not a solution. The almost total lack of sex specific studies reinforces "the notion that women's jobs are safe and that women's concerns about environmental influences are unfounded, hence it is justifiable to exclude women's jobs from prevention efforts" (Messing, 1994: 11). Indeed, Vezina and Courville (1992) demonstrate the difficulties of comparing the working conditions of men and women in different situations. Their findings show that in most cases job classifications in terms of heavy and light work of women's and men's jobs are not the same.

For instance, they found that an "[e]rgonomic analysis of sex typed jobs in a clothing factory and a plastics factory revealed that the total weight lifted in women's jobs exceeded that in a typical male labourer's job" (Ibid. 1992: 97). Yet, there were no regulations covering the women's jobs while men's jobs specified maximum force or weight to be lifted in a day. Furthermore, they note that the characteristics of work organization and work rhythm also differed between women's work and men's work (Ibid, 1992; 97). In other words, even though women and men may hold the same job titles, their duties and thus any possible health problems they may encounter, can vary significantly (Messing et al., 1994).

Compounding the difficulties of comparing the occupational problems of men and women is the fact that "[w]omen and men do such different jobs that too few women workers may undergo a condition for studies to be valid" (Messing, 1990b: 26). O'Donnell and Hall (1988) demonstrate that even when we attempt to compare the occupational health problems of women and men, the standards for exposure levels and measures of performance are based on data which is incomplete for race, age, and sex, and that these data are then inappropriately applied

to individuals. For example, many work processes were designed for average male populations rather than average worker populations. Thus, especially in male-dominated areas, task and workplace design are often hazardous to women, and to many men. In view of the increasing level and range of women's participation in the paid workforce, it is inappropriate to design tasks specifically in relation to the capacities of either sex or to make the performance of a task dependent on sex-specific characteristics (O'Donnell and Hall, 1988).

In addition to all of the aforementioned problems, the differences in physiology between women and men complicates the ability of researchers to make comparisons between women and men (Messing et al., 1990b). Fausto-Sterling (1985: 8), contends that scientific research about sex differences frequently contains methodological errors and in most cases experiments are only done on males "from which the investigators draw conclusions about females". She also states that "scientists themselves emerge as cultural products, their activities structured, by [current] social issues" (Ibid.: 9). Therefore, she continues, "it is inherently impossible for any individual to do unbiased research" (Ibid.: 10), while studying

gender. Moreover, the family wage ideology (Krahn and Lowe, 1993) perpetuates the marginalization of women's work, not giving it the recognition it deserves and hence not giving it the importance and attention it needs in terms of occupational health and safety. Indeed, "it had been argued that women's paid employment was infrequent or fleeting, [hence], any potential ill effects were negligible compared to those of the male workforce" (Brabant, 1992: 128).

Even when studies do attempt to focus solely on women, problems may occur. Brabant's (1992) study of women workers in a laundry show that the physical requirements of women's jobs are seriously underestimated. This is particularly important given that the work is classified as 'light'. The thermal work environment of the laundry added to the women's discomfort and led to cardiac strain. Indeed, the study revealed that the heat exposure standards were based on male models in ideal study situations and were inadequate for the women's work situation. This is due to the fact that "[k]nowledge about the effects of work in hot environments is mainly derived from the study of 'heavy' muscular activity and current heat exposure standards are based on an energy criterion according to

metabolic load" (Brabant, 1992: 119) However, Brabant (Ibid.: 119) notes further that "[m]etabolic load does not reflect cardiac strain associated with sedentary, repetitive work, involving static effort". It was demonstrated that the women in Brabant's study surpassed the recommended levels for cardiac strain, despite the fact that they operated well within the established thresholds levels for its prevention. Hence, Brabant (Ibid.: 119) argues that "threshold levels should be redefined to include the prevention of cardiac strain resulting from cumulative effects of heat stress and sedentary, repetitive activity, typical of women's jobs with low energy requirement". This illustrates the difficulties involved with the comparison of male research results to female work settings. It also points to the problems associated with providing occupational standards and exposure levels for women. So, even if some researchers may make the claim that research strictly involving men could be applied to women, they would seem to be in error to do so.

Messing (1990a) argues that the problem with scientific research is rooted in the idea that subjectivity cannot and should not enter into 'objective' scientific studies. What is needed is a re-orientation of how

research is performed in the context of using objective and subjective data (1990a: 349). Messing's experiences as a researcher have revealed "that there is no granting agency in Canada which has a priority to fund research initiated by unions or other community groups in order to respond to needs defined by them" (Ibid: 354). Research institutions, in fact, frown on worker-initiated studies. Such studies do not receive funding because they are not considered to be "objective", whereas "university-industry projects are actively encouraged by granting agencies" (Ibid.: 355). Moreover, scientists do not believe that scientific studies should be conducted in the workplace. In fact, "[i]t is considered more accurate to model the workplace in the laboratory ... with workers modelled by college students or army volunteers" (Ibid.: 355). The position of the worker in this case is that of an object, one who is studied and analyzed; one whose subjective experience must give-way in the face of contradictory "objective" empirical evidence.

The positivist methodological stance[3] inherent in these studies emphasizes "passivity and manipulation, ...[and] endorses a research methodology that immobilizes and even obliterates the 'subject' it studies, rendering them as personally invisible, as faceless, and as interchangeable..." (Code, 1991: 174). However, this "objective" disinterested view of scientific methodology and of scientific researchers is in fact a work of fiction. The view of "objective", unbiased health and safety researchers cannot be sustained when we investigate case studies of occupational health and safety problems:

> The positivist vision of scientists disinterestedly proffering evidence to policy makers, on the basis of which the latter could

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[3] Positivism, according to Code (1991:21), serves to legitimate under the guise of objectivity and impartial neutrality just the kinds of social practice feminists are concerned to eradicate. She contends that the impartiality of empiricist analysis, the interchangeability of its subjects of study, work to provide rationalizations for treating people as 'cases' or 'types', rather than as active, creative cognitive agents. Such rationalizations Code posits, are common in positivistic social science. In other words , qualitative assessments are not taken into consideration when considering positivist data. Thus when there is a study on workers and their health in the workplace, their concerns are not taken into account in terms of analysing the data. Hence the argument that such studies are not objective since only one view is taken into account, that is the view of the researcher and the views of its subjects are excluded.

> make their determinations, was shattered by the bitter encounters surrounding the efforts to regulate workers' exposure to coal, lead, and asbestos -- encounters that unveiled the realm of scientific politics. **In each of these cases scientists, engineers, and physicians assumed partisan stances definitively marked by the social interests with which they were allied.**
>
> (Bayer, 1988: 7; emphasis added)

Many researchers have recently challenged the prevailing view in occupational health and safety research (Bayer, 1988; Judkins, 1986; Rosner and Markowitz, 1987; and Smith, 1987). These authors contend that the perspective of the injured workers, their views and experiences, must be included in any study of occupational health and safety injuries. Messing (1991: 355) contends that a "really effective way to ensure good quality data is by involving the subjects in the study". There should, she argues, be a place in occupational health and safety research for the documentation and statistical description of workers' perceptions (1991: 356). How else can knowledge of workers' true working conditions be gained? Of course, as Messing has pointed out, the problems faced by such a call for action include scientific, industrial/capital, and state opposition. Equally important is the fact that many of the people in these institutions who oppose such a project are also male.

Despite Messing's contention, the existing "objective" occupational research studies are given the legitimation and funding. Unfortunately, these studies are used to set exposure standards, to determine policies, and establish occupational health and safety regulations. Thus, it can be surmised that the resultant regulations do not adequately address the workplace health and safety concerns of women since they are often not included in the research.

Regulatory standards are suspect at the best of times (Ziem and Castleman, 1989; see also Castleman and Ziem, 1988). Ziem and Castleman (1989) argue that threshold limit values[4] are not truly reflective of safe levels of exposure to hazardous substances. Their study showed that representatives of interested corporations were instrumental in setting the limits upon which occupational health and safety policies are based. In fact, they contend that the threshold limit values for human exposure

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[4] TLVs are intended as unofficial guides of acceptable/permissible exposure levels/limits to chemical and physical agents in the workplace. However, TLVs are widely applied as official limits by many states and countries. These limits or levels refer to maximum allowable concentrations of a substance to which workers may be exposed while at work. In fact TLVs "represent conditions under which it is believed that nearly all workers may be repeatedly exposed, day after day without adverse effect" (Ziem and Castleman, 1988: 911).

to dangerous substances, as worked out by these same interested industry representatives, and upon which occupational health and safety policies are set, are too high and are in reality not safe for human exposure. Obviously there is reason to suspect certain occupational standards and the manner in which they are arrived at. This is especially the case given that women are excluded from research studies and thus the possible effects of their exposure to many substances are not known.

This state of affairs is not isolated, however, to the actual research itself. Messing (1994) contends that researchers have consistently ignored and under-analyzed studies on women workers (cf. Walters, 1993). Indeed, the whole process of occupational health and safety research is affected. A particularly vivid example of this is with regard to the funding for occupational health and safety research. For instance, during the late 1980's in Canada "less than 0.1% of the health research budget ha[d] been devoted to women's occupational health, [albeit] most women ... work" (Messing, 1990a: 25). Given the fact that women have been increasing their participation in the labour force from over 40% in 1981 (Armstrong and Armstrong, 1984) to over 45% in 1995 (Statistics Canada, 1996), it seems

almost criminal that their occupational health and safety concerns should be so under-funded and under-researched.

These examples illustrate an important point. A major barrier to the inclusion of women as research subjects in occupational health research lies in the scientific community (Messing, 1994; Doyal, 1983). Messing submits that research techniques currently employed by scientists "obscure the types of health problems women experience at their jobs, and help maintain the illusion that women are physically, mentally, and emotionally 'the weaker sex'" (1994: 13). The attitudes of some researchers to the inclusion of women into occupational health and safety research are frequently biased, and they tend to view women's health concerns as marginal and unimportant. The institution of scientific medicine does not merely reflect the discriminatory views of women held in the wider society, it plays a particularly strategic role in actively creating these stereotypes and in controlling women. Doyal (1983) contends that at the ideological level, medical knowledge and medical practice are part of the means by which gender divisions in society are maintained. In Marxist terms medicine plays a part in the overall reproduction of the relations of production and production.

Such attitudes reflect and perpetuate a "malestream political economy ... that ignores the sex/gender dimension and marginalizes women" (Maroney and Luxton, 1987: 6). Indeed, important in all research and investigations of the health of women is the fact that "we cannot simply assume that conclusions based on research on men are necessarily true for women" (Miller et al., 1979: 67). A central conclusion one can draw, then, is that the occupational health and safety concerns of women are not a priority of researchers.

Obviously the existing structures of scientific and policy analysis will not, and cannot, include the concept of sex. In order, therefore, to study occupational health and safety at the theoretical level we must include an understanding of the exclusion of women in the wider context of the patriarchal and capitalist nature of society. Consequently, we must not only look at women's exclusion in occupational research studies, but we must also study their unique position within the overall paid labour market.

Thus, to address women's concerns as workers who face occupational health and safety problems, we need to be able to adopt certain important concepts. What is needed

is more research which puts the views of workers and their perceptions of occupational health and safety problems at the centre of the analysis. Such a study would also focus on a health issue that affects women and has not received much attention. One such issue is Repetitive Strain Injury. This occupational health problem has been demonstrated to affect women more than men due to the type of work they perform (Meekosha and Jakubowicz, 1991). An analysis of this particular problem will go some small way to broadening the research of issues affecting women's occupational health and safety.

Repetitive Strain Injury: It's All in A Name

There does exist a body of research which has focused upon the conflicts, opposition and resistance that workers and their unions have demonstrated in relation to various workplace health issues, such as coal, asbestos, lead, cotton and radium (see Bayer, 1988; Judkins, 1986; Rosner and Markowitz, 1987; Smith, 1987). These analyses place the views and consideration of the workers centrally within the study. Such research, as stated above, is important for obtaining a more complete view of occupational health and safety problems. However, these

studies are based on earlier issues and investigations of the particular health and safety problem. What is missing from these studies is an analysis of a contemporary stuggle to construct an issue as a health and safety problem, with a focus on women. Such an investigation will allow us, for instance, to assess the extent to which there is resistance on the part of capitalists, health care researchers and professionals, and the state, to the construction of a new injury category.

Repetitive Strain Injury (RSI) is just such a current issue (cf. Brisson et al., 1989; Tieger and Bernier, 1992). It is a generic term which encompasses a number of different medical conditions "occurring in both white- and blue- collar workers" (Arksey, 1994: 453). Statistics reveal that RSI-related injuries are the leading source of workplace injury (Korrick et al.,1994; Ashbury et al.,n.d.) in North America.[5] Although RSI injuries affect both women and men, research demonstrates that women tend to develop RSI more often than men, because of the type of jobs women do (Meekosha and Jakubowicz, 1991). The umbrella term RSI

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[5] Yet, controversy exists around RSI type injuries. Indeed, the validity of these injuries is taken into question in terms of their work-relatedness, in fact, whether RSI actually exists (Kilbom, 1994; Arksey, 1994).

includes conditions such as "musculoskeletal disorders of the tendons, muscles, nerves, and bones of the upper extremities resulting from strains precipitated by repeated movements" (Robinson, 1994: 183). Indeed "RSI, is not a single entity but an assemblage of discrete disorders" (Hopkins, 1989: 248). RSI is suggested to develop from prolonged exposure to repetitive tasks which increases the risk of inflammation of the joints; specific repetitive motion injuries include "carpal tunnel syndrome, tendinitis, tenosynovitis, and epicondylitis" (Robinson, 1994: 183)[6]. Thus, a number of distinct medical conditions

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[6] Carpal Tunnel Syndrome - nerve damage in the area of the wrist known as carpal tunnel.

Tendinitis - inflammation of a tendon, also known as tendonitis or tenonitis. A tendon attaches a muscle to the bone, in contrast to a ligament, which attaches two bones together, without any muscle in between.

Tenosynovitis - Inflammation of the sheath of a tendon, causing swelling and pain when the tendon is moved. Synovitis is the inflammation or infection of the membranes that produce synovial fluid. These membranes and their synovial fluid surround tendons, joints, and other places where friction occurs. Also known as capsulitis or bursitis.

Epicondylitis - inflammation of the epicondyle or tennis elbow -- pain over the lateral epicondyle of the humurus, radiating to outer side of arm and forearm, aggravated by
dorsiflexion and supination of the wrist, or turning your hand over and back.

are brought under one single term in order to account for the cause and nature of the disease or injury.

There are, however, a large number of researchers and physicians who do not recognize the existence of the condition known as repetitive strain injury. Essentially these researchers believe that the symptoms described by the patient are all in the patient's head (Voiss, 1995). Indeed, Arksey (1994:449) notes that "RSI-type conditions are a contentious [issue] within medical circles in so far as there is little or no consensus on causation or pathology, or even on whether they exist". Moreover, a number of different terms are used to describe essentially the same set of symptoms in different countries, further confusing the issue. For instance, in the USA repetitive strain injury is called Cumulative Trauma Disorder or CTD, while in Australia, the terms repetition strain injury, repetitive strain syndrome or occupational overuse injury are preferred (Littlejohn, 1989, Hopkins, 1989). Diwaker and Stothard (1995) found that when asked about the meaning of the term RSI, doctors in the U.K. attached a host of completely different meanings to the term. In fact, the authors argued that the meanings attached to the term RSI

by the doctors were so variable that the term in itself should be considered meaningless (Ibid).

Apart from confusion over the meaning of the term RSI itself, there have been many medical researchers who have argued that the symptoms of RSI are reflective of a broader condition known as fibromyalgia[7] (Littlejohn, 1989; Waylonis et al., 1994)). Littlejohn (1989) argues that those who were diagnosed with RSI during the Australian epidemic in the 1980's exhibited remarkably similar symptoms to those who had been diagnosed with fibromyalgia during the same time period. Indeed, Littlejohn contends that RSI and fibromyalgia are, in fact, one and the same medical problem. Moreover, he (1989:50) notes that a

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[7] Fibromyalgia syndrome is generally taken to denote a clinical state of widespread musculoskeletal pain, stiffness, and fatigue but its pathophysiology, physical and psychological is unknown. The term is also known as polymyalgia or fibrositis. It is officially recognized by the arthritis society as a legitimate condition (Cohen M. and J.Quintner, 1993). Moreover, fibromyalgia like RSI, is a contentious issue among physicians. It has also been debated in several court cases that highlight the role of physicians as expert witnesses. In Alberta, a judge discounted the evidence provided by a rheumatologist who ran a clinic that treated fibromyalgia patients. The Alberta judge ruled that fibromyalgia "is often found in individuals who will not or cannot cope with everyday stresses of life and convert this inability into acceptable physical symptoms to avoid dealing with reality" (Capen K., 1995). See also footnote on polymyalgia.

change in nomenclature would perhaps be prudent and suggests the term "Regional Pain Syndrome". Research by Waylonis et al. (1994), tends to support Littlejohn's contention that RSI and fibromyalgia are one and the same condition. Their study, conducted in the United States, revealed that fibromyalgia sufferers experienced the same set of clinical symptoms as RSI sufferers. As well, it was found that these symptoms developed in similar work environments as those of RSI sufferers, in other words, jobs which entailed among other activities, keyboarding or typing, heavy lifting and bending, repeated movement and lifting of sometimes heavy objects and the like. Currently, however, it is not clearly established that fibromyalgia is a workplace health and safety issue. Researchers who conduct investigations into RSI are not willing to believe that fibromyalgia is necessarily the same as RSI. In fact, confusing the terms RSI and fibromyalgia dispels the work-relatedness of a set of debilitating, crippling and painful symptoms exhibited by a large number of workers, most of whom are women.

This discussion over nomenclature and symptoms is not simply a pleasing diversion but has important significance for focusing the efforts of health and safety

representatives of workers and the medical community, as well as the state (in the form of regulatory bodies, e.g. the Workers Compensation Board) and industry. What is occurring is that the status of RSI as an occupational health and safety issue is still being socially constructed. While some physicians may be willing to acknowledge the fact that a worker has an injury, say tendinitis, they are unwilling to classify it as RSI. Disagreement among physicians as to the basis of RSI-type disorders is widespread, existing in the United Kingdom (Arksey, 1994), Australia and the United States (see for instance Hopkins, 1989; Hopkins, 1990; Meekosha and Jakubowicz, 1991). Competing claims have been made by physicians as to whether the problem is physically based, or whether the problem is psychological (Arksey, 1994: 453). For instance, members of the British Orthopaedic Association, concluded that RSI does not exist, whereas, British rheumatologists maintain the contrary (Ibid.: 454).

The inconsistency over terminology makes it very difficult to compile accurate data from existing official statistics. This is due to the fact that official statistics of worker injury do not necessarily recognize RSI as a cause of injury, or injury type. Hopkins (1990:

370), for example, notes that statistics in the United States show that keyboard operators - data entry workers - do not suffer from RSI, but blue collar assembly line workers, on the other hand, do. In Australia, however, the opposite is true; keyboard operators suffer from RSI, blue collar workers do not (Ibid). In both countries, then, RSI is present in the official statistics, but in different categories of workers. What we are seeing in the differing categories of workers afflicted by the injury is the extent to which the category of disease is being differently defined in the two countries.

Indeed, Hopkins notes that in the Australian case, RSI seemed to be widespread among Australian Public Service Workers during the eighties, reference being made to an RSI "epidemic". Claims were made that RSI was a "purely Australian phenomenon, ... [in fact] ... an 'Australian disease'" (Hopkins, 1990: 365). However, the reaction by many in the medical community was a tendency to deny the 'reality' of any such injury; the problem was deemed to be imaginary, "a result of hysteria conversion" (Hopkins, 1990: 371). Resistance by physicians to a category of injury called RSI thus manifested itself as denying the physical nature of the problem and attempting to blame the

individual. In the United States, on the other hand, RSI has not been given legitimacy among keyboard operators. Instead, injuries caused by repetitive motion are given a specific medical term - for instance bursitis or tendinitis, thereby obscuring the RSI problem among those who work with keyboards. The tendency was not to deny the reality of the disease in the case of keyboard operators, "but to deny that it was work related" (Ibid., 1990: 371). Yet, at the same time, it is acknowledged that blue collar workers who work in the manufacturing sector, on the assembly line, do suffer RSI injuries (Hopkins, 1990; Jenson, et.al., 1983), thus concealing the RSI problem in some job sectors, while acknowledging the syndrome in others. Hopkins (1990) argues that this is due in part to differential societal and institutional responses between countries. He places some importance on "the role of institutional factors in generating or suppressing public awareness of the problem of RSI" (Ibid.: 366). He contends that a number of factors come into play such as the importance of nomenclature, or the manner in which - or if - data are gathered and recorded on occupational health problems. Such factors can facilitate or repress recognition. For instance, an analysis of Ontario Workers'

Compensation Board statistics for the years 1990 to 1994 do not yield any reported cases of RSI (Workers' Compensation Board, 1995). Instead, injuries are reported under specific medical terms (for example: tendinitis, bursitis or carpal tunnel syndrome), hence rendering RSI officially invisible in Ontario between the years 1990-1994.

Hopkins' (1989: 251) research in Australia demonstrated that RSI cases are distributed, most likely, amongst five classifications:

1. Polymyalgia
2. Peripheral enthesopathies and allied syndromes (including tendinitis, epicondylitis and peritendinitis)
3. Disorders of the synovium, bursa and tendon (synovitis, bursitis and tenosynovitis)
4. Disorders of muscle, ligament and fascia
5. Other soft tissue disorders

The medical terms for injuries thus spread out the number of workers suffering from RSI and their true extent are not then known. What this does is to impede any organizing on the part of workers around an injury issue. As Hopkins (1990: 367) contends, "none of these more precise medical terms has the easy appeal of RSI....the absence of any consistently applied terminology ... hinders the widespread recognition of the problem of injuries caused by repetitive

motion". Thus, we need to investigate the extent to which workers in Ontario suffer from these particular medical conditions in order to gain a general view of how widespread the problem may be[8]. Indeed, evidence suggests that health care professionals may very well make differing determinations of the cause of the injury, even when faced with the same symptoms and concerns. Given the problems inherent in relying upon official statistics for our data, we have chosen to examine a sample of workers in order to obtain views and perspectives of their injury. One aspect of our research, then, will be to investigate the circumstances encountered by injured workers when they went to their physicians. How did the physician treat their injury - as part of a larger category of injury (i.e. repetitive strain injury) or specifically as a medical condition (e.g. tendinitis)? Did their physician believe they had a physical problem or was their injury treated as a psychological problem?

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[8] Obviously it must be remembered that not all people who suffer from these medical conditions do so as a result of RSI. However, it is likely that a large of number of cases of RSI are included in these official categories.

RSI: Lessons to be learned from the black lung experience

The experience of coal miners in the United States during the sixties who fought to get 'blacklung' recognized as a legitimate and compensable work-related disease (Bayer, 1988; Judkins, 1986; Smith, 1987), is extremely informative in indicating how a disease comes to be constructed as legitimate within the medical community and therefore broader society. Smith (1987) notes "that doctors ignored or redefined as individual faults the manifest economic origins of [the] disease" (1987: 15). Indeed, instead of acknowledging the occupational or economic causation of disease, the cause was linked to the individual. What occurred, and still occurs, was a tacit acceptance of a belief that the source of occupational injury or disease could be attributed "to poor personal hygiene and unsanitary life styles" (Seltzer, 1988: 245); and "to self destructive personal habits like alcoholism" (Smith, 1987: 16).

Yet, there was a time, Smith (1987) contends, when physicians were accountable to their patients and the words of the patient were heard. She notes that during the first half of the nineteenth century there was no rigid division of labour between the theory and the practice of medicine;

the biological world of the body and the social world of the patient were not divorced (1987: 7-11). However, with the birth of modern medicine the patient's words are no longer heard. Instead patient's bodies turned into media for disease and the physician's focus changed to identifying discrete pathologies (1987: 10).

What this transformation yields is a new method of disease identification and control. If we cannot find an identifiable clinical entity, "or at least a quantifiable deviation from physiological norms" (Smith, 1987: 10), then the patient is by definition declared healthy. However, if a patient insisted on not feeling well, they were sent to the psychiatrist (Smith, 1987). Obviously, at least to those who adhere to this perspective, if no empirical evidence exists to suggest a possible cause then the malady is psychological in nature and not physical, despite what the patient may, or may not, say. Indeed, "the [p]atients' own testimony concerning their condition was relegated to a distinctly secondary, even suspect, status" (Smith, 1987:10).

The present RSI experience in Australia, the United Kingdom, and the United States reveals similarities between the struggle, during the mid-1900s, for the recognition of

black lung as a legitimate occupational disease and the acknowledgement of RSI as a genuine work-related disease (Smith, 1987; Hopkins, 1990; Reid et.al., 1991; Meekosha and Jakubowicz, 1991). Unfortunately circumstances have not changed much since the time of the black lung struggle. Generally, today, medical philosophy still does not challenge the economic interests of capital. In fact, economic origins of disease are still redefined by physicians as the individual's fault. Workers who suffer from RSI are often referred to a psychiatrist by their physicians, with the belief that their 'feelings of pain are in their head' (Reid et.al., 1991). Apart from accusations of malingering - as happened to miners who complained about lung ailments (Smith, 1987) - sufferers of RSI are told they are experiencing mass hysteria or normal fatigue, among other accusations. The cause of the malady or injury is thus seen in terms of an individual problem rather than having a work-related basis (Reid et.al., 1991; Hopkins, 1990; Bammer and Martin, 1992). Reid et.al. (1991) note that critics of RSI do not acknowledge the phenomenon as an organic reality, nor do they accept that RSI is a work-related injury or disease. Bammer and Martin (1992: 222) have found that those who do not accept RSI as

a work-related organic injury "also criticise recognition of a unified entity called RSI". In other words, critics of RSI are not willing to accept RSI as a legitimate disease arising out of the work activity of labourers and instead tend to focus attention upon individuals. Given the evidence above which suggests that RSI is a leading source of workplace injury, and that women have traditionally been excluded from much of the occupational health and safety research, and further that the views and perceptions of workers are also omitted from such research, it is timely that a project should investigate these areas. In order to do this we will need some theoretical underpinning to explain why women have been excluded and to explain the reactions of workers to their injury.

Feminism

Theoretical models from feminist authors exist which have attempted to account for the oppression of women. However, there is no single universal feminist view that can, without compromise, capture women's oppression in its entirety. In fact, it is difficult to use the term "feminism" on its own without some clarification. This is due to the fact that left by itself the term "feminism"

understates the contentions, the anxieties, the complexities of issues and the multiplicity of expressions and preoccupations that theorists are confronted with when they attempt to explain why women are exploited and are subordinated in society (see Jaggar, 1983; Tong, 1989; Bryson, 1992). In fact, Adamson et al. (1989) point out that "despite the commonalities of women's experience, their life circumstances differ considerably on the basis of race, class, and sexual orientation" (1989: 103). They argue that it is necessary "to deconstruct the unified category of 'woman' sometimes found in feminist analysis" (Adamson et al., 1988: 102). Hence, it is difficult to proffer one universal feminism; not everyone experiences, nor do they perceive, life's encounters and their solutions in the exact same manner. Therefore, feminists, despite the fact that most of them are women, have different ways of 'explaining' women's oppression and consequently suggest different answers to eliminating gender inequalities and their subordinating power relations.

It is exactly because of the different life experiences women encounter and the variety of situations in which they find themselves that a number of different feminist theories have evolved to explain their situations.

These various views are frequently grouped together into a smaller number of general approaches, based on their similar theoretical and methodological premises. These general theoretical views tend to emphasize differing phenomena as important in explaining women's circumstances and what mechanisms affect women's position in the social world and what women can do to effect change. However, it is beyond the scope of this study to differentiate between the different feminist theorists.

In spite of the fact of differing theoretical explanations, at the heart of these numerous analyses "there is widespread agreement that the ideal society would be one in which gender inequalities [are] ended and women enabled to realise their full potential in all areas of life" (Bryson, 1992: 264). While it may be advantageous to categorise different feminist theorists according to certain presumptions and theoretical considerations, Code (1988) correctly warns that attempts "to distinguish among separate strands of feminist thought should not ... obscure the significant overlap from one kind of feminism to another" (1988: 44). Indeed there are a number of "common causes [which] unite feminists of seemingly disparate ideological persuasions" (Code, 1988: 44). Specifically,

the recognition that women want to achieve gender equality. In other words, regardless of the particular feminist perspective, it is agreed that women are subordinated and encounter gender inequalities in society. What differs is the way in which each view characterizes the subordination and what means should be used to overcome it.

Yet, here we observe some problems within feminism. While feminists call for gender consciousness, so that women can eliminate gender inequality, they urge not to concentrate upon similarities - gender - too much, for fear that we generate a false universalism. In the meantime we are faced with a paradox because "just as feminism requires gender consciousness, [so that women can] eliminate gender roles; it urges [them] to
recognize their unity while attempting to account for their diversity", a diversity based in race, class, culture, age and sexual preference (Code, 1988: 45).

Patriarchy

Any discussion of women's oppression has to consider the way in which men dominate them based in patriarchy. Unfortunately, a definition of the concept of patriarchy is not as obvious as certain feminist authors

patriarchy they must address more than one level of reality and both social structure and ideology - gendered subjectivity - must be taken into consideration. Patriarchy, as a political process transforms "biological sex into politicised gender, which prioritizes the man while making the woman different - unequal - less than, or the 'other'" (Fox, 1988: 175). This process of differentiating woman from man which operates partially on the level of ideology, leads to the division of the private from the public world while it "establishes the sexual division of labour, the distinctness of family and market, patriarchal controls within the market, and so on" (Ibid.: 176). Thus, gender inequality is the product of social construction which confers power to men over women, while women are defined as the 'other'; in other words, patriarchy is the organization of male domination, at a structural level and at an ideological level.

Indeed, what we need is an analysis of patriarchy in combination with an analysis of capitalism. However, rather than having two systems which interact and overlap, we need to look at an approach that combines both concepts. Here the focus is on material, economic and social oppression. The term "patriarchal-capitalism" (Adamson et

al., 1988) expresses the fact that patriarchy under capitalism takes on a historically specific form which is intimately connected and inseparable from the workings of the capitalist system, thus both a class and gender analysis. The emphasis is upon the way in which both gender and class play a fundamental role in the explanation of women's oppression (Tong, 1989: 39; Jaggar, 1983: 370). Thus it can be argued that the position of women is affected by patriarchy and also directly affected by the mode of production understood in the Marxist sense (Doyal, 1983).

Furthermore, any analysis of women and their work must take into account the fact that women perform paid as well as un-paid work. This "double day" of work means that women's paid and un-paid labour are integrally entwined (Gannagé, 1986; cf. Luxton, 1986: 33). This has implications for how women workers perceive their work surroundings and their own identity as workers. Gannagé (1986: 18) explains: "While women ... work, their thoughts never leave their family responsibilities". Therefore, when investigating women's occupational health and safety we must attend to how their paid and un-paid labour are "dynamically intertwined" (Gannagé, 1986: 18).

What feminism seeks to do, then, is raise the awareness of how the dynamics of industrial capitalism make securing women's health problematic (Ruzek, 1986). As such, there is a vast possibility to integrate the central concepts of patriarchy and capitalism into a single theory. This would allow researchers to overcome the universalising bias of certain feminist conceptions of patriarchy and to establish that gender and class are important to understanding women's oppression. An important aspect of feminist theorizing in general is that women are not a homogenous group. Code (1988) and Adamson et al. (1989) have indicated that factors such as class, race and sexual orientation are important in shaping the life experiences of women. These factors would have to be considered in any analysis of women's subordination and experiences of occupational health and safety. Regard must be given in our approach to the different experiences of women and the multiple social divisions which affect their lives.

In addition to explaining the oppression of women, any study of women's occupational health and safety must take into account the fact that it is people's bodies which are being affected by the production process. Therefore, not only must we investigate the problems of women as

workers, but also explain how the body of a worker is affected by, and subjected to, the production process - whether that process be in a manufacturing plant or in a service sector occupation. Theoretical considerations of the body have tended to, recently, follow the work of Michel Foucault.

Bio-Politics: Regulating Society through Normalization

The concept of 'bio-power' encompasses the disciplining of the body as well as the regulation of the social body, and was a principle "element in the development of capitalism" (Foucault, 1978: 139-141). The disciplining of the body is aimed at achieving conformity and docility, it internalizes obedience, control and "produces subjected and practiced bodies,'docile' bodies" (Foucault, 1977: 138). Disciplinary power is about bodies which are regulated, trained, maintained and understood. It works at two levels. First, the individual body: "its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls (Foucault, 1978:139)". In other words the training and observation of individual

bodies, what Foucault (1978) called: "an anatomo-politics of the human body". Second and concurrently, populations are monitored. Foucault referred to this process as "regulatory controls: a bio-politics of the population (Foucault, 1978:139)". He argued that within social institutions bodies are examined and information is processed about them. In fact, specialists compare, differentiate, hierarchize, homogonize and exclude, in other words normalize (Foucault, 1979:183) information about people and their attributes, gathered through observation and examination. Additionally, the details of the human body are constantly subject to scrutiny and the knowledge of bodies, in aggregate, contributes to the development of the social policies. Moreover, there are three main instruments of disciplinary power: first, hierarchical observation, which refers to the sites (schools, hospitals, factories, prisons) where individuals can be observed. Second, normalizing judgement which refers to the fact that the actions of individuals are compared to those of others. Third, the examination which combines the normalizing judgement and the hierarchical observation. At this level the individual and his or her attributes are assessed and corrected. Thus, normalization is a sub-

category of bio-power, which in turn is a sub-category of disciplinary power. Furthermore, the concept of normalization, within the context of the thesis, refers to the regulatory steps people take obediently without question - such as going to the nurse, going to the doctor, going to the specialist, and filing workers compensation. Each step taken means that knowledge is gathered by specialists and normalizing judgements are made about the collected information on the individual. Thus, by following through these regulatory steps, ideas, disease, injuries and other attributes of individuals are normalized. Such obedience indicates the self-disciplining of bodies, it indicates a power - bio-power - that works from within as well as from other external sources. In this context Foucault talks about the multiple sites of power[9]. Therefore, it can be surmised that disciplining power is about normalizing judgement, which is needed to construct obedient bodies and by extension advances normalization. Obedient bodies - a necessity in a

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[9] The researcher understands binary power to be but one aspect of Foucault's broader conception of power as a multiple constituted phenomenon. Indeed, Lloyd (1993) argues that Foucault recognizes that power is located within relations of domination.

capitalist economic system - are subjected to constant surveillance in one form or another. The art of surveillance is an essential technique used in the operation of bio-power: it ensures a hold over the body without having to resort to the apparent use of excess force or violence (Ibid: 177). Thus, bio-power is about normalizing behaviour and regulating people.

As noted, bio-power is but one aspect of Foucault's broader conception of power. Moreover, Foucault (1980: 88) argues that power is commodified in a capitalist economy; it is in fact "taken as a right, which one is able to possess". He contends, however, that power is not, and can not, be possessed by anyone, it is instead permeable. Power surrounds the social body as well as individuals, indeed, "power is neither given, nor exchanged, nor recovered, but rather exercised, and it only exists in action" (Foucault, 1980: 89). In other words, Foucault "discard[s] the binarism characteristic of feminism (dominators versus dominated); but [acknowledges that] power is nevertheless still thought within a logic of relations of domination" (Lloyd, 1993: 444). Thus, Foucault does not deny the existence of systemic domination, however, he does reject the notion that "global

domination is the product of a binary structure and instead conceptualizes [power] as a multiple constituted phenomenon" (Ibid.).

Therefore, Lloyd (1993) argues, we need to reconceptualize patriarchy and incorporate a Foucauldian analysis of patriarchy within a feminist interpretation. She assures us that this will adequately address "gendered inequities within contemporary social and political discourse and practice" (Ibid.). It would mean a reconceptualization of patriarchy "as a particular and not universal historical phenomenon, such a reconceptualization does [acknowledge] the existence, or reality, of gender inequality as one of the hegemonic effects of power" (ibid.).

In other words, patriarchy should be understood as not one universally applicable, homogeneous, and centralized definition, but rather as a "multiplicity of discourses and practices that have had and continue to have specific bearing [on women's lives]" (Ibid.). Such a reconceptualization will then allow us to explore the diverse conditions under which different medical discourses emerged "concerning women's essential ... natures and their utilization within education, the labour force, health and

safety policy, in ways which discriminate against women" (Ibid: 445). It will allow us to see that the concept of patriarchy in itself is already fragmented, indeed such a reconceptualization "disestablishes it as totalizing and entirely dominative" (Ibid.). Thus, feminist strategy must change and opposition must come from multiple sites, rather than one unified position.

Central to the conception of bio-power, and a site of oppression of workers, are examinations. Examinations are "at the centre of the [disciplining] procedures that constitute the individual as an effect and object of power and as an effect and object of knowledge" (Foucault, 1977: 192). They combine acts of hierarchical surveillance and normalizing judgement to ensure the distribution and classification of the body. Through examinations, data are gathered and knowledge is created. For example, knowledge is gathered by the Workers' Compensation Board, with members of the medical profession acting as the examiners and gatekeepers to ensure that normalizing procedures are followed and injured workers are placed in their proper categories thus legitimizing their claims and normalizing their injuries.

Foucault (1980) states that scientific medicine regards patients as cases; the treatment of disease is stressed rather than the treatment of patients (Smith, 1987: 210). In other words, the technique of examinations turns patients into cases - knowledge gathering. But as Smith (1987: 207) contends, "[t]he practice and knowledge of science have been and are shaped by the social context"; that is, they are socially constructed. In fact the same holds true for "...the scientific construction of all disease, and the social role of physicians in controlling and applying that definition" (Ibid: 209). What is emphasized is "curative techniques, including surgical intervention, rather than on disease prevention" (Ibid: 210). Disease only exists when "it is experienced by the individual and diagnosed [- legitimized -] by the physician, not at the point when it is being produced" (Smith, 1987: 210). Thus, the very definition of disease constrains the possibilities of prevention (Ibid).

Furthermore, the scientific knowledge of physicians, which informs their understanding, is not neutral and is itself a social product "[i]n the context of policy formation, the scientific knowledge of medicine plays a mediating role between the interests of [capital]

and the actions of the state" (Smith, 1987: 214). In fact it facilitates distance between economic and political institutions, and "appears to ground policy in the neutral, technical knowledge of a third party" (1987: 214). Thus, policies and regulations set by the state determine the legitimacy of disease. These policies can be broad or restrictive. Smith (1987) demonstrates that such policies are created at the hands of politicians who have political motivations which do not take the needs of patients into account, but do take the needs of capital into account. In other words these policies are not based on 'legitimate' medical considerations but rather, they are based on political considerations. This in turn can mean that **disease can be defined, or defined away** (cf. Rosner and Markowitz, 1991). Thus, it can be argued that occupational disease, although a reality in and of itself, is a social construct - a definition described to indicate its contextual relation to the workplace.

As such, it will be argued, occupational injuries and disease are normalized by the state, the medical profession and workers themselves. Workers rationalize work-related injuries as 'normal'. To be injured on the job has become part of the workers' 'expectations' of their

job; especially when the worker perceives that there is no alternative to the job - 'bills have to be paid'. Moreover, the Foucauldian concept of disciplined bodies underscores the hegemonic effects of capitalism to the point where workers obediently report their injuries so that they can be added to the knowledge of the discipline. In other words, not only are women disciplined through the hegemonic effects of patriarchy, but they are also disciplined in a Foucauldian sense. By normalizing injuries it is not questioned whether you should expect to get injured on the job; in fact, the prevailing acceptance is that the injury becomes part of the job. If you want to work, expect to become injured (Judkins, 1986: 197-200).

Conclusion

A review of the occupational health and safety research literature shows that, while some researchers have completed interesting and compelling studies, much remains to be done. Specifically, a greater focus on the perceptions and views of women workers needs to be integrated into the occupational research process. Kaufert (1988) asserts that women must become better informed and take control of their bodies. A first step would be through a feminist epidemiology concentrating on women

rather than men. In keeping with Messing (1994), Kaufert argues that there is a need for a new feminist consciousness among researchers, a willingness to ground research in the experience of women and to treat other women not as objects of research but as participants. Medical researchers tend to downgrade the value of knowledge based on experience, treating it as subjective data of dubious validity or reliability. But Kaufert contends that women's experiential knowledge is needed; indeed, women's own knowledge of their situation must be taken into account at all stages in the research process.

For our purposes, then, research needs to be extended outside of the typical areas (such as, for example, focusing on women's reproductive problems) to reflect the wide and diverse occupational settings in which women are employed. One such area is the issue of repetitive strain injury. Our coverage of the RSI literature demonstrates a need to examine the manner in which women are affected by this disease. Evidence presented suggested that women may, because of the type of paid labour they perform, be more likely than men to suffer from the disease. In addition, a struggle is still proceeding to have this disease constructed as an

occupational health issue and this will afford us an insight into the manner in which the women workers attribute their health problems to the workplace or to something else.

Concepts from our review of the literature and theory will be used to account for the perceptions and views of the women workers. The reason for using feminist approaches is that these analyses have sought theoretical explanations for women's subordination. Some feminists argue that relief will be attained through an approach that works to change the prevailing system's socialization and legal barriers to allow women's full participation in the public sphere. While there have been gains by women through concerted action to change laws (such as the action around suffrage or equal human rights), these changes have not been reflected in a greater appreciation of women's important contribution to the paid labour force or their occupational health and safety problems. Such an assessment might be challenged by other feminists who argue that the legal system can be changed so that women will be included in research, and that women's work will be recognized as they become entwined in the paid labour market.

Yet, it must be understood that simply "adding-on" women to research studies is not enough. We must recognize the fact of the multiple determining factors of women's experiences and bring these into our research. There needs to be a shift in the way in which the experiences and feelings of women workers can be brought into the research process. Opposition to this comes at an ideological, methodological and structural level. Scientists are unwilling to have 'subjective' elements enter into an 'objective' research project; capitalists remain unwilling to allow workers' experiences to shape their work environment without some 'objective' data. What is necessary is not simply to provide equal opportunity for individuals, there needs to be changes to the law such that the occupational health and safety concerns of women are addressed. This must also include a restructuring of representation for women workers. The fact that women could, perhaps, participate equally in the paid labour force does not address any occupational health concerns that may be affected by their gender or complicated by the structural aspects of their subordination.

If we concentrate on the concepts derived from these feminist views, we see that the important dynamic

which capitalism plays in women's oppression is joined by the role of patriarchy. Feminist theorizing has attempted to integrate these concepts into a historically specific analysis of patriarchal-capitalism. But, this approach must take into account the various problems associated with feminist views, explaining the reason why women are structurally oppressed and why it is men who do the oppressing.

An interesting approach has been offered by Bale (1990) to the problems of workers' occupational health. Bale argues that work relationships in capitalist societies obscure the extraction of a surplus of workers' vitality, in addition to the extraction of a surplus of workers' value. This extraction is expressed most directly in work related injury and illness. Work-related injury and disease are part of a more encompassing class-based oppression written on workers' bodies. The accidents and illnesses from work are thus signs focused on the human body. Thus, the toll on womens' bodies reflects the subordination of their bodily vitality not only to the imperatives of capitalist production, but also to the imperatives of a patriarchal society.

The effects of work injury inscribed on the body of the worker are part of the Foucauldian conception of bio-power. Worker's bodies are disciplined so as to obtain an obedient work force. Examinations and surveillance, such as by medical professionals, obtain a hold over the worker's body and lead them to view occupational disease and injury as part of their work; something which is to be expected and accepted as normal. In order to change such a view it is necessary to demonstrate that injury and disease can be controlled and are not a natural part of work.

The usefulness of these concepts and ideas will be tested on a sample of women workers. We will investigate their perceptions and experiences in their work and of their disease - RSI. As well, the research will observe how their paid and un-paid labour activities are experienced, in the context of their injury. From our literature review it was demonstrated that the views and opinions of medical professionals are influential with regard to occupational health perceptions. Our study will, therefore, test for this information. Also, we will investigate how the women workers were treated by their work supervisors and bosses, as well as co-workers. Our

objective is to allow these working women to have a voice and let them explain how they perceive their injury, while explaining these within the larger context of concepts from Foucault and feminism.

Chapter 3

Research Methodology: Summer of '96

Rationale and Research Design

This study grew out of my interest in occupational health and safety issues affecting women, with a particular focus on repetitive strain injury (RSI). The design of the research was, therefore, based upon a number of factors. Given, the debate of whether RSI is a work-related condition, the controversy regarding the use of subjective perceptual data, and also the fact that little is known about the extent of the disease in Canada, it was decided that this study should be an exploratory design relying upon purposive sampling (Babbie, 1995). Thus, any conclusions reached would be tentative, and suggestive of new areas for future research.

Evidence from Arksey (1990) and Hopkins (1990) demonstrates that RSI has been attributed to both blue and white collar occupational settings. This dictated that data should be collected from each of a white and a blue

collar workplace. The choice of which specific blue and white collar workplaces to investigate was determined by convenience of access for the researcher and the cooperation of the unions in each workplace. Two workplaces, known to the thesis supervisor, were identified as fitting the requirements of having union contacts and also being situated in the traditional blue and white collar sectors. One of the workplaces was a library situated in Southern Ontario and the other was a manufacturing plant company, within the same geographic area. Since we were attempting to research the views and perceptions of workers it was natural to include the representatives of workers in the workplace, namely their union, in the research process. The unions keep track of occupational health and safety problems and thus union health and safety activists would be likely be able to identify sufferers of RSI.

The main thrust of the research was to obtain the views and perceptions of the workers, an element missing in much current research on occupational health problems (see Messing, 1990a). This would involve in-depth interviews with RSI sufferers in both workplaces. The results of the interviews would serve as the basis for our tentative

conclusions. Our review of the literature has demonstrated the need to focus on women workers as a group most prone to RSI. Therefore, it was decided, reflecting the exploratory nature of the research, to select a small sample of women workers from each of the two workplaces. We chose to interview twenty women - ten each from the blue collar and white collar sectors. By the end of the research process, however, my sample was fourteen women - five from the white collar sector and nine from the blue collar sector.

Identification of Study Groups

Having decided what workplaces to investigate, it was next necessary to obtain access to these workplaces and identify the groups for study. The contacts used by the researcher in both workplaces requested that the companies not be identified and the researcher assured the companies involved that all information would be kept confidential.

In the blue collar workplace I was given permission by the union local to do this study and received their full co-operation to conduct my interviews. The union also wished to inform management of the research. The resulting data, therefore, involved a fully co-operative effort between the union and the company. While the union laid

the ground work for the initial contact between management and the researcher, there was no further contact with the union after that. A contact person in the Human Resources Department served as the point person.

Gaining access to the white collar workplace proved more difficult. It had been my original intention to study the library workplace, but there seemed too few people for the sample, only seven rather than the desired ten. Attempts to establish contacts in another workplace proved to be fruitless. It was decided, since the study needed to proceed, that seven subjects would be better than none. A union health and safety activist in the library workplace was contacted and used to identify and put me into contact with, the injured women to be interviewed. There was no contact between management and the researcher at all in this workplace.

Seeking Interviews

The Human Resources contact in the manufacturing company identified ten prospective respondents, set up and then scheduled each of the interviews. Each interview was conducted on the premises of the employer. Out of the ten subjects originally identified, nine were actually

interviewed. The women seemed secure in their employment and were not hesitant about participating in this research. Unfortunately one prospective worker cancelled her scheduled interview. A make up interview with another subject was promised to me, but was never scheduled. This was due to the fact that while the data collection phase was proceeding, the company experienced an increase in their production line and workers needed to be recalled to work or additional workers needed to be hired to meet production needs. At this point I did not think it prudent to insist on that last interview, since it became rather hectic for the Human Resources contact.

The union contact in the white collar workplace was, as stated, only able to identify seven prospective subjects. This was smaller than the originally intended ten women. One of the prospective interviewees was a former union member, and union representative on the occupational health and safety committee, but is now in management. This person has, though, suffered through RSI.

It was harder to secure the co-operation from the workers in the white collar sector than the blue collar sector. Indeed, for a number of reasons, it would prove to be impossible to interview all seven women. The major

reason related to the fear of job loss. Some employees, despite the fact that they were unionized, were afraid to follow through with their commitment to be interviewed. The white collar sector library is currently experiencing financial restructuring as a result of funding cut backs. Hence, the women, in this workplace, were less confident in their job security and not all of them wanted to participate in the interviews. In fact, one of the women stated:

> Yeah, right now, as you know, with all the cutbacks ... people really are a little bit scared that they might be out of a job, so they hold back. (Interview #1, 1996).

I was, therefore, only able to secure five out of the seven promised interviews. Attempts by the union contact to obtain more interviews proved to be ineffective. At a much later date the researcher learned about a group of workers, within the library, who were diagnosed with an alternative condition, who could have possibly qualified for an interview. However, these injured workers were not willing to be interviewed at all.

Since the library's management was not involved, interviews with the white collar workers were conducted outside of the workplace, in their homes. This allowed the

women to be in a more relaxing and familiar atmosphere. The context was non-threatening. However, on occasion, this venue was not appropriate as interruptions and distractions from family members (such as husbands) did occur. Such interruptions did not significantly affect the quality of the answers, perceptions, and thus the data collected were sound.

Performing Interviews

The interviews for this study were conducted from January, 1996 to April, 1996. An interview schedule had been constructed and approved by the thesis committee, as well as a release form that had been approved by the ethics committee. The interview subjects were assured that all information and data collected would remain confidential and that the management of the work places would not be given any information. A copy of the research thesis report is promised to the respective unions.

My interview schedule was devised based on information and findings from the literature review. It was designed to obtain information regarding the research subjects' perceptions and experiences with the disease/injury they encountered in the workplace and how

this affected them at work and at home. The main areas of interest were:

section A: Workplace

section B: Self-evaluation of the injury
i) Evolution of illness: perceptions of
ii) Actions: Addressing the issue
iii) Miscellaneous

The interviews were conducted at the company in the case of the blue collar workers and at the homes of the white collar workers. Each interview was tape-recorded and the researcher took additional notes when necessary. The interviews were then professionally transcribed verbatim, between the middle of February to the middle of June. Additionally, an extra set of batteries and tapes were brought to each interview in case there were any difficulties or that the interview should last longer than expected.

It had been my original intention to follow the interview schedule closely and diligently. This would provide for the greatest validity and reliability of answers from the subjects and subsequently better data. However, the nature of the research process, and of human dialogue and interaction, are such that the best laid plans

of mice and researchers do tend to go awry. As best as was possible the interview schedule was followed. Nevertheless, the subjects' answers to the first questions on the interview schedule were frequently quite comprehensive or strayed off the topic of the question. This meant that later questions were unnecessary or needed to be qualified. This led, therefore, to the researcher using the interview schedule as a guide to the major topics which needed to be covered in the interview process. Additional information and insights were noted by the researcher and included as guides for later interviews.

Since the role of the union in workplace occupational health and safety education is a key consideration, the researcher also interviewed union representatives from each workplace in order to flesh out the data obtained from the interviews of the women RSI sufferers. In the case of the white-collar union this was a relatively easy process since I simply requested the needed information from my union contact. However, in the blue-collar workplace there were difficulties. The present union has only been representing the workers since the early 1990s. Prior to this time another union had represented the workers. While I was able to obtain some

information from a former contact of the previous union, it proved impossible to get information from the present union contact. Attempts to acquire this information were unsuccessful. Contacts from the union were not forthcoming.

Analysis of Interview Data

Having conducted, collected and transcribed the data, it was necessary to organize and code the interviews. This was a long and laborious process. While I had given thought to using computer software to speed-up the analysis of the data, I felt that given the time constraints, the learning curve and small sample size, it would make the analysis relatively easier if performed by hand. Indeed, the coding of the data meant that I became more familiar with the overall content of the interviews and data.

I organized the coding scheme so that it reflected generally the organization of the interview schedule. The coding scheme was identified thematically as follows: 1) Worker ID - some demographic background; 2) Workplace - labour process as well as workplace background; 3) Personal Action - actions the women took to alleviate the pain; 4) The women's perceptions of - their treatment by medical professionals and treatment by others (such as family

members and co-workers); 5) Union participation - their involvement with the union; 6) Self-evaluation - in this section the women give their impressions of their experiences with the disease/injury, how they feel about their condition, the problems they encounter, in other words, the core of the thesis.

The information on union educational programmes and the emphasis put on health and safety issues within the workplace, were provided by the union representative interviews. These data were integrated into the interview data from the women workers to give a fuller context to the workplace perceptions of the women.

Study Limitations

Our research design was chosen to minimize as much as possible, potential weaknesses. Unfortunately, it remains incomplete on certain issues and areas.

A problem that I attempted, unsuccessfully, to address was the small sample size. While satisfied with the nine women from the blue collar workplace, I remain somewhat concerned regarding the five women from the library. In part this is due to the fact that only four are presently union members, the additional subject having

been a former union member. Also, the sample size remains approximately half that of the blue collar workplace sample. Therefore, our research from the white collar workplace may be affected. While our conclusions are tentative, we do feel that there is likely to be some applicability to a more general group. However, with our small sample this is somewhat compromised. Nonetheless, it must be remembered that it **is** an exploratory study and I believe that the conclusions drawn from the data although tentative and suggestive, can be supported by the data - even given the small sample size.

An additional problem is that the sample of women chosen from the blue collar workplace, the manufacturing company, were identified by a Human Resources contact. This means that a bias in the selection of cases may have taken place. People who potentially could have been included may not have been. For example, the possibility exists that the sample may be biased in that RSI sufferers who were asked to participate, were known to be non-active union members (that is, they did not attend union meetings or participate in any other union related activity).

Furthermore, it is also conceivable that this study was perceived as solely a management initiative by the rank

and file membership in the manufacturing plant. Therefore, those who were active in the union and had RSI may have refused to participate in the study, because they felt that they could not trust it. These are assumptions at best. However, they are noted so that the apparent inactive union behaviour in this group of women can be contextualized. Then again, it might be that the women with RSI injuries in the manufacturing company are just not active in the union.

Conclusion

The women workers suffering with RSI are experiencing unique and painful circumstances. It is not possible for anyone to purport to know nor imagine what these women actually experience. At best they have allowed us a brief glance at a very personal situation, which barely scratches at the surface of their true condition. Time constraints and the inexperience of the researcher acted to hinder the implementation of an ideal research plan. Yet, the evidence obtained seems to be significant. Additionally, while a larger sample size may have lent more weight to the conclusions derived from the study, the researcher remains convinced that the results are very useful.

Chapter 4

I can't hold my baby

Introduction

This chapter is one of two which will serve to introduce the data collected. Given the exploratory nature of the research design, a major part of our discussion in this chapter and the next will concentrate on describing the data. However, preliminary analytical observations will also be integrated into the discussion. Our aim is to present the workers' own insights, feelings, encounters and understanding of their injury, how they were treated and coped with the situation, and how this is connected to the normalizing process of work related injuries. This chapter, following generally the layout of the interview schedule (see Appendix XX), will investigate the experiences and perceptions of the female employees in a white collar sector workplace. We will begin by setting out the workplace job tasks and conditions of the workers.

Following this we will focus on the personal acts and experiences of the women attempting to deal with their pain. This will lead into a discussion of the women's perceptions of their treatment by co-workers, families, the employer and medical professionals. Furthermore, we shall detail how the pain and suffering of the injury has affected their paid and un-paid labour. In spite of these problems, some of the women do not perceive their injury as being caused solely by repetitive work, nor do they view the employer as being responsible for providing a workplace that would prevent such injuries. Lastly we will describe how those women who did seek Workers Compensation found it a tedious and laborious procedure.

Sample Characteristics

The sample selected from the library consists of five female workers employed an average of 18.4 years with an average wage of $19.50 per hour. Given the small size of the sample any of the conclusions drawn from the data can only be suggestive. However, while this may be true, the information provided by the women in their interviews does yield some important insights into the problems they faced with their injury. As well, the material from the

interviews allows us to do a preliminary comparison with the women in the manufacturing plant, again contributing useful information.

All of the women in the library had held at least three different positions, or had worked in at least three different departments. In other words, none of the interviewed women had worked in just one single job, department or branch for the duration of their employment. While it was difficult for the women to remember exactly if the duties they performed in all of their previous jobs fit their actual job descriptions, in most cases they remembered that there was little or no difference between the job descriptions and actual job duties they now performed, or had performed in the recent past. The repeated work task movements and motions, therefore, were not isolated to a single job task, category, or department but rather were an integral part of all the women's jobs.

On average, this sample of women had worked seven and a half (7.6) years before they became aware of their injury. Three of the women had worked fewer than ten years, while two had worked ten years or more, prior to becoming aware of their injury. All of the subjects had children, ranging in age from as young as five years old to

as old as thirty eight years old. Moreover, all of these subjects were married.

All but one of the five women interviewed from the library were union members, three were or had been active in their union local. Two women still attend union meetings, while the third is no longer involved. In fact, she is no longer a union member. She had been the occupational health and safety representative for the local, a post she had to give up after she was promoted to a managerial position. In other words, two out of the five women still attended union meetings or were otherwise involved in union activities.

Workplace

The white collar sector workplace selected by the researcher is a library in Southwestern Ontario. Traditionally such workplaces are female-dominated and generally perceived to be safe and appropriate for women (Krahn and Lowe, 1993: 72-75). Additionally, the chances of getting hurt in this workplace are not considered to be high.

The work tasks performed by the women in the library involved a variety of hand and wrist movements, as

well as repeated lifting, putting down and pushing of - sometimes heavy - books within 'tight' time constraints. These "fast paced" (Interview #4, 1996) employment responsibilities were performed repeatedly during their work shift (normally 8 hours) and over an extended period of time, in the words of one of the women: stamping "hundreds and hundreds of books, just pound it ... and pound it [all day long]" (Interview #1, 1996); doing "the same thing over and over again" (Interview #3, 1996). Exhausting employment tasks were performed in difficult work situations:

> People come and pile the books on the desk. And you might get four or five hundred books in the course of an hour and a half to two hours, books and records and whatever. And you need to scan all the bar codes. And as they pile up high you need to sort of stack them so you're working at a really awkward angle. Up and moving things, and then shoving them on shelves and giving them to people ... with this gun that had a trigger. (Interview #4, 1996)

The employment duties also entailed fine finger work such as flipping "through two, three, four, five, six, eight hundred [cards] a week" (Interview #4, 1996).

Apart from repetitive manual tasks such as lifting and moving books, the women had to perform typing or computer duties, entailing performing searches or

communicating over e-mail. All of this meant using the keyboard extensively over eight hour workdays as explained by one of the respondents:

> I have 6 or 7 programmes open and running which would include e-mail, internet, search assisting, programming [and the like]. I might have two or three sessions of our automatic library system open in just that one machine (there are two in her office, running simultaneously). I am back and forth between keyboards, the phone and talking to people. (Interview, #4)

Or as another respondent noted:

> When I first started at the library, I was basically just typing. Straight typing orders is what I began with. And I did that constantly all day long. I sometimes unpacked books too. I also did a lot of circulation work, a lot of getting the books ready to reserves. Like putting wrappers on them, putting them on the shelves. The majority of my job was to check books in and out with the wand. You spent 4 hours a day on the desk. Handling the books and the wand and even when you were off desk you were doing the wand a lot 'cause you brought books down. We used the wand over the bar codes, but if the information wasn't there, you had to type in the information. I did a lot of processing, repairing books. I used to handwrite all of the information onto sheets and then put [it] into a computer, so I was doing a lot of typing. [Now] my job duties are processing invoices [on the computer]. Books are unpacked and the slips are pulled. I then, using a calculator, add up to make sure that we got what we ordered and it was the right price and that the price balanced with their invoice so they're not short. [However], at present we're in the process of changing our jobs and we're doing a lot more computer work. Typing and processing magazines, getting them ready to

> go down to the floors. I edit books so therefore I'm doing a lot of checking, making sure that we got the correct book we ordered. These are the things I do with my hands that bother me. (Interview #3, 1996).

As the interviews demonstrate, library work does not entail solely checking in and out of books, nor cataloguing and processing books. It also includes doing research for clients, doing searches for the library, highlighting articles and transferring information into computer data banks. In the words of one of the respondents, it meant:

> I would get all the journals and catalogues and I would highlight the important, the relevant fields of information that the typists need to quickly spot what they needed to type. So I was highlighting, turning the page, highlighting, turning the page, highlighting ... I had both highlighter and pen in my hand and I was flipping the pages. Or there would be a massive ordering campaign [which precipitated] a very heavy spurt of typing. [While] I was doing a lot of news magazines, catalogue page turning, highlighting as well as putting through the slips, as well as programming on the computer. All day long! (Interview #4, 1996)

Moreover, this same respondent commented on the use of the wand at the check in and out counters. She notes that:

> One of the things you'll find at libraries in the checkout desk, [is that] we used to stamp [the books]. Well, some brilliant person invented a stamp [which has a wipe pen] on one end. So you wind the thing and then twist it and stamp.

> [Thus] you wind and stamp, you wind and stamp. Just a stupid idea, wipe, pen, stamp. (Interview #4, 1996)

Instead of just stamping or just wiping over the barcodes, now the women have to combine the action. This means twisting your wrist, pound the stamp and swiping your arm, everyday, in four hour shifts, in addition to other repetitive duties to be performed. One of the respondents noted that instead of the library lightening the load of their jobs, "there are new jobs being added on [to our workload], because other ones are taken away" (Interview #1, 1996). Thus, fewer people are used to do essentially the same amount of work. This same respondent looks after the daily newspapers, which means that: "I check them in. Staple them together. I stamp them and I put them out" (Interview #1, 1996). Furthermore, "I do a lot of item entry and a lot of corrections, [which means] a lot of keyboarding" (Interview #1, 1996). It had been mentioned by all of the women that they were in the process of switching to a new computer-system. This meant that all of the women experienced an increase in keyboard use. One of the women notes that "now everything's computerized, so I'm spending a great deal of my time now at the computer" (Interview, #5, 1996). She also makes reference to the

fact that her work "has become more of a repetitive thing than it was before ... [when] I did an acquisition clerk type job" (Interview #5, 1996). She continued by explaining that:

> I handle all standing order titles, things that come out every year. I actually place the orders, receive the orders, do the invoicing, handle large books, 'cause usually they're large, real heavy books. I type order forms, but it's mostly handling books and you know, processing them. I take them from the book truck to my desk. I actually have to handle every volume of every title where before I handled only one copy of it. But now we're handling each one, bar coding them and writing in them. So it's a matter of now pulling a book down, putting it on my desk, doing whatever I have to do with it, putting it back on the truck. So each item's handled now. Hundreds of them (Interview #5, 1996).

Yet, another respondent noted that the job duties varied, "depending on whether I'm at a small branch or a large" (Interview #2, 1996). She explains that in "a small branch ... you do basically everything, from checking in the books, giving new cards, handling the books as well you do the clerical stuff" (Interview #2, 1996). However, at a large branch "my main function is to work at the reference desk, that's it. Most of the day I'm using the computer, I help people answer reference questions. Of course, I'm usually typing" (Interview #2, 1996).

There are no medical facilities at the workplace. The library does not make available or employ a company doctor or nurse for its employees. Should a worker develop a work-related injury - such as Repetitive Strain Injury (RSI) - they must visit their personal physician, or their preferred alternative medical professional, to have their injury tended.

In sum, the work performed by the women involved repeated bending, moving, twisting and overhead reaching of the arms, hands and wrists. The women also had to contend with changes to the workplace as keyboarding and computer use were increased, which put a further strain on their arms and fingers.

Description and Experience of Pain

The unpredictability of the pain associated with their injury was a great source of stress for the women. This was due to the fact that while the respondents reported experiencing episodes of intense pain, the episodes where intermittent rather than constant. All five of the research subjects expressed their anxiety and frustration with their pain: "the pain would be so bad that I'd sit at the desk and cry (Interviewee #3, 1996)". In

spite of having taken steps to address their condition, each of the women still worried, and for each the pain had been or still was severe enough that it woke them up at night. In fact, their injuries were such that all of these women could no longer perform the full range of tasks that they could do at the time they were hired. One interviewee noted that "I can't do things that I used to. I don't have a grip anymore (Interviewee #3, 1996)".

The unpredictability and severity of the pain filled their lives with uncertainty - never knowing where, when and if the pain would ever go away, or if there would be an answer to their condition. Indeed, this unpredictability added to the stress suffered by the women since they began to question their own judgement. They frequently felt anxious about their condition, especially because their pain/injury could not be seen. One respondent noted:

> [I]t took me a long time to even admit that there was something [wrong] - but, it amazed me at how hard it was to get anybody to take me seriously (Interview #3, 1996).

It did not seem to matter what tasks the respondents performed during the day. Often, a sudden onset of pain left them wondering what had been different

from the day before, what had caused the pain this time. The pain of the injury affected the women and was a constant reminder of their ailment:

> I was in chronic constant pain ... sometimes it was localized to maybe my wrist or a finger, or the elbow, or the lower shoulder. ... It wouldn't be swollen. It would just be in pain ... (Interview #4, 1996)
>
> I have pain in my wrist and [when I work a lot] then it gets really bad. When it gets bad it works right up to my shoulder (Interview #2, 1996)
>
> If you leave it alone then it [is]n't so bad, but the moment you try to use it - well...(Interview #1, 1996)

Thus, for the women living with the daily pain of their condition, the uncertainty of their situation added to their stress of coping with their predicament.

For all of these women the pain of their injury was an ever present problem. Yet, the women varied in terms of how they accounted for their injury and pain. One woman was certain that the injury and pain were directly attributable to her job: "[I] think that it [the injury] was work related" (Interview #3, 1996). However, most of the women were willing to follow the diagnosis of their doctor; if their doctor did not attribute it to their job then neither did they. One of the women originally had

believed that her injury was work related, but subsequently changed her mind when she was diagnosed with fibromyalgia (Interview #4, 1996). One of the women was convinced that her un-paid domestic labour was perhaps a contributing cause to her injury (Interview #1, 1996). The women were certain that their pain was real, but there was variation in how they accounted for the pain.

Personal Action

All of the five women sampled suffered from an injury. Four of the women had been originally diagnosed with carpal tunnel syndrome, while one woman had been originally diagnosed with golfer's elbow or tendonitis. Subsequently, however, one of the women with carpal tunnel syndrome and the woman with tendonitis were diagnosed as suffering from fibromyalgia. Each of the women had sought the assistance of a medical professional for their injury.

Reid et al. (1991) describe the process through which women suffering from RSI in Australia sought to obtain medical help as a "pilgrimage of pain". Their "pilgrimage" followed a "meandering course from general practitioner [GP] to GP, GP to specialist, to physiotherapist and so on ... in search of relief" (Reid et

al., 1991). This process was mirrored in the experiences of almost all of the women in the library sample. All but one of the women had gone to their family physician for consultation. Following this, some of the women went to a specialist or to surgery. Of the five women sampled, three had at some time visited a specialist, and four of the sampled women had at some time gone to a surgeon, albeit not necessarily in that order. Furthermore, three of the women attended a physio-therapist, though two of the women felt that this did not help, or had made the injury worse. Two of the sampled women had also sought treatment by a chiropractor. In fact, one of the women had only gone to the chiropractor and not to the doctor. It was the chiropractor who informed her that she suffered from carpal tunnel syndrome. While four of the sampled women had visited a surgeon, only three had undergone surgery for carpal tunnel syndrome.

Four out of the five women had taken time off work due to their injury, but not necessarily for surgery. Of these women, only two had reported their injury to the Workers Compensation Board (W.C.B.) and received benefits. Both women had undergone surgery. Of the three women who did not claim Workers' Compensation, two had not undergone

surgery while the third woman had surgery performed, but had only claimed sick benefits through her place of employment. Surprisingly, this woman did not recognize her injury as work-related. Indeed, she argued that it would not be possible to "prove that this was a workers' compensation situation, because, you know, I do a lot of other things. I mean, I do things at home too" (Interview #1, 1996). So, only two of the five women injured had actually filed a claim with Workers' Compensation and received benefits for the injury because they felt that it was a work-related problem at the time.

The four women who had originally been diagnosed with carpal tunnel syndrome wore wrist supports at night and during the day while at work to help cope with the pain. These wrist supports were a source of anxiety for some. One of the subjects felt that it was awkward and uncomfortable especially at night: "I couldn't bend my wrist .... both hands, I had to sleep like that" (Interview #4, 1996). Another felt that it stigmatized her: "I have to wear a splint all the time. Because I can't grip properly ..... people can see me" (Interview #1, 1996). A third woman wanted to hide the injury/pain from her employer: "I try not to let them know that [the injury]

affects me. [But] everybody sees that I wear the wrist band because it's quite large and lots of people commented on it, actually" (Interview #2, 1996). Yet another noted that:

> It's really ugly looking and it's awkward for sleeping because you got to put one on and then get the other one on ... I hate the night braces. I wish they'd come out with something a little more comfortable. You look like you're a monkey!! (Interview #3, 1996).

All of the women sampled were on medication for their injury. Two of the women had also been treated with cortisone shots. Neither of them liked the cortisone injections; in fact, one of them had an adverse reaction:

> I finally had cortisone in my wrist and it crystallized. It never happens, but it happened to ... me. That's why I've been leery to have it done on this one. (Interview #5, 1996)

Anti-inflammatory medication had been prescribed for, and was being taken by, three of the women. Of the two remaining women, one took aspirin while the other noted that she was allergic to all types of anti-inflammatories and hence could not take them, including ASA (Acetylsalicylic Acid - Aspirin).

Interestingly, two of the women were taking mild anti-depressant medication to help them with their sleep

patterns. This was not necessarily greeted enthusiastically by the women. One of these women questioned her physician:

> ... I'd be stiff and what not. And I saw him [the doctor] several times before he finally gave me a prescription. And when ...I checked out what the prescription was and it was for an anti-depressant. And I called the doctor's office right away, very angry, why he had given me an anti-depressant when he hadn't told me that's what it was. Because I knew damn well I wasn't depressed. (Interview #5, 1996)

According to the women, the rationale articulated by the physicians for giving the mild anti-depressants, was to help their bodies re-learn how to relax during sleep, so that their muscle tissue could get recharged for the next day. The condition which the physicians were describing, the inability to reach the level of sleep in which your body relaxes and refreshes its soft tissue, is called fibromyalgia (Interview #4, 1996). A condition that is not recognized by the workers compensation board in Ontario as work-related (interview #4, 1996). Thus, the women's pain was attributed to a sleeping disorder.

What this latter diagnosis did, however, was to shift the focus away from the repetitive activities performed by these women at work and any possible

consequences this may have had for their pain. Instead, blame for the pain is placed on the personal/non-work-related activities of the employee. In fact, Littlejohn (1989) argues that fibromyalgia is synonymous with RSI in most cases. He contends that it is another term for explaining painful conditions which workers develop during the course of their employment for which there are no ready answers and are, thus, difficult to solve. Of course, redefining repetitive strain injury in this manner obscures the work-relatedness of these painful conditions workers endure and undermines the ability of workers to mobilize around the condition as a work-related disease. Unfortunately, the two women diagnosed with fibromyalgia willingly accepted this diagnosis that their pain was not work related. Indeed, one of the women had originally thought her injury work-related but subsequently changed her mind when informed by her physician that it was fibromyalgia. The main concern expressed by both women was to find a treatment to make the pain go away.

Perceptions of Medical and Social Treatment

The women's experiences varied in terms of how they perceived the treatment they received from their families,

colleagues and employer as well as their physicians. Nevertheless, a common underlying thread was that their condition had caused them social and emotional problems to differing degrees. In most cases the women found that their family physician was very supportive, accepting and understanding: "He sent me to people, he sent me to specialists, tested me for lyme disease when I insisted he do it. He was quite good and he was very supportive" (Interview #4, 1996). However, some women found that the specialist was less accepting of their condition or the urgency of their injury; they were often not as understanding or supportive of their situation. As one woman explained: "the specialist was questioning everything I said, ... I got the feeling that he thought that it was in my head" (Interview #5, 1996). In fact, one specialist explicitly stated that he did not want to bother with a workers' compensation case:

> ...he was very cordial and was washing his hands of it. He made me feel like a second-class citizen. Like it was all in my head. And I walked out of that office very disillusioned, almost in tears, because I knew my hands were hurting and I knew this wasn't in my head (Interview #3, 1996).

Some doctors attributed the injury to the workplace. One of the respondents noted that she considered herself lucky, since her family doctor was very progressive and "knew it was work related" (Interview #4, 1996). However, she prefaced this remark by noting that as the previous occupational health and safety union activist, she knew of "some other people in this local, who had repetitive strain injuries [and whose] doctors weren't necessarily as supportive" (Interview #4, 1996). Other doctors attributed the injury to normal wear and tear and the ageing process of the body:

"Well, ...[I was told] 'You're getting older and it's osteo-arthritis and it's normal wear and tear'" (Interview #1, 1996).

The women whose doctors did not want to acknowledge the work-relatedness of their injury, were themselves not willing to attribute their condition to the workplace. One woman, though, was quite insistent that her injury was caused by her job. She explained that she:

> ... was sitting down crying at work. Because, before that, it was like -it seemed to be worse when I used my hands at work. And when I get home and stuff like that, the tingling and that would stop till I went to bed. And then ... again in the morning, you know.... and it seemed

> to be after I did my job for a little while, that the numbness would come and the pain would come... (Interview #3, 1996).

The response from her surgeon was that her pain and injury were pregnancy related. This woman, however, was very sure it was not and reacted quite strongly:

> Excuse me? ..Pregnancy related? I said, why then with both my pregnancies, all three of my pregnancies, all while I was pregnant I never had a problem? ... I don't understand that one, because if it's pregnancy related I could accept that. But why is it, it hurts now after I've had the children? And I am back at work? [I] think that it was work related (Interview #3, 1996).

She explained further that it was clear to her that he had dismissed her and the fact that this doctor was not willing to give her legitimacy was quite disturbing to her and a further cause for distress. She began to doubt herself, but felt that the pain clearly could not be just in her head:

> ...It's the state that it does to your mind. I went through a real depression because they wouldn't listen to me. And it really affected my mood. It affected the way I reacted to my children ...the way I reacted to my husband. (Interview #3,1996)

Other women experienced similar self-doubt regarding their injury and its cause:

> I know I have it because when I read material, you know, someone else's experience, '[O]h yeah, yeah, that's what's wrong with me'. And then other times I'll say, 'Maybe I don't have that. Maybe it's something else'. I've got to the point where I question myself sometimes. (Interview #5, 1996)

The stress suffered by these women was exacerbated by the fact that their treatment from the medical profession did little to alleviate the pain.

Despite the fact that the symptoms of the respondents were similar in all cases, several different diagnoses - fibromyalgia, carpal tunnel, bursitis, tendonitis - were given for essentially the same condition. This situation is not uncommon. Ewan et al. (1991: 176) note that RSI is a mystery to health professionals, as a result there is no "accepted medical diagnostic criteria for soft tissue or musculo-skeletal pathology". Moreover, the authors note that:

> the Medical Journal of Australia carried articles on RSI [identifying it as an] ambiguous condition similar to (or the same as) tenosynovitis, tendonitis, bursitis, carpal tunnel syndrome, fibrositis [or fibromyalgia], rheumatism, thoracic outlet syndrome, de Quervain's syndrome and so on (Ewan et al., 1991: 169).

The experiences of these women are clearly comparable to Reid et al's (1991) account of women with

repetition strain injury and their "pilgrimage of pain", where it was found that the dominant theme of the women's accounts was the anxiety about being believed by their doctors, friends, families and workmates. The women felt that some sort of legitimacy had to be established. Their injury had to be validated; the use of a wrist brace made their condition visible, however, a surgical operation was perceived to be the 'real' thing:

> It's surgery right? They're cutting [you] open ... nobody likes that ... (Interview #4, 1996)
>
> They had to open up in the carpal tunnel and it's definitely ... real (Interview #1,1996)
>
> I've had surgery for mine. [And after my surgery] I am sitting at my desk and the manager she looked at me and she says, 'I didn't realize you had that problem'. And I am just sitting there thinking ... so now it's O.K.? (Interview #3, 1996)

Respondents also felt it necessary to note that they were not malingerers and wanted to ensure that the legitimacy of their claim was understood and accepted by all - co-workers, family, employers and physicians. Indeed, they went to great lengths to point out to the researcher that they wanted to work and that they enjoyed their work:

> I don't want to be seen as roguing them, I'm not trying to be one of these people that get paid and stay home. I enjoy going to work (Interview #3, 1996).

They wanted to be seen as hard workers; in fact they perceived themselves as working harder than others:

> I am a very conscientious worker, you know. I never got anything for nothing since I was sixteen years old. You think: Look, I don't want to put some - you know - put up a false front, you know - I am not faking it. I am a good worker and I never shy away from doing any work (Interview #1, 1996).

Moreover, the women needed to work. Indeed, the decision to keep working and to contribute to the family's financial resources was a another source of anxiety:

> I want to make sure that I am called in another day. I make sure that, no matter how much it hurts, I continue. I don't slow down. I don't want to say: 'No, I don't want to do that one task because it's too heavy'. So, I don't let it because I'd rather have the pain later than have to take the chance of losing the, you know, the work....I am afraid that if it gets really bad that I won't be able to work...and we really need the money because my husband doesn't have a regular job. He lost his job two years ago. [So] I try to keep up with everybody else because I'm just afraid in this job market that I ... (Interview #2, 1996).

At work some of the women were lucky enough to be able to cope and devise strategies to circumvent the aggravation of their injury. They were in a position where

they could re-arrange their work schedule so that activities at the office were more evenly paced, thus reducing the possibility of further aggravating the symptoms: "I changed the way I did the work ... [by] spread[ing it] out over the week rather than blitz it all in four hours" (Interview #4, 1996). Other women were lucky enough to have understanding supervisors:

> We asked R. We went in there and I said: 'How come you don't want us to stamp the due date [in those books] anymore?' And he said, 'Well it's too hard on your hands.' And then I said, 'Well, yeah, I agree.' I showed him my hands (Interview #1, 1996).

> I know the signs. When I feel it coming on I'll stop the typing. I actually listen to my hands more. When my hands are aching and stuff like that, I do go to my supervisor and tell her that I'm having problems with my hands. [I'll tell her that] I can't do this. There have been a couple of occasions where I said: 'I'm sorry, I've got to go home. I'm no good here' (Interview #3, 1996).

However, the co-operation of the employer was very much an individual matter and differed between departments. One respondent explained that:

> [It] seems to be varied from department to department or from library [branch] to library [branch]. I noticed in department A that every keyboard had a wrist support, a proper wrist support. And that was wonderful. I thought that was great. But other places, there's no

> concessions. The key boards are poorly placed, they really don't care if you bring any comments up. 'Sorry, we don't have any money for that sort of thing' [is the answer you get]. So, it's very much an individual departmental or branch thing (Interview #2, 1996).
>
> It's not an overall library policy [and] it depends on how well read they are on repetitive strain in that particular department. I work in department O [and] the people seem to be very work-injury related in this department. Much more so than any other I've worked in. The department I'm in now is wonderful. Not all of them are like that (Interview #3, 1996).

Yet, when asked if they felt that their employer was considerate of them, almost all of the women felt that their employer only had their best interest at heart - why else would they willingly forward their claim to workers compensation? However, it was conceded that preventative action depended on the department and was not an overall library policy. Thus, there was no conformity between the departments or branches in terms of preventative action. Instead, respondents felt that it was the duty of the union to ensure that such safety standards and proper ergonomics were brought to the attention of the employer and it was also their duty to make sure that such standards were implemented and enforced:

> Not all departments take preventative action. Not all of them are like that. And I think that

> that has to come from the union (Interview #3, 1996).

> A lot of this stuff [preventative measures in terms of occupational health and safety] is left up to the individual branch manager. And unless there are active union members ... and the health and safety committee, like they're the ones who come up with those back pillows, or plan the workload around - so you wouldn't get too strained... you know (Interview #2, 1996).

In other words, if a branch or department had weak union representation, little or no preventative action would be taken. However, some of these women had experiences which contradicted their belief that the employer had only their best interest at heart:

> And it's not like they'll sit down and take the time. So I say to them [personnel]: 'I can't do certain things' and she put me in this position [job] anyway. My supervisor at the time knew that I had had carpal tunnel from previous[ly]. She couldn't believe that they were putting me in that job (Interview #3, 1996).

Another of the library workers feared that if she let her employer know that she was suffering from RSI they would not call her into work again. A third respondent, when asked if her employer accepted the idea that the work in their workplace was the cause of hand injuries, sighed and answered, "not really" (Interview #1, 1996). Yet, all three of these same respondents maintained that their

employer had their best interest at heart. Such evidence is suggestive of normalization. The women are willing to accept that the employer is not responsible for injuries occurring on the job. The employee may have problems with a direct supervisor, but the employer overall is seen in a better light. This occurred in spite of the fact that the women doubted whether the employer had their best interests at heart.

These women did not seem to consider that it <u>should</u> perhaps be the responsibility of the employer to provide a safe workplace. Indeed, evidence suggests that it is the employer that is able to determine the timing, scheduling, pace and design of the workplace, though this control is neither total nor without resistance from labour (Krahn and Lowe, 1993: 283). The problem, as a study by Walters and Haines (1988) demonstrates, is that workers are often unaware of what their rights are under existing occupational laws, and they frequently lack the knowledge to deal with the complex health hazards they encounter. If it is the work that the women perform that is causing their injuries, then it seems well within the employer's purview to re-design the work tasks so as to avoid injuries. However, the information provided by the sample respondents

suggests that the employer is unwilling to take such voluntary preventative health and safety measures. As Tucker (1992) contends, it will only be when health and safety issues are integrated into corporate decision making that workers will be truly able to exercise their rights.

Although only two respondents claimed Workers Compensation, they both experienced remarkably similar problems. In both cases the women had to wait a long time before they were compensated and in each case they had to fight to get their claim approved:

> I filed for W.C.B. ... but I had to really document ... I mean it wasn't just fall off the ladder, they'd pay right? So, I had to prove and had to document the number of slips. It took months before they awarded (Interview #4, 1996).

The other respondent noted that "it took a long time for it to come through" (Interview #3. 1996). Moreover, she noted that the W.C.B. doesn't like it when you take time off work "because they figure you can continue working and do physiotherapy. And then you go back to work. And then you need to learn how, how to avoid the injury" (Interview #3, 1996). The perception that these women have, based on their experiences with the W.C.B., is informative. Both women are of the opinion that the W.C.B. is making it

difficult for claimants to receive their awards if they need to take time off work. Claims, they believe, are only awarded when a sufferer has surgery, further underscoring the perception that the injury is legitimate if an operation has been performed.

Apart from the effect the injury had on their working lives, the women also had to learn to cope and to live with the disruptions of many routine non-work-related activities. Tasks such as simply holding a glass of water, changing a child's diaper, holding social functions (which meant cooking meals, the washing and cleaning up of dishes, holding trays and moving furniture), participating in family outings, became difficult following their injury. Tasks which the women had taken for granted that they could perform, prior to the occurrence of their injury, now became a source of great anxiety for them.

The idea that they were not able to fully partake in their perceived role as mother, for instance, made them feel inadequate - that they had lost control. Their injury prevented them from doing (self-defined) motherly tasks, such as caring for the baby: "I couldn't even change a diaper, she was only six months old" (Interview #3, 1996).

> I can't do things I used to do. I remember being in tears. I couldn't do any of my daily hobbies. I couldn't sew for my kids. I couldn't do any hand sewing 'cause you can't grip anything. I like sewing for my girls and stuff like that. I have to limit my time. You don't just sit in one position and read the paper or anything. Even reading a book can cause them to go. Like, holding the book can cause my fingers to go numb. It's just everyday things. You [can] never take your hands for granted. (Interview #3, 1996).

> My kids want me to do things with them. Like last week they wanted me to go tobogganing. I didn't want to because my shoulder was aching (Interview #2, 1996)

> We have a pretty good division of labour in the family. But, as the mother, I tended to do a lot more. I couldn't do it anymore [and] I felt like I wasn't carrying my weight ... Like I was imposing on them. I felt like I was out of control.... Letting them down (Interview #4, 1996).

Despite the fact that these women contributed significantly to the household by working full-time in the paid labour force, they perceived their injury as a disruptive element which prevented them from fulfilling their (self-defined) 'motherly' tasks. A central part of their self-image, as capable mothers and/or wives as well as hard working and deserving employees, was therefore eroded. Instead, they had to change their accustomed images of themselves as able and capable women and learn to live with the fact that they perceived themselves to be

neither good workers nor good wives and mothers. While it may not have been what they wanted, it can be argued that some of these women benefited from a reduction of some household chores and hence a more equitable division of labour within the household. But some still strove to complete all of their previous tasks in spite of the injury, further aggravating it.

Furthermore, taken-for-granted household chores became arduous and painful burdens. All of the women expressed difficulty in carrying out their daily housekeeping tasks. Some of the respondents felt it necessary to make a reference to the state of cleanliness of their home and were apologetic[10]:

> I tend to put off things that could aggravate it - like heavy scrubbing and things like that. Sometimes the house gets really dirty, because I just can't bear the thought of pulling out the vacuum cleaner again because it's been a bad week for my wrists or whatever ... (Interview #2, 1996).

> Things that you just took for granted are very hard to do. Just everyday things you never gave a thought, like vacuuming, holding a broom to sweep and things like that. As you can see, my house isn't very neat now. (Interview #3, 1996).

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[10] The interviews of the white collar workers were conducted at the homes of the women.

One of the difficulties the subjects had to face was that roles in relationships had to be renegotiated and/or redefined. Having to rely on others was problematic for some of the women and exacerbated the social and emotional problems caused by their condition. Simple, everyday activities or chores such as opening a can of pop, opening jars or sweeping the floor became difficult tasks to manage for these women. Indeed, the women found it impossible to avoid household chores, and often the help of family members had to be elicited:

> I make one of my kids do [the vacuuming] and then they get grouchy...I will wash the clothes, but I make my kids and my husband carry the basket up. So, I get them to do that (Interview #2, 1996)

> I couldn't do the normal things at home. I had to ask my kids to do my laundry - not just theirs. I mean, they did theirs [already], but ... (Interview #4, 1996)

> I have to be careful that [pots and pans] don't fall out of my hands. So, my husband does the cooking, or washes the windows or the floors - anything that has pressure on it. I once dropped a bottle of wine out of my hands. It dropped just like that (Interview #1, 1996).

It was very important to these women to bring a sense of normality and ordinariness to their lives as best they could; hence, they adopted strategies to help minimize

activities which might aggravate their pain. Pacing their daily activities, hiring a cleaning lady or purchasing new equipment were some of the ways in which their burden was eased:

> [Before] Christmas when I was getting really steady work, I had a cleaning lady come in once a week. And she did the mopping the floors and vacuum the heavy stuff and it just makes such a difference (Interview #2, 1996)

> I had to buy a brand new vacuum cleaner because [the old one] was too heavy to push ... and the vibration from the vacuum cleaner [would] start to cause the tingling [again] (Interview #3, 1996).

The uncertainty of how the day, week or month might unfold, in terms of discomfort and/or pain, and the inability to know exactly what might advance or aggravate the pain, were added sources of anxiety for all of the respondents. Frequently, it led to the abandonment or restrictions of activities, some of which were sources of enjoyment to the women such as hobbies or sports and other leisure activities like knitting and cross-country skiing:

> I couldn't take the dogs for a walk because I couldn't hold on to the leash. It hurt, which [was too bad, because] I really enjoyed that. ... You know, I [also] like to ski and I knew if I would go skiing I would [have to] take 2 or 3 Toradol [an anti-inflammatory/painkiller] a way ahead of time. And I know the next couple of

> days it would hurt more, but it was worth it. I wanted to ski (Interview #4, 1996).

A common theme among these women was their fear of losing their job and thus their financial security. References were made to difficult economic times and budget cutbacks on several occasions. Indeed, the idea that one day they might not be able to work at all was a source of concern:

> I'm afraid. What if it gets to the point where I can't work. I enjoy going to work, but I'm afraid that's going to be taken away from me eventually (Interview #3, 1996).

Naturally this was a great source of stress for them. Indeed, one of the women stated that "It took a terrible toll emotionally, [on my] family and [my] work (Interview #4, 1996)".

Conclusion

The five women who composed our research sample performed paid labour tasks involving repetitive motions. Work place duties and un-paid labour tasks were all affected by their condition. Most of the women were forced into a situation of moving from one medical professional to the other in an attempt to find out what caused their injury and obtain some aid for it. Three of the women had

been operated on because of their injury. Two of the women who believed it to be work related and went through the arduous task of filing a workers compensation claim. Each of the women was forced to change their paid and un-paid labour tasks; their lives would never be the same because of their injury.

It is important to stress that there was also a large degree of diversity of experience and perception between each of the women. Two of the women were not diagnosed with RSI, but were instead determined to be suffering from a form of sleeping disorder - fibromyalgia. Furthermore, four of the women did not see their injury as being employment related or even something which the employer could effectively prevent. Instead, the sampled women were more likely to suggest that the injury was either caused by activities outside of their workplace or was only exacerbated by their paid employment duties. In fact, views expressed by some of the women indicated their belief that the workplace union, rather than the employer, was the appropriate organization through which any changes to the organization of employment tasks should take place.

What we can observe, then, is that in many instances the women's experiences were similar, and many

where their experiences diverged. Such evidence cannot be said to be startlingly novel! However, this would be a premature observation. What we must bear in mind is the fact that we are looking for evidence that these same people would be likely not to see the injury as work-related, or if they did, that they would see it as normal. Each of these women consulted at least one specialist, a regulatory step in the normalization process. The mere fact that these women reported their injury to specialists demonstrates a self-disciplining of the body, a bio-power or anatomo-politics of the human body according to Foucault (1978: 139). Moreover, the fact that these women are caught up between competing medical discourses as well as being placed within power relations in the context of work indicates the multiple sites of power. It is this process of obscuring the true nature of a process and making people accept it as 'normal' which underlies the process of normalization. We know that people in everyday life tend to get hurt, and this is accepted as normal. This part of life is also accepted by most workers. There are some, however, who choose to resist the idea that being hurt on the job is normal. They need an explanation of how they came to be hurt. An answer is offered to them - they got

hurt by working at a dangerous or unsafe activity. Of course, we then offer them a long, and tedious process through which they can claim benefits because of their injury. Little consideration is given to, and people are actively dissuaded from considering, the possibility that employers should be held responsible for changing the work process itself so as to prevent these injuries. While the women in the library may have had their duties changed in order to achieve some respite from the repetitive nature of their tasks, someone else still had to perform the tasks. The employer did not change or re-shape the actual production tasks so that the repetitive tasks were altered or were no longer performed. Thus, injury becomes accepted by paid workers as part of working at that particular job, or simply as part of living in this modern world. The experiences of the women at the library, seem to correspond to a scenario of normalization.

Chapter 5

I'm Faster Than Most

Introduction

Our focus in this chapter is on a sample of women working at a blue-collar company. We will begin by concentrating on the paid labour tasks which these women perform requiring repetitive motions and twisting of their bodies and arms. Each of the women have worked at these jobs for an extended period of time and are experienced line workers. Our discussion will move from their workplace perceptions to investigate the pain and discomfort suffered as a result of their injury. We will then look at the personal actions undertaken by these women in order to have their injuries dealt with. This will lead into a consideration of their experiences surrounding the medical treatment both at the company and from their own family physicians. Lastly, our investigation will reveal the effects that the injury has had: on the women themselves, in terms of their work life; on their treatment

when seeking compensation; and on how their family life was affected by the injury. Throughout we will be letting the workers' own perceptions and views guide our investigation. These experiences, it will be argued, can be accounted for by the concept of normalization.

Sample Characteristics

A sample of nine women was selected from this workplace with an average wage of approximately $15.00 per hour. Their average length of employment was 14.2 years with this employer, ranging from 10 years of service to 22 years[11]. In other words, all of the research participants had worked at least ten years or more[12]. Each of the women had held many different positions and worked in several departments within the company. None had worked in just one single job or department. They had worked on average 7.8 years before they became aware of their injury. The

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[11] The average length of overall employment of this group of women was 17.2 years, not all with this employer, but in the same line of work.

[12] The reason for this was that there had been workforce lay-offs in the recent past which reached as far back as 1985 in terms of seniority. Thus, at the time the study started, there was an older workforce with at least 10 years seniority. However, toward the end of this study the company was recalling part of its workforce.

manufacturing company is what would be considered a traditionally male dominated workplace (cf. Krahn and Lowe, 1993).

These women had also worked in different departments and could not remember exactly if, in the jobs they had held in the past ten years, all job descriptions fit their actual job duties. In most cases they remembered that there was no difference between the job description and the actual job duties that they had performed. However, one interviewee had mentioned that her job description did not capture the entire job procedure accurately enough. She felt that job descriptions were too simplified. She notes, for instance, that while her present job description is simply to "connect hoses", the task is more complicated and should in fact state "pull back a lever and push on[to] [the] connection" (Interview #6, 1996). The job duties as described do not capture a number of other body movements which could affect the likelihood of injury.

Of the women interviewed only one had been active in her union local as union steward, a position she gave up after her children were born and her family demanded more time of her. This woman does not participate in union

activities any more, although she does still support the union. In other words, of the women interviewed at the manufacturing company, none were presently involved in union activities, and many were not union supporters.[13]

Workplace

The manufacturing company is a manufacturing plant in Southwestern Ontario. The women interviewed worked on the line for eight hour shifts producing large manufactured products. Job assignments on the line are fast paced and continuous. Indeed it was noted that "the jobs are really tight, you have to work like crazy [to keep up]; you should not have to work like that" (Interview #14, 1996).

All of the women interviewed at the manufacturing company are assemblers with the exception of one who called herself a pre-packer. The type of work performed by these women was essentially assembly-line work. Most of the women worked on the main line while some worked on sub-assembly. The difference being that, in the words of one of the respondents, "sub assemblies are off the line" (interview #9, 1996). These women do highly repetitive

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[13] However, as noted in chapter three this sample may be biased.

tasks in that they repeat their tasks anywhere from 300 to 1200 times in a 8 hour shift. For instance:

> I hook connectors from the units to the pump. And put clips on ... and put clips on. The same thing over and over. You hook a clip on to a wire bracket, and squeeze it. I do that approximately 1380 times a day. There's 680 units that go through and I do it twice on each (interview #6, 1996).

Sometimes these tasks are not simply straightforward and repetitive and require some strength and the use of force:

> I'm a tall girl so I'd reach over and grab that corner and ram that thing in. I'd rip it in and whack it in 'cause there's no other way of getting it in there. You've got to use force to get it in. (interview #11, 1996)

This process was repeated over and over again each day. Other women pointed out that the workplace was not designed well. For instance, one of the women stated that "a tall person bends down to do the job and the short one's got to reach. It's always the same" (interview #12, 1996). In one other instance the respondent noted that:

> I was on dividers, you have to put the divider in your ...[product] section, but what you're doing is using your thumb constantly. You push the wire into the top. You have to do that 350 times and each one takes, I'd say 7 tries. So constantly you are pushing. Like, I'm only 5 foot 1. Now to put me working in a [product], it's silly because I can't even reach the [the

> product]. You know you have to deal with the size of the person. Well, after you have stretched, where you shouldn't be stretching in the first place, it really takes a toll on you. And this is where a lot of people go off on comp. (interview #8, 1996)

In all cases the women used their hands and wrists repeatedly as explained by the following worker:

> Wiring goes on the panel on the back of it. It requires pinching, pushing, grabbing the wire and pushing it. I was wiring the switches. And that repeats, that job just repeats. Most of the pressure is actually on my thumb. I have developed what my doctor call a carpal tunnel syndrome (interview #10, 1996).

Another woman noted that she does a "lot of squeezing [on the job]. A lot, an awful lot" (interview #13, 1996). Moreover, it was also noted that the line keeps on going, even when you can not keep up:

> It's like running. You run and you run and you run and your legs' muscles start to really ache. Well, you stop when it hurts. Well, you can't stop when the line's moving. You have to keep pushing yourself. The next day you start, 'Oh cripes, I don't want to go in there' (interview #8, 1996).

The employment duties of the workers entailed a variety of tasks: the repeated lifting, putting down and pushing of objects; continual bending, moving, twisting and overhead reaching of arms, hands and wrists; and extremely

fine finger and motor control work. In other words, both the library and the manufacturing company required its employees to perform tasks which entailed repeated movements with their arms wrists and hands, "the same thing over and over again", (Interview #6, 1996) over an extended work period.

Unlike the library in the previous chapter, medical facilities are available on the premises of the manufacturing company where a company nurse and doctor tend to injured workers. Thus, work-related injuries can receive immediate medical attention, if the person so chooses. Indeed, the women interviewed in the manufacturing company frequently refer to visits to the company nurse as "going down to medical" (Interview #11, 1996).

Description and Experience of Pain

The experience of intermittent chronic pain and physical discomfort in terms of repetitive strain injury, was an overriding theme that emerged from the interviews. The women invariably made reference to the fact that their injury affected their lives significantly both in the workplace and at home. Furthermore, it was commonly

mentioned that the injury forced them to alter their life styles and change their self perceptions. Whereas previous to the injury they had seen themselves as able and capable working women, they now had to admit to themselves that certain activities were no longer within their reach. Indeed, they were forced to give up some of their leisure time activities.

Not all of the women interviewed in the library had been willing to attribute their injury wholly to the workplace. Some felt that tasks performed at home had in fact aggravated their injury. In contrast, **all** of the women interviewed in the manufacturing company viewed their injury as caused solely by their paid labour tasks. In their minds it was a work-related matter. Nothing that they had done at home could have caused their condition: "Oh. I knew it was my job. No doubt about it" (Interview #9. 1996); "I knew [my injury] was caused by the job. It affects my work at home. But my work at home, I wouldn't consider that it affected my injury" (Interview #7, 1996). In other words, the women at the manufacturing company were very conscious of the physical problems associated with their repetitive work tasks. They perceived RSI as a work-related problem rather than an individual non-work-related

problem. Indeed, the injury affected their ability to perform certain work tasks in the company: "[at work] I couldn't reach very well and my hand was getting so numb I was dropping the gun many times and I'm sure I damaged a lot of [merchandise] ..." (Interview #7, 1996). The approach of the union in the manufacturing plant provides a possible explanation for why these women were more willing, than those in the library, to see their injury as work related. The union at the manufacturing company was very conscious of occupational health and safety problems, particularly when it came to ergonomics, and paid particular attention to them (Interview OFL, 1996).

The most frequently reported symptoms of their work-related injury mentioned by the women were aches, pain, pins and needles or numbness, as well as tiredness and weakness, swelling and puffiness, and muscle tightness. One woman recalled feeling: "numbness prior to pain, ... it's just a continual, gnawing pain. It just aches" (Interview #9, 1996), while another stated: "Oh. And my fingers. My fingers felt the size of my leg, my arm. Oh yeah, painful!" (Interview #12, 1996). Most of the women differentiated between pain and discomfort. The difference

was felt in terms of keeping them awake at night or waking them up during the night:

> Sometimes it was just an ache. When the hand ache, moved to more of a-from wrist, arm to elbow ache, it was sometimes ... sharp pains in the wrist. When ... it started getting that bad that it would wake me up and I couldn't feel my hand. It was so numb it hurt. The hand, like it just throbbed ... I couldn't feel anything from my elbow down. I couldn't even pull the quilt up. I couldn't use my hand. That was definite pain, yes! (Interview #7, 1996)

In other words as soon as the discomfort kept them awake, it was identified as pain. Indeed some of the women used it as a yardstick, a way of measuring the severity of their condition:

> Even [the other hand] hurts. The doctor says it needs to be done (surgery) too but, it's not bothering me. It's not waking me up at night, so I'll wait (Interview #12, 1996).

When the women were asked if they could describe their pain, it was interesting to note the different descriptions they gave to try and relate their discomfort:

> I always describe the pain as somebody choking me. Something right here ... it's so painful. It was awful. Awful! (Interview #12, 1996),

> It got to the point that I just couldn't do [my work] anymore. It [felt like] my arm was going to fall off. One minute it was uncomfortable and the next it was sheer pain. Like, I would go

> down on my knees it would hurt that bad (Interview #14, 1996).

The intensity and frequency of the pain which the women experienced differed between the respondents. There was no general and unified progression in terms of development of the condition. Each case's development was unique. However, while the injury's development may have differed, once the women had developed the pain their experiences were very similar, and they could not be certain if the pain would ever go away. Some found that the condition got progressively worse:

> [I]t's not something that just happens suddenly. It's a gradual thing. Like you go home at night and your hand is, you know, you can't sleep on your arm because your hand's numb (Interview #9, 1996),

> I can't say the pain was ever gone. It eventually got worse. It never got better. No, never really went away. It was always there. It was never gone. (Interview #7, 1996).

For others, the pain would disappear, only to resurface, sometimes in the same area, sometimes in a different part of their body. The pain, when it did return, varied in intensity:

> I have a damaged thumb, ... I've had cortisone treatment in here [for my thumb] to help ...I hurt my shoulder bad. And, oh man was it bad.

> [My doctor] gave me 16 treatments of ultra-sound,... Oh, I've never had that much pain ever again.... So, now both my hands have carpal tunnel ..... (Interview #11, 1996)

> I felt numbness in my hands for years. Coming and going. Now and again it would bother you. It doesn't bother you every minute of the day. But there are times when it bothers you a lot. My fingers are still going numb but I can't, uh, say they've ever been right since I've had [the operation] (Interview #9, 1996).

> It sporadically hurts off and on. Sometimes it feels like a toothache and sometimes it is tolerable. Oh yeah, it did go away [for a while] when ... they eventually changed my job. It did get better. And then it went back to the same thing again (Interview #6, 1996).

The injuries sustained by these women were perceived, by them, as work-related and forced them to take action to alleviate the pain they endured. The cause of the injuries was the repetitive tasks they performed at work.

Personal Action

The most common diagnosis for the injury sustained by the women, as in the library, was carpal tunnel syndrome - affecting seven women. Of the remaining two women, one was diagnosed with bursitis, the other with tendonitis in the shoulder and in the thumb. None of the women were specifically diagnosed with repetitive strain injury (RSI). Rather, the respondents were given a specific diagnosis -

such as carpal tunnel syndrome. Thus, in the medico-legal discourse none of the respondents were officially diagnosed with RSI.

As with the library workers, the women in the manufacturing company used a variety of methods to address the injury which they sustained. Similarly, they followed a 'pilgrimage of pain' as detailed by Reid et al. (1991). While all of the subjects had visited the company nurse, not all of them had visited the company doctor. Interestingly, every one of the women had been to their family physician, despite the fact that a company physician was available to them. In fact, one of the nine women took a previous company physician as her family physician. Further treatment had been sought by seven of the women who visited a specialist. As well, five of the women had gone to a surgeon, with four having had surgery performed - all for carpal tunnel syndrome. Each of the women who had been examined by a surgeon had also visited a specialist (such as a chiropractor or physiotherapist). Only one of the sampled woman had sought the help of a chiropractor. Two of the women who had not received surgery had attended a physiotherapist; neither of these two women felt that

physiotherapy had helped. In fact, both women thought that it made the injury worse:

> I went to physiotherapy for 6 months. But the scar tissue never did go down (Interview #9, 1996)
>
> I had to go to physiotherapy, [however,] I found that [it] made it worse 'cause the exercises that they get you to do there, ... didn't do anything for me (Interview #14, 1996).

Thus, the company doctor and nurse notwithstanding, all of the women had sought other forms of medical attention.

This is not to suggest that the women made little use of the company nurse and doctor. Indeed, all respondents made full use of the company nurse on the premises. As mentioned, all nine of the women had visited the company nurse, though only four had sought the attention of the company doctor. The medical staff were used, but they were not the sole source of medical attention and information for the women. By necessity, the paths taken by these women were many and varied.

While not all of the women specifically reported whether they were on medication, six women did mention that they had received drugs: three women were taking prescribed anti-inflammatories; one was taking a mild anti-depressant; and two women had been given cortisone shots.

Neither of the women who had been administered cortisone injections liked the experience. In addition to the prescribed medication most of the women were also using wrist splints, braces or protective gloves while at work, or wrist splints at home during the evening while asleep.

Eight of the women had reported their injury to Workers' Compensation. However, only six had actually made a claim: the remaining two felt it prudent to merely report their injury. This action was taken in the event that they might need to claim at a later date:

> I just wanted to [report it], in case ten years down the road, it's really bothering me, I wanted to have it registered (Interview #6, 1996).

Thus, six of the women had taken time off work due to their injury, of which four had surgery.

Perceptions of Medical and Social Treatment

As seen in the previous chapter, the women employed in the library faced many problems including self-doubt about their injury, and their treatment by the medical profession and their co-workers. They found it difficult at times to convince others that their injury was a very real problem. A notably similar, and even more starkly

evident, process was found among the research sample from the manufacturing company. Convincing medical specialists and physicians of their pain and injury involved some difficulties for the women. A few of the women experienced scepticism and doubt from their family doctors regarding their injury. Their physicians, as perceived by the women, did not seem to accept that they were injured:

> My first doctor, she didn't feel there was any big deal about it. No, I don't think she believed me. At the time, I guess, I felt, ...ohh she's a doctor from hell (Interview #11, 1996),

> I had to go back a few times to finally convince him that **I was** having problems, a lot of problems with my hands. there was something wrong. I remember him saying something about - and I got very angry - something about it being hereditary or something. And I got really, really mad. Because it was almost like he did not believe me, you know, like it was all in my head. I work hard and I don't [go] and see [him] unless something is wrong, really wrong! (Interview #13, 1996; emphasis added).

However, in most cases, the family physicians were relatively supportive:

> My family doctor? He was really good that way. He knew, he knows what the company's like. So, it's like, they really don't do too much for you. Put you off onto another job or something like that and, uh, so that's when he just puts you off (takes you off the job) because he knows that you're really not going to get that much help at

> work so you might as well just go off and get a rest and hopefully everything will be back. He was very helpful. Like he told me what exercises to do to help out (Interview #14, 1996),
>
> My doctor, he believed me right away. Like, he knows ... my type of work over here, so ... My doctor is just like, he doesn't feel like a doctor. He's just ... somebody I know, at home. Yeah. He's very good. Like, I can go in there and talk about anything. I can talk about government, politics. I can talk about anything (Interview #12, 1996).

The four women who chose to visit the company doctor thought, for the most part, that he had done a good job. They felt that he was supportive and believed their condition to be real. However, one respondent felt that, though the doctor was friendly enough, he did not supply her with the information she needed and wanted about her condition. Her experience was that she was kept in the dark:

> He seemed like he cared, he made me feel like he cared. That he was involved. But he was withholding vital information. Like, for example, what was wrong with me. I needed to know what was wrong. Why I was feeling this way. Why I was having this injury because then I would know ... what not to do and what to do on the job. But he never told. He kept me in the dark (Interview #10, 1996).

Instead, this respondent felt much more comfortable with her family physician. It was her family physician who

finally supplied a diagnosis and sent her to the specialist: "You have to go to your own doctor to know anything, what's wrong with you." (Interview #10, 1996). This observation was echoed by another woman who had similar experiences with the company doctor. While the company doctor had treated her well, she more secure with the advice and treatment received from her family physician:

> I went to the company doctor first and then I went to my family doctor. And see, he's the one that asked that we will put you on restrictions if you're gonna, if you need restrictions. No using pressure to the thumb. No lifting over your head, or-it's your family doctor that you have to bring the note from. Your company doctor can do the same thing but your security is with your family doctor. If you've got your family doctor on your side, you know darn well that the company has to listen to them (Interview #8, 1996).

In other words, the women perceived the company doctor to be a nice person. However, generally these two women felt that he would not go out of his way to make it easier for

them in terms of allowing restrictions[14] or by taking them off the job, if that was necessary.

Some women, though, refused to have any dealings with the company doctor at all. Indeed, a majority of the women in the manufacturing company did not seek the services of the company physician. One respondent, in particular, felt very strongly about not wanting to see the company doctor:

> I've never seen this doctor here [the company doctor], you know. I don't believe them. I wouldn't [even] go to who they would refer me to. I have my family doctor refer me (Interview #7, 1996).

This subject's perception of disbelief regarding the services offered by the company doctor centres around the fact that the company doctor is seen as biased.

Sympathy and acceptance from medical practitioners has been demonstrated to be very important for sufferers of such conditions as RSI (Ewan et al., 1991). On the other hand, disbelief and non-support from their physicians is a

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[14] Within the workplace if an employee wishes to have any changes made to their work tasks, such as not being able to use certain tools or lift heavy objects, they must first have a physicians note detailing exactly what tasks are to be avoided. These are then referred to as 'restrictions'.

cause for distress among these same sufferers. The need to be believed is important to the women. In general the medical profession seemed to be supportive of these women, despite the fact that some specialists may have treated their patients in a matter-of-fact and sterile manner:

> Well, a lot of specialists are just that. They're special. He was very business like. Always. And very matter-of-fact and, you know, that's what it is, this is what we can do, wait for so long, blah,blah,blah, and see if it gets any better. If not we'll, you know, schedule in the surgery now. You can cancel it if you don't need it. If it doesn't get any better then we'll do it. So he was very business like. He just is a person that does his job a certain way and that's what I meant about him being very business like (Interview #9, 1996).

However, equally stressful for these workers is to be doubted by co-workers. Several respondents observed that despite the fact that the very nature of their work presents a greater risk of getting injured on the job, co-workers are suspicious about the legitimacy of any injury. Many of their co-workers expressed disbelief in the women's story of being injured or in pain:

> Some I have worked with in the last few years, even since the surgery, don't believe there's anything wrong with me (Interview #7, 1996).

> Everybody feels that, 'Yeah, right, sure it hurts you that bad', or 'everybody's sore, so ...' (Interview #6, 1996).

Some of the women complained that they were being identified as whiners. In order to counter such accusations these women deliberately decided to make sure that they did not "bitch too much" (Interviews #6; #11; #13, 1996). It was important to the women to convince others that their injury was real. This was due to the fact that they themselves were starting to have doubts about their injury and its pain. Moreover, it became a source of anxiety for them:

> When you go to the supervisors and they don't believe you [it] is a lot of stress. Because then you start doubting yourself (Interview #6, 1996).

> But you keep pushing yourself. And like I say, the attitude has a lot to do with it. Sometimes you don't want to say anything because you're going to be called a whiner. You have to have somebody that's going to listen to you. There are people that'll just think, 'Gosh she's whining again.' You get a lot of that. And from there you just go 'should I tell anybody?' They're never going to listen to me anyway. (Interview #8, 1996)

The fear these women have of being identified as a whiner, stems from the fact that injured workers get assigned to 'light duty' work. This is especially the case

when the workers have restrictions imposed by a doctor regarding the types of work they can perform with their diagnosed injury. The fear, however, is balanced by the fact that the women are injured and have to be very aware of what jobs they can or cannot perform without aggravating their injury. Comments from the women express this predicament:

> Well you know something I discovered about being injured in the workplace is that once you report or you even say anything about the injury, people started to treat you differently. And certain ... people, sometimes they feel as if you're using an excuse not to do certain jobs, and you get this treatment as if you are, you know, as if they don't want to be bothered with you. You're a trouble maker or something. But there's so many of us in this position that those jobs (light duty jobs) are not very easy to come by because you have a lot of people here with injuries who-whether they are legitimate injuries or not ... they have some of those particular jobs and they never get taken off. So those jobs are always occupied. (Interview #10, 1996).

> I have to be careful what I do. I could be put on a job that, I cannot do. So then I have to fight that I cannot do this job. And then I have to go to my doctor and I have to get a note (restriction) and I have to see the nurse and I have to get ice. And they try to get me to stay on the job first to see if it's just because it's a new job or it's my injury. This is what happened at the beginning when I went on the main line. That's what they tried-they tried to ice it twice a day, hoping that it would calm down once I got used to the job. Of course it didn't. And it just got worse. That's what they try to

> do. They try to keep you on the job. If you [are taken] off the job [that] you can do, because of bumping and seniority and up and down in the rates (production); but [I've been lucky], I haven't been bumped out of this [job] yet. There's no guarantees I won't be. That's just it. You never know if you're gonna end up on a job you're gonna have to fight for the fact that you have an injury. And there's always that thing that they can say. 'Well, I'm sorry we don't have a job for you.' Oh. They can say that. And there's always that fear. (Interview #7, 1996).

> You have to watch what jobs they put you on, so that makes it tough. And when they do put you on jobs that you can't do and then you got to go and [fight] then they take you off that job and then somebody else has to go on that job. So then somebody gets mad at you because well, it gets to be one big vicious circle out there ... (Interview #14, 1996).

This fear and concern was felt by most of the women, and was regularly commented on during the interviews. The scarcity of light duty jobs in the company further exacerbates problems between the injured workers and those in the light duty position. When an injured worker is assigned to a light duty job, the person already in that position must go to another job. Such 'job bumping' can readily lead to resentment from co-workers. It creates antagonistic feelings among the workers; a loss of worker cohesion - especially if the bumped employee gets re-assigned to a job that may have caused an injury to them in

the past, and thus they stand to be re-injured or perhaps aggravate their existing injury. Of course, the process of 'job bumping' aids in the normalization of workplace injuries in that the organization of work does not get changed. Instead, injured workers are placed in jobs which are perhaps less taxing on their injuries, but remain repetitive nonetheless. As such, 'job bumping' is yet one more step taken among the many other steps, which serve to normalize the injury.

As with the library workers, the women in the manufacturing company believed that surgery was one way of showing to the outside world that their otherwise invisible injury was in fact real:

> I went to medical, and I said, 'You know, I've learned how to play the game now.' I said, 'It's Comp first, safety last.' 'Oh no,' they said. They were both (the nurse and the head of medical) in there screaming and I said, 'Oh ladies, ladies, you taught me, you two girls taught me how. Compensation first, safety second. If you get a Compensation case, there must be a problem with this girl's wrist so we'll accept it.' It's that clear. If I have an operation, carpal tunnel, you'll think, 'My god, she does have something wrong.'(Interview #11, 1996),

> There are so many people with so many injuries in a place like this that, you know, after a while you start wondering if it's true or not. You can't help it. It's sort of a reaction. But I don't-I think mine, sort of. There will always

> be some that don't believe. So you're actually, you know, gone in and had the surgery. I can't imagine anybody doing that for the hell of it (Interview #9, 1996).

In other words, the women saw surgery as legitimizing their injury. It was utilized by the sufferers as a "'red badge of courage' of their condition, evidence that they had a definite, well accepted clinical injury" (Ewan et al, 1991). This is all the more tragic since evidence in the medical literature suggests that surgery in some cases does not help, and is in fact unnecessary (Higgs and Mackinnon, 1995).

Nor would these women let their injuries stand in their way of doing their job at the plant - and doing a good job at that: "I'm faster than most, I'm always pushing myself, eh? I work harder to keep myself going" (Interview #7, 1996). They did not want to be identified as whiners, people who could not pull their weight:

> In this company you don't tell anyone you've got a problem. No one, nurse, your foreman, union. They say, 'You want the job ... You got to get with it. If you want the pay ..., you have to take what comes with the job'. Medical department's idea was, unless it's a compensation case, I don't want to hear about your problem. You're a whiner, that's what you are. (Interview #11, 1996).

This motivation, while admirable, in certain instances simply aggravated their injury, leading to more pain and suffering.

In most cases the threat of losing their job or their income appeared to be the main motivation for the women returning to work too soon after surgery, or not going for medical attention at all:

> My hand was getting worse, so finally I went to the doctor myself. Went and had it done (surgery). My left hand is getting to the point where it's numb a lot of the time and I can't feel it. But I can't afford to go off. It took me 16 weeks to get money from compensation when I had my right hand done. I was back to work more than 9 weeks before I got my money. That's why I haven't gone off with the left even though it needs it. After the surgery [on the right hand], within 6 weeks, I came back to work.
>
> I knew it had to be the job but I never thought of it as something that I should concern myself with. Because in the back of my mind, there's only one thing I wanted to do .... To be working and making a living. I had my son in school. And if I don't work there's no money. You know? I just put more tape on my fingers because I don't want the injury. But, I was injuring it anyway. (Interview #10).
>
> I never had the operation. No. No, I haven't missed any [time] I think that goes bad for you if you don't miss time, but I don't miss time. My husband's been out of work for 3 years and I don't take an hour off. (Interview #11, 1996).

Again, as in the library, maintaining their income was a significant concern for the research subjects. The women were a major, if not the only, contributor to the household income.

In the workplace itself, the women had to contend with jobs which perhaps were not suitable for their recovery. Although light duty jobs were available, there were not enough of them. Thus, the women were often placed back into their old job - the exact same job which injured them. Only when the women made a point of complaining, at the expense of being called a 'whiner', a 'bitch' and the like, did they get relocated in the company:

> We (respondent and physician) had a meeting, with the foreman, the union and the company lawyer. I said, 'he (the foreman) has no other job for me in the plant where I can stand up.' The company lawyer said, 'He can't keep you on this job. I'll talk to him and he'll take you off.' And the next day, uh, I said to the foreman, 'Where do I go? You have a job for me.' He said, 'I have no other job for you in the plant, you go right there and you do the job.' So, the company lawyer came by and said, 'Why are you still on this job?' I said, 'Because [the foreman]... said there's no other job in this plant for me. It's either this job or out the door.' He said, 'I'll go talk to him.' So he went and talked to the foreman and he come back and said, 'They're going to move you tomorrow.' O.K.,' I said, 'Yeah that's fine.' At quitting time I asked the foreman, 'Where do I go tomorrow?' He said, 'To your regular job there, that's it.' The next

> time the company lawyer comes through within a couple hours of me starting, he said, 'You don't do another unit.' The foreman comes over and he is just yelling at me, 'Well I found a place that'll take you. They take all the garbage.' So that was me. All I had to do was have a job where I was to stand up. (Interview #11, 1996).
>
> It started to hurt. That's when I made it a point of making it known that it is hurting me. And I said it to the supervisor. He brought the health and safety rep. over. And I talked to them about it and they left me ... He told me there was nothing he can do about my job. I was doing a very heavy job. And I am not in the habit of complaining unless something is wrong and I complained because I was working with discomfort. I'm doing more work than the guy beside me. And I did not think that was right so I made a point of pointing it out to them and I figured they didn't like that idea at all. So I got angry. I had to get angry and walk off the job and I told the coordinator at the time I'm going to see the nurse. And that's when I started to get some kind of attention. (Interview #10, 1996).

In fact, the preferred method chosen by the company or its officers for dealing with these injuries seems to be changing the injured women from their current job assignment to a different job assignment.

The women in general did feel that the company was accommodating and considerate of their needs. Nevertheless, a number of these same women expressed frustration with management, particularly with the individual in charge of placing injured workers who have

restrictions or who return to work, into a job position:

> Mind you, the way that the company doctor and, uh, the person who is head of medical here, perceived things-totally different. The company doctor would say, 'Yes, you have a problem.' And the head of the medical department would say, 'Well, is it a problem?' .... she doesn't like to recognize that it's work related. She would say 'Well you can still do this job'. (Interview #6, 1996).

> Yeah my employer recognizes the condition, but whether they do something about it is a different story. Your supervisor probably wants to help it as much as he can, but he has to listen to the head office, too. Like he has to do what they say. There's this one woman that's in the HR [Human Resources]. She's the lady that goes around and puts you where she thinks that you can do these jobs. Very nasty attitude. Uh, your doctor will write down what restrictions you have and I don't think she knows how to read, or comprehend as to exactly what it says and what exactly the job takes to do. Like, it says 'no over the head.' No over the head work? And I have to reach up and grab the gun. And I said to her, I says, 'Excuse me,' I says,-and then she said uh, 'Well, it seems that you had your therapy and everything, your injuries should no longer be affecting you. You can do whatever we tell you to do.' And I'm like, well, I says,'I don't think so.' So that's when you've really got to start complaining and that's when you get something done. She's a very hard person to deal with. (Interview #14, 1996)

In other words, the company will address the issue, but only if they are faced with someone who is willing to push for it. Thus, most of these women perceive that the company is not willing to make changes unless forced into

it. Yet, the company is thought by the women to be accommodating. This contradiction can perhaps be explained by the fact that the women will take issue with their immediate superiors but not with the company. It is almost as if the company is seen as a separate entity, as if it has a life all its own, one apart from the women's direct superiors. Given the perceptions of these women, it does not seem likely that the company will voluntarily change the work process in such a way that future injuries can be prevented.

Most of the injured women reported their injury to the Workers Compensation Board (W.C.B.). Of the women, six claimed W.C.B. benefits, one woman's claim was denied, and another woman only reported the injury, without seeking benefits. The women's experiences of dealing with the W.C.B. was varied. It is interesting to note that in some instances waiting 6 to 8 weeks for their claim to go through was perceived as a terrible experience, while others perceived that to be acceptable, though most women felt that approval and payment of the claims took too long. In fact, in one case it took 16 weeks before she received her compensation. In another case the claim was denied while other claims were being accepted during that same

time period. Indeed, some felt that the system was inadequate and far too slow:

> They want to know from you as to what happened. You get it filled out from the doctor and you send it back and forth and the doctor fills out everything that he's supposed to and then they send it back to you again saying they need more information. It's a constant battle back and forth. All their paperwork is nothing but a bunch of nonsense. It took them 4 months to figure out whether to put me under a new claim or old claim. (Interview #14, 1996).

> I put in a claim for compensation. They wouldn't recognize repetitive arm movement they said and so they never did.... [M]y claim was rejected. This was the late eighties. They are recognizing it now. (Interview #6, 1996).

> The Worker's Compensation needs a big overhaul. They need to stop being so high and mighty about people who are injured. There are people who screw the system, uh huh. You always get that. That's no excuse to blame others. So you should never lose what you get because, heh, you've got to live because you'd be working if you could. You don't ask to be hurt at work. I took the paper down myself because they're so damn slow. They need an overhaul like I wouldn't believe. (Interview #7, 1996).

Other women experienced no difficulties with the system and were satisfied with how it worked:

> The Worker's Comp. were fine. They did not give me a hard time either. No they didn't. I think it probably took them 6 to 8 weeks to pay me. (Interview #9, 1996).

> Worker's Comp. were good to me. I haven't had any problem with them, of course, I don't get any time off for making the claims for money. But, when they came to investigate, a man came and I did my little sob story and he said, 'Will you sign here?' They approved my claim. (Interview #11, 1996).

The interesting part is the fact that most of these women actually had similar experiences in terms of Workers' Compensation. However, their perceptions differed to the point where some felt that the W.C.B. was "fine", while others noted that it "needed a big overhaul."

To be injured at all was cause for distress. The sampled women made a number of references to this:

> There's a lot of people; they're legit and they're honest. And when they go in and they say they're hurt, they're hurt. Maybe sometimes you hurt mentally. This pain, this job is just getting on your nerves. And sometimes that's the worst thing to damage, is your nerves. Just get me away from this for a while. But they wouldn't do that. They don't look at the mental state. And the mental state has so much to do with it. Like I say, if you like your job, you enjoy coming in. If you're not comfortable with your job, you hurt. Even if it hurts your nerves. Even if it bothers you, mind wise. That hurts more than anything else. The mental state has a lot to do with it. Sometimes that is more damaging than a muscle. Anything that hurts [you] you don't like. You don't like getting a needle because it hurts. It's just knowing that it's going to hurt. That's the mental part of it. The mental part of the injury is 75% of the injury. The mental part is 75% more stressful than [the] pain. (Interview #8, 1996).

Indeed, like the experiences of the women at the library, the injury had a negative impact on the women's ability to perform certain domestic tasks. Performing household chores and/or pursuing leisure activities became arduous tasks:

> [My injury] makes things difficult. Like, I can't, I can't stir to make cookies and things like that. I have to get my sister's machine that does it for me. I can't write a letter. I have to use the computer because I can't hold a pen more than a few minutes. (Interview #7, 1996)
>
> I can't wash walls or it's hard to wash floors or anything. Sometimes just shaking out rugs or carpets or whatever, it really hurts (Interview #6,1996).

Moreover, having to ask for help signified a loss of autonomy and was considered as a source of stress:

> It's a stress to think that, you can't do this job. Your hands aren't working. Like, this isn't working and it's, like, at home because of the injury I can't do some things at home and you know, like, I might have to call my husband, but he's not there all the time, you know? And I can't be asking him all the time. He's not always going to be there ... And then I tell myself, oh you can do it .... I try to do everything myself. But I can't sometimes and I have to ask for help. And I don't like that and that's a stress. I don't like to ask for help (Interview #7, 1996).

Most of the sampled women found that leisure pursuits had to be curtailed. Some expressed discontent and frustration

at the thought of not being able to pursue any of their hobbies or sports, such as gardening, volleyball or bowling:

> It's frustrating... Like, I can't play baseball. I wanted to play baseball. If I play volleyball, I can't. Or if we want to go bowling, we can't do that either. I don't even bother trying it anymore because I don't need to aggravate it anymore than it already has been. So I just don't do those things anymore. (Interview #14, 1996).

> I like carpentry. I like quilting. I like crafts, gardening, all sorts of things. And I do all that stuff. You see for me gardening is my favourite. I love to have a big garage with nice saws and stuff like that. I don't know, I just love working with wood, I don't know what it is. But I can't do it now ... (Interview #12, 1996).

These women's self-perception had been violated. To reconstruct their self-image was a task some of these women found extremely difficult, if not impossible, to accept. In order not to give in to the condition, which would mean accepting defeat, a few women adopted strategies that allowed them to continue with their household tasks without intervention:

> I try to use my left hand more, like with the vacuuming and that. But with the baking -I could buy a mixer that would do all that for me. But, basically I try to use the other hand and try to compensate or just do a little bit at a time. (Interview #14, 1996).

A small group of the women continued with their household tasks and/or hobbies in defiance of their affliction. They were not willing to concede to the disruptions the disease had caused in their lives. It was their attempt to regularize and stabilize their circumstance as best they could:

> I just do everything I'm supposed to do except, like ... Well, my husband helps as much as he can. But men are not great at housekeeping and NOBODY touches my laundry but me. But he will. He will do the help if I ask him. And now I have a housekeeper. She cleans the house. I do the laundry. (Interview #7, 1996).

Support from the women's families was relied upon, as with the women in the library, in order to take on the responsibility of performing some household duties:

> Well I've got two daughters at home that I explain to them all the time that they've got to help. I don't know whether that works or not. But they help with the vacuuming, washing the windows, making the beds. My husband as well. My daughters help under protest a lot. Under duress. (Interview #6, 1996).

However, some did not have the benefit of support and help at home. Hence, they had no choice but to do the household chores themselves. For instance one of the respondents noted that she had two sons, but "Boys will be boys" (Interview #12, 1996):

> I mean, they're good ... One of them was a short order cook in a restaurant and they know how to do the wash .... But I guess it's a woman's job, you know, mother's job. (Interview #12, 1996).

Under such circumstances the future becomes tenuous - especially for those without help. One woman, a sole parent expressed great concern:

> Well sure I was worried. It was my life, my housework .... It was my income, my livelihood. Well not just that. It started to interfere with things as-doing my hair, my makeup. You know, getting dressed, because that's, you know, more of a chore. But you try ... The curling iron and you know, that's how I got the perm. It's just easier and messier and, you know, you don't have to be as meticulous with it. You know, I can't hold my hands up, you know, for long periods of time. (Interview #13, 1996).

A common theme surfaces from these accounts. All the women interviewed focused on the role of homemaker and their ability and/or inability to cope with the living up to it. In most cases the women were adamant in maintaining that role, despite the fact that they were injured. This theme that threads together these accounts underscores the importance the women placed on their identity as a housewife and mother. It was important to them to maintain a semblance of routine and regularity within their disrupted lives. This entailed, in other words, minimizing

the erosion of their role as homemaker. They devised a number of strategies that helped them cope with the disruptions to their daily lives, while reducing their pain and continuing to do a good job as primary caregivers. For instance, one of the respondents (Interview #7, 1996) made sure that we understood the reason for hiring a housekeeper:

> Mainly because, not because of my injury, but mainly because I just don't have the time to do it with everything else we do. I had to hire a housekeeper, I mean ... she cleans the house, I do the laundry. (Interview #7, 1996).

Thus, it was not because she was injured, but because she did not have the time to do the housework herself. In other words she was, and still is, a capable homemaker. Her injury, although painful, did not stand in the way of performing her duties in that capacity. Yet, despite their injury and despite the fact that they had full time jobs, the women's frustration - that they perhaps could not perform competently as mothers, cleaners and wives - remained. The idea of their husbands helping - where there was a husband - was not what they envisioned to be correct. After all, as one of the respondents noted, husbands are not good housekeepers. Unfortunately, their injuries were

only exacerbated this way. Even though some had refrained from participating in sports or pursuing other leisure activities, it was often mentioned that a hand needed surgery again, or the other hand needed surgery. In any case, the injury sustained in the workplace was a disruptive element in their lives, one that reached far beyond their paid employment.

Conclusion

In terms of the women's overall perceptions of their experiences, they all felt and perceived events in a similar light. Generally, the company was perceived as accommodating, yet immediate superiors were not. There were no changes to the manner in which their jobs and work tasks were organized and performed, but changes and switching of jobs were allowed. In some instances family physicians were perceived by the women as supportive, while others felt that their physicians did not believe them. Most of the subjects did not visit the company doctor, but all had visited the company nurse. Most of the women who did visit the company doctor felt comfortable with him. However, all of the women were still not sure that their condition would ever be rectified. None of the women had

ill-feelings towards their employer. Yet, it was the manner in which the company organized the job tasks to be performed, that is the very reason why the women were injured.

The one overarching experience which all of the women agreed upon was in terms of their pain. The respondents, without exception, felt that discomfort turned into pain when it started waking them up at night or kept them awake. They all perceived that surgery made their injury legitimate, in terms of visibility. However, when a second or third operation was needed they were far more reluctant to have it performed. It was almost as if that first operation was proof enough to show that they were not whiners after all! All of the women devised strategies which allowed them to establish some semblance of normality and regularity to their lives. In some instances labour saving devices were purchased, while in other instances the help of others was elicited or purchased to do household chores. At work, they found it necessary to work harder, better and faster, if only to convince themselves that they could still do their job. But the most striking feature of all was the focus these women placed on the importance of their role as wife, mother and housekeeper. As long as

they could continue fulfilling that role they saw themselves as normal. Oddly enough the pain was never questioned and was accepted "as being part of the job and lifting and whatnot" (Interview #13, 1996), or "It's just my job" (Interview #12, 1996). The experiences therefore, of the women in the blue collar manufacturing company, fit into the theoretical view of normalization of injury. They simply saw their injury as part of the work process. The changes necessary to cope with the injury weighed heavily on their mental as well as physical health but not enough to blame the company for their affliction.

Again the disciplining of the body became apparent when the women described their many visits to specialists. In this workplace, their journey on the path of normalization began invariably with the company nurse. In order to get relief the women were required to go to medical and get the injury iced by the nurse. This step was but one more regulatory step to take in the process of normalization. Here too the women were caught up within different power relations. Apart from the internal disciplining of the body and dealing with the medical practioners, they also had to contend with the workers' compensation board, their co-workers as well as their

supervisors. Each of these representing multiple sites of power, at individual as well as aggregate levels, both internal and external.

Chapter 6

I Took It As Being Part Of The Job

Introduction

The two previous chapters examined separately the data derived from the interviewees of each individual workplace. We will now focus on both workplaces and combine the data. This chapter will consist of analysing the data and placing it within the context of our theoretical concepts from feminism and Foucault. Based on the information from the women regarding their recollections and perceptions of their experiences with the disease/injury, we will look at how they perceive their role as women workers, mothers and wives. As well, we will address our research question regarding how women workers' perceptions reflect the normalization process in the construction of repetitive strain injury (RSI) as a workplace health and safety problem.

My subjects were female, who had all been diagnosed with a form of RSI. With one exception, all of the women

were union members. Furthermore, the women in both workplaces had worked in paid employment for relatively the same length of time. The average length of employment of the sample was 17.6 years; 17.2 years for the manufacturing plant and 18.4 years for the library. All women had held different positions or had worked in different departments within their respective workplaces. In other words, none had worked in just one single job or department for the duration of their employment with their respective employers.

Union Participation

There were only two union activists in this sample, both were from the library. None of the women interviewed from the manufacturing company participated in union activities. However, consideration must be given to the circumstances under which the participants in the manufacturing company were identified. While the union established the initial contact between management and the researcher, there was no further contact with the union after that. It was left up to management to identify prospective respondents and schedule their interviews. Thus, the possibility exists that the sample may be biased

in that RSI sufferers who were asked to participate were known to be non-active union members (i.e. they did not attend union meetings or they did not participate in any other union related activity). It is also conceivable that this study was perceived as solely a management initiative by the union's rank and file. Therefore, those who were active in the union and had RSI, may have refused to participate in the study because they felt that they could not trust it. These are assumptions at best. However, these speculations are noted so that the apparent inactive union behaviour in this group of women can be contextualized.

In the library, it was a trade union activist who put me into contact with the injured women to be interviewed. Indeed, there was no contact between management and the researcher at all in the library workplace. Based on this, therefore, it can be surmised that the library sample is probably less likely to be composed of members who adhere solely to a neutral view on union affairs. Hence, it appears that the library has a more active union membership than the manufacturing company.

Workplace

Requests were made at both workplaces not to identify the library and manufacturing plant. The researcher assured both workplaces that the names of the interviewees and their workplaces would be kept confidential. As noted in the previous two chapters, it is perceived (cf. Krahn and Lowe, 1993) that the chances of women getting hurt in the library are considerably less than in the manufacturing company. Additionally, the manufacturing company is considered to be a traditionally male dominated workplace, one in which women had to prove themselves when they started to work there:

> I was put on a man's job to start with so the job was a bit heavier so any discomfort that I might have felt I just associated it with kind of being a man's work so of course, I mean. I would be a little more tired, you know, my hands being a little bit more swollen. I was one of the first women, ... , and my foreman felt that if I could do this one specific job then I could do anything in the plant well. I had to prove myself, right? I don't know. I didn't bitch too much. You know, I wanted the job. You know, you didn't, what do you do ....? (Interview #13, 1996).

> When I started ... the women had to prove themselves. The men didn't have to. But the women had to. We had to do ten different jobs. I think eight or ten different jobs ... The hardest jobs in the plant. And the men didn't have to ... The women are more accepted now. You know, things change, but in the mean time

> they still stay the same. I mean they are preaching about this ... [But] things aren't really different. I think it's worse ... More sneaky. (Interview # 12, 1996).

The library, on the other hand, located in the white collar, service sector, is considered to be a traditionally female dominated workplace. In fact, a male working in these surroundings is thought of doing essentially "a woman's job" (Interview L, 1996).

The contention that a library is a relatively safer workplace than a manufacturing plant is reflected in the fact that the library in this study does not support any medical facilities for its employees. Hence, if their employees get injured in the workplace, they do not have access to a company doctor nor a company nurse. On the other hand, the manufacturing company, has medical facilities available on the premises, attended by a nurse and at times a doctor. Thus, the blue collar workforce, in this case, has immediate access to medical attention. However, the women in the library have to visit their personal physician or their preferred alternative medical practitioner if they get injured on the job.

Neither workplace seemed to make any attempt to change the way in which work was being organized, despite

the fact that women developed RSI type injuries. Women who returned to work, after carpal tunnel surgery for instance, were more often than not placed in their old jobs upon their return - the very job which injured them to begin with, as explained by respondents from both the manufacturing company and the library respectively:

> When I came back [to work] they put me in the same job again. I tried it, said I couldn't do it and they moved me right out of my area [into] a couple of loser jobs. I thought when I got that, ... they had no use for me at all. It really wouldn't help (Interview #9, 1996).

> I think they thought I was trying to get time off. Even now, it's like, the job is still affecting me because when I came back she put me in my previous position. The company is not very accommodating when it comes to changing any of my jobs, no. (Interview #3, 1996).

Many of the women noted that you "have to go and complain (Interview #1, 1996) before they will listen to you. In other words, in both workplaces, the women were given 'light duty' work only if they spoke up. Yet, most of the women from either workplace, did not feel that their employers could be held accountable nor did they feel that the organization of their work should be changed. In fact, they felt empathy for their respective employers, citing

poor economic times and hence financial and economic difficulties as their concerns for their employers.

Furthermore, most women did not see the need to change the organization of work. They perceived getting injured on the job as a fact of life - it comes with the job, something you "have to learn to live with" (Interview #3, 1996). Indeed, some women expressed the "need to learn how to avoid the injury" (Interview #3, 1996). In other words, they were willing to place no blame, or if they did, emphasis was on personal/individual responsibility rather than on the shoulders of their employers. Nevertheless, there were some women who did comment on the need to change the organization and management of work:

> I know every company has to look out for production and how many they're getting out ... but they have to look after the people too. They ignore you completely. They just walk by. It takes a toll on you. You have no time to sit down. You have no time to even smile. You're too busy. It's like, 'Let's get this thing over with.' That's a hell of a way to work. It really is. I mean, everybody has to put in 8 hours, make it the best 8 hours that you can. I'm not saying cut jobs in half, but maybe you could take just one screw, put another person in, give him a few screws from everybody. You created another job that was needed to be created. You take a little bit of weight off of everybody, not a lot, but just a little bit. [A]nd that little bit that you've taken off just gives that person the time to be able to sit down

> and go, 'Thank you.' And it's amazing how many people would say thank you if you just took one screw away. (Interview #8, 1996).

Moreover, if any changes in terms of health and safety were being made it was found that they depended on departmental heads or supervisors, not the company overall. As expressed by one of the respondents: "it varie[s] from department to department or from library to library" (Interview #2, 1996). In fact, it was noted by the women in the study that neither company seemed to address health and safety concerns in an uniform way. The perception of all of these women was that despite the fact that their respective companies might try to be accommodating at an individual level with respect to their injury, there did not seem to be a consistent and overall company attempt to eradicate health and safety problems pertaining to repetitive strain issues in the workplace. For instance, it did not seem to be common practice, in either workplace, to issue a company directive establishing ground rules and guiding supervisors in dealing with the treatment of injured workers, ensuring consistency across all departments within the workplace. Indeed, it was noted by several of the white collar respondents that there was no cohesion between departments. This meant that some

departments were very safety conscious while other departments claimed lack of funds and would not address any occupational health and safety concerns. Thus, any changes that were made encompassed decisions at a departmental level only, involving supervisors and department heads. Such changes, however, did not affect the overall organization of work. The same can also be said for the blue collar workplace. For instance, one respondent pointed out that "the company overall, [had] been accommodating, I can honestly say that. But, some of my supervisors, they make their own decisions ..." (Interview #6, 1996). Indeed, most of the women seemed to adhere to contradictory points of view in terms of how they perceived their employer. On the one hand, the company would be hailed as considerate and accommodating, while, in the same breath, the women would go to great lengths to explain how their immediate superiors would not take them seriously or into consideration.

Many of the women also felt that the union had not been instrumental in helping their individual condition. In most cases, it was found that the union played no role in addressing workplace injuries at the individual level. The general consensus among the interviewed women, in the

manufacturing company especially, was that "they weren't helpful really" (Interview #9, 1996), while, in the library the feelings about the union, in terms of dealing with their injury, were mixed. Some thought they had been very helpful and "were very supportive (Interview #1, 1996), and others felt that:

> The whole time that I've asked questions and stuff like that, I didn't know who I could go to. When you ask your union steward and they look at you and they say, 'I don't know.' ... It's like, O.K., so, you're not better than me. ... I think right now, their main objectives are on job security and stuff like that. They're not really giving [occupational health and safety issues] their hundred percent. (Interview #3, 1996)

Walters and Haines (1988:420) posit that workers' "main tie is typically with their supervisor". In fact, they note that the tie between workers and their health and safety representative is "often weak or non-existent (Ibid.). Similar observations were made in this study, where it was found that workers dealt almost exclusively with their supervisors. Health and safety representatives were generally called in after the supervisor had already been consulted - if the health and safety representative was called in at all. As one respondent in the manufacturing company explains:

> I made a point of making it known that it (the injury) is hurting me. And I said it to the supervisor. **He** brought the health and safety rep. over. (Interview #10, 1996; emphasis added).

While another respondent in the library noted:

> I believe that there is an occupational health and safety officer from the union available [to me], but I don't know who she is. I should know. I can ask. (Interview #3, 1996)

The interviews indicate that the workforce in the manufacturing company had been cut in half, while production was increased by 100 percent. This naturally translated into an increased workload as well as increased speed for the workforce, a development not exactly conducive to preventing RSI type injuries. However, during the early 1990's this company also introduced an experimental concept of a rotating production line so that jobs were rotated among workers during the course of eight hour shifts. This meant that workers would still do repetitive tasks, but they would do them two hours at a time and then change stations. The women interviewed who had actually worked on this line liked it:

> It's less flack you know. Like you don't have to just stand and crimp all day. It's a variety. And it's a change, too. You change. You don't

> change the way you crimp though (Interview #9, 1996.
>
> Right now I am on a different job and I love it because I'm rotating with 3 other co-workers. I'm so happy now. Rotating is you're doing one job for 2 hours. And then you move to another one for another 2 hours and then you go to another job for another 2 hours and another one that lasts 2 hours. Now that gun (an automatic screwdriver usually dangles over the workers' heads.) may present a problem. But because you're not doing it continuously, for 8 hours, it doesn't affect me the same way because as if you are doing it all day long. (Interview #10, 1996).
>
> I am using different muscles all the time. And it's frankly the best job I've ever had in here. (Interview #8, 1996).

A rotating production line meant that different groups of muscles were used during the course of the day. It also meant that the job allowed for some variety, and, hence, was not so boring. However, it did not alter the way in which the actual job was being done, even if it did alter the way in which production was being organized. Although the initial idea was to convert the entire plant to this method of production, it never developed beyond a few production lines (Interview M, 1996).

Most changes, then, in the workplace were not made at a structural level, but more on an individual level. That is, complaints that were addressed depended heavily on the supervisor of the respective departments. The overall

organization of work was essentially not affected. In other words, repetitive tasks remained just that, repetitive tasks. However, discrete individual changes, such as newer and lighter airguns or keyboard pads to aid in getting the job done while reducing the risk of further aggravating the injury, were considered if the supervisor agreed. However, it was left to the individual worker to bring occupational health and safety issues to the attention of their supervisor. Only if the supervisor /department head was sympathetic to such issues were changes made to improve their situation. Thus, similar occupational health and safety situations were treated differentially at the overall organizational level.

Similar experiences between the two groups

This section will highlight some of the experiences and perceptions all the women interviewed had in common. Indeed, there are a number of similarities, which the women in both these workplaces have experienced. For instance, parallels can be drawn between: the way in which the women, from both workplaces, experienced RSI as a disruptive element in their lives; the chronicity and the uncertainty associated with the pain which the women experienced in

both groups; the need to be believed by others - in other words the need to validate their symptoms and their suffering. In terms of experiencing discomfort, while at work, it was found that all but one of the women experienced pain while performing their tasks.

RSI: a disruptive element

For these women, to be diagnosed with RSI meant significant disruptions to their lifestyle. Most of these experiences were inimical in that they affected and challenged the sufferers' self-concept, taken-for-granted assumptions and behaviours, as well as their financial resources. To develop and be diagnosed with RSI, meant that household chores became painful tasks and paid employment had to be interrupted. Moreover, leisure activities such as hobbies, crafts and sports, could no longer be pursued. This sparked a series of emotions from the women, ranging from resentment: "Like I can't play baseball. I wanted to play baseball. If I play volleyball, I can't. Or if we want to go bowling, we can't do that either. Even gardening seems to bother my arm" (Interview # 14, 1996) to disappointment: "I am sorry that I can't [cross-country ski anymore]. I checked with Dr. H.

and he said 'I know you love doing it, but ...'" (Interview #1, 1996). Simple 'taken-for-granted' daily routines such as opening a car door, holding and/or talking on the telephone, curling and/or washing hair, putting on make-up or driving a car had become arduous tasks and were all of the sudden not so simple and routine anymore; instead they had become painful acts in and of themselves. Furthermore, the numbness in their fingers and hands prevented them from gripping anything at all, hence drinking a cup of coffee became an ordeal.

In order to cope with their painful and debilitating conditions, strategies were adopted to overcome their discomfort while adequately maintaining their households. In some instances the women had hired cleaning ladies to take care of the more taxing tasks such as vacuuming, while in other instances "labour-modifying devices" (Ewan et al., 1991:188) were purchased to aid in baking chores. Family members were enlisted in helping around the house, like carrying the groceries or bringing up the laundry, or doing the dishes. Essentially their focus was on changing their daily routines in such a way so that their injury became manageable while maintaining a

semblance of normality and minimizing the effects of their loss of autonomy.

Interestingly, each and every one of the women workers interviewed primarily focused on their reduced ability to function as a wife, mother, and housekeeper. As expressed by one of the women, she "felt like [she] was imposing on [her family]" (Interview #4, 1996), when she had to ask them for help. Another noted that it took a while before she got her strength back after her surgery, which was not easy because she "had two small children at home" (Interview #9, 1996). A few of the women, for instance, felt it necessary to make excuses to the researcher as to why their houses were in disarray[15]. Having to depend on others, for help around the house, was troubling and stressful. Their self-identity as women and mothers suffered in this capacity and they felt that their injury took "a terrible emotional toll on the family" (Interview #4, 1996). Although, most of the women said that they had help at home, it seemed that they remained the primary care-givers, despite their injury. One such rationale given was that, "men are not great housekeepers!"

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[15] As mentioned in chapter 3, the women from the library were interviewed in their homes.

(Interview #7, 1996); and another woman made excuses for her sons not helping "...I guess it's a woman's job, you know, mother's job". (Interview #12, 1996). In other words, help at home notwithstanding, the women still worried about their inability to fulfill what they perceived to be their role: to stir the cookie dough, fold the laundry and walk the dog, and so forth. There was not one woman who mentioned that the help received at home, upon learning about their injury, replaced fully their control of household tasks - this responsibility remained the women's domain.

Such a situation may be understood in two ways: first, as a struggle by the women to maintain control over a part of their lives which was actually under <u>their</u> direct control; and/or secondly, as an example of the rigidity of the roles within society, which perceives certain domestic work as the province of women. The conflict experienced by these women with regard to their domestic work, points out how ingrained the existing societal ideology is which assigns domestic labour duties to women (Gannagé, 1986: 177; Luxton, 1986: 35). Control over their paid labour in either the factory or library, is not easily gained or influenced. Within the home they have control over certain

duties, ones which they perceive to be theirs to complete. Their injury, though, makes it impossible for them to fulfill this role without suffering pain: "I tend to put off things that could aggravate it - like heavy scrubbing and things like that" (Interview #2, 1996). Attempts to overcome this predicament take the form of negotiating with family members to take-on a greater share of the household duties, or hiring extra help. Nevertheless, data from the interviews suggest that such arrangements are not totally satisfactory for the women. A role which they expect of themselves to perform, they cannot. When they attempt to live up to the societal ideology the result is aggravation of their injury. Yet, the result of not living up to the societal ideology leads to stress by the women, that they cannot perform duties which are perceived to be theirs. Therefore, it seems that the women are expressing reservations over their attempts to reconcile their role of domestic worker with the physical limits now in place as a result of their injury, incurred in the paid workplace. These women not only have the double day of work oppressing them, but also the physical limits imposed as a result of their paid labour. The result is greater stress and anguish. As Gannagé (1986), Luxton (1986) and Tierney et

al. (1990) demonstrate, the double day of work imposes great strains on women. The data here suggest that this is compounded when injuries, particularly ones which are difficult to observe physically, prevent women from completing these perceived domestic duties.

Chronicity and Uncertainty

All of the sampled women expressed concern over the chronic nature of their symptoms and their pain. For example, symptoms were variable, disabling and invisible. Moreover, the women in both workplaces perceived and experienced the pain associated with RSI similarly. For instance, they felt that, once it woke them up at night or would keep them awake, the injury changed from simple discomfort into pain. Furthermore, their pain was expressed in terms of a feeling of 'pins and needles' in their hands; numbness in hands and fingers; a chronic and aching type of pain in the wrist, which never really dissipated; as well as a sharp shooting pain along the arm into the neck and across the shoulders. Common complaints included headaches, the inability to sleep at night, and a "reduced range of upper body motions" (Interview #4, 1996). Among other descriptions, the pain was most often described

as "burning" (Interview #12, 1996). While some of the women did experience pain intermittently, their overall experience was chronic, since the pain regularly returned and it never totally disappeared.

When visiting their doctor, the women suffering RSI disorders, in both workplaces, received advice from their respective physicians to just "shake out their hands" in order to relieve their pain and feelings of discomfort. The most common of these disorders is carpal tunnel syndrome[16], it is also the most commonly used diagnosis for the symptoms noted. This is also true for the sample of women in this study. The majority of them (11 out of 14) were specifically diagnosed with carpal tunnel syndrome. Moreover, the women who had been diagnosed with carpal tunnel were referred to specialists, and then quickly channelled towards surgery. Unfortunately, such action may

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[16] Carpal Tunnel refers to a channel formed by the wrist bones. This tunnel provides a passage way for blood vessels, tendons and the median nerve. The Median Nerve controls the action of the hand, thumb, index, middle and ring fingers. It also provides the hand and these fingers with sensations of hot, cold, pain and touch. Swelling of the tendons which surround the Median Nerve reduces the space in the tunnel and places pressure on the median nerve. Pressure to the Median Nerve results in symptoms known as Carpal Tunnel Syndrome (Occupational Health Clinics for Ontario Workers Inc., n.d.).

be unwarranted. Evidence in the medical literature suggests that too often physicians tend to channel their patients into unnecessary surgery (Higgs and Mackinnon, 1995). Indeed, Higgs and Mackinnon (1995: 9) note that "the role of surgery is limited, since studies have revealed a high incidence of persistent symptoms in workers undergoing carpal tunnel decompression". In fact, they contend that in most cases carpal tunnel surgery "in general relieves median nerve paresthesa[17] but not proximal pain or discomfort" (1995: 9).

Furthermore, they (1995:3) note that "the most perplexing disorders are those associated with compressive neuropathies [such as carpal tunnel] and nonspecific pain complaints", for instance pain in the entire upper extremity, neck, back and shoulder. Vague pain complaints are explained in terms of "overuse syndrome" by Higgs and Mackinnon (1995), a term preferred by these authors since it denotes more accurately the conditions a worker encounters. They posit that some muscles are strong due to repetitive tasks performed daily, while other muscles are

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[17] Paresthesa is a term referring to a loss of sensation or numbness (Occupational Health Clinics for Ontario Workers Inc., n.d.)

weakened due to under use. Exercise to restore the balance between the muscle groups is the only answer to rectifying the condition. Furthermore, Higgs and Mackinnon (1995) note that common practice has it that different specialists will give differing diagnoses for the same disorder. The authors continue that such "cases have sparked the most contentious controversy" (1995:3) among specialists. The underlying contention being that critics are doubtful of the work-relatedness of these complaints, mostly because a clear and unifying pathology has not yet been established. This presents problems in effectively diagnosing and treating the symptoms. It also places sufferers of these symptoms in the middle of competing discourses.

What this evidences indicates is that while the operation was successful at reducing the pain in the short term, the pain simply returned later. This is in keeping with our data. In both workplaces, most women who had been operated on, in both workplaces, spoke of needing another surgery. They were re-experiencing tingling in their hands and fingers, one of the first noticeable symptoms. In fact, some women had more than two surgical interventions already and the numbness and the pain was returning. Sadly, most resigned themselves to the idea that their

condition was permanent and was something they "had to learn to live with (Interview #9, 1996)".

For these women to have been diagnosed with RSI, was similar to receiving a life-sentence of pain. To them it meant no hope for total relief or full recovery of their condition. Their condition worried them and expressions of concern were often voiced. For example, one of the women noted: "I'm afraid [the injury] is permanent ... what if it gets to the point where I can't work [anymore]? That's what scares me" (Interview #3, 1996). Indeed, to most of these women, the future looked bleak. For them there was a real potential for future loss of income and security. In some of the cases the women were the sole breadwinners, and the thought of possibly losing their job was a devastating prospect - especially when there was a family involved. As well, a few of the women's husbands were unemployed meaning the burden was on their earnings to provide desperately needed income. Hence, despite their injury, they would work extra hard to convince their respective employer that they were still capable of doing their job. Attempts were made to ignore their condition and their pain, "no matter how much it hurt ..." (Interview #2, 1996). Unfortunately, some women, ignored job

restrictions (doctor's notes) as well. Under the guise that they did not need them and that they were " ... not complainer[s]" (Interview #12, 1996). However, invariably by doing so, their injuries were aggravated to the point where they became acute and any chance of recovery was, thus, thwarted (cf. Higgs and Mackinnon, 1995).

Need to be believed

Most of the women experienced the onset of their condition during the mid to late 1980s. At this time the condition was not readily recognized in either workplace. One of the respondents noted that during the mid 1980s, "a lot of people didn't even know that things like [RSI] existed. That was when I had my first surgery done in 1986" (Interview #1, 1996). It was hard during the period from the mid to late 1980s for these women to convince others of their injury, especially because it could not be seen. Being believed by their doctors, friends and family, as well as their co-workers, was a very important issue to the women. The fact that they had developed an unseen and obscure set of symptoms which translated into pain and discomfort and subsequently incapacitated them regularly was a source of considerable stress. Comments were made

that it affected their mind, "because you think that you're not capable" (Interview #3, 1996). In fact, one of the women mentioned that she "was petrified that they wouldn't listen [to me], and that they would tell me it was in my head" (Interview #3, 1996). In other cases, the women would proudly use their surgery as "a badge of honour" proof of validity of their condition. Moreover, the need to be believed spilled over into their search for answers and relief of their pain. When, the women would come across a physician who doubted their symptoms and had no ready made answers or solution to their problem, they would search for a physician who would believe them and give the support they were looking for and needed.

Other similarities, included the fact that the women in both sectors worked on average the same number of years within their respective occupation before they became aware of their injury. This is intriguing given that the blue collar sector is perceived as the more risky industry, in terms of getting injured. It would seem to suggest, at least with regard to RSI, that the repetitive nature of the work gradually leads to the condition and injury. Additionally, in both workplaces the women remembered life events in terms of their children's experiences and ages.

In other words, surgery was remembered in relation to a son's birth or a daughter's grade level in school.

Differences

Apart from the availability of medical facilities on the premises, the most significant difference between the two groups of women was the fact that the women in the white collar sector did not accept the work-relatedness of their problem as readily as the women in the blue collar sector. This section will address this and other differences.

Work-relatedness

As noted above, the one difference which stands out is the fact that the women in the library were less willing to attribute the cause of their injury solely to the workplace. Instead, they perceived their injury to have developed over time, through a combination of factors including their everyday household activities as well as their paid work tasks. One of the library women noted that: "my physician [explained] that it was a[n] ... accumulation of a lot of things. **I mean I do things at home too.**" (Interview #1, 1996; emphasis added). Her doctor

simply attributed her condition to "getting older ... and normal wear and tear" (Interview #1, 1996). Similar views were expressed to the women of the library by their physicians. Physicians individualised the cause of the injury.

One of the women encountered a physician who alluded to the fact that she should "go home or lose weight" (Interview #3, 1996). It is in keeping with the manner in which women's health concerns are trivialized and overlooked by the medical community (Reid et al., 1991; cf. Sanford and Donovan, 1984). When one of the women did attempt to address the work-relatedness of her injury by seeking compensation, she had a difficult time. She chose to go the "compensation way" instead of taking "[time off] on my sick time" (Interview #3, 1996). However, this action caused her stress because "I felt that [my employer] looked down on me because I was causing [them] problems" (Interview #3, 1996).

Other library women were simply diagnosed with fibromyalgia, a relatively recent syndrome which "is almost like a new disease" (Interview #5, 1996). Workers at the library "tried to claim fibromyalgia as work-related. However, there has been a real hard time on that"

(Interview #4, 1996). In fact, fibromyalgia is not widely recognized as a work-related syndrome, hence thwarting recognition of its work-relatedness.

On the other hand, women in the blue collar sector were adamant that any activities they performed outside of the workplace did not, and could not, have caused their injury. For these women their injury was solely a workplace related matter. In the words of one of the company workers: "there is nothing that you actually do at home that is so repetitive, that you can't get around [it] somehow" (Interview #9, 1996). In fact, their perception was that their injury had greatly affected their personal life, rather than their personal life in any way affecting their injury.

This point is significant in terms of beliefs and perceptions which the women in the two workplaces had regarding the source of their injury. One partial explanatory factor might be that the blue collar sector had medical facilities available to its workforce that may have given the blue collar workers a predisposed impression that the injury was work-related. Indeed, these women had access to a company nurse, who would give them ice-packs or heating-pads for their injuries at work. In other words,

treating them for their pain while at work thereby establishing the recognition/link between their pain and work. Equally important in this regard was that the sampled women in the manufacturing company recognized that in spite of their household chores, such domestic activities lacked the excessive repetitive nature of their paid employment jobs and could not have caused their injuries. The lack of such a facility at the library may have frustrated any such work-injury connection by the workers there.

Diagnosis: the social construction of disease

The differing attitudes between the women in the two workplaces regarding the work-relatedness of their injuries must to some degree be connected to their diagnosis and treatment by health-care professionals. Nettleton (1995:18) reminds us that "medicine might be based on an objective science, [however], the application of medical knowledge [i]s not". She makes a strong case for the social construction of illness and disease. She notes that the medical profession's knowledge and evaluation of disease is "mediated by the social and political circumstances in which doctors practise".

Additionally, Theriot (1993) points to the fact that patients can get caught up between competing discourses in the politics of medical specialization. It is therefore interesting to note that some women from the library, with the exact same cluster of symptoms as those diagnosed with RSI, were diagnosed with a syndrome which is not as readily proven to be a work-related health and safety problem, namely fibromyalgia. Indeed, fibromyalgia is more suggestive of an individual, personal problem, rather than a work-related issue. In spite of this, the diagnosis of fibromyalgia brought relief to these women. Their pain and injury had a medical diagnosis, including medication which blocked the pain - a band-aid solution at best, but an answer for the sufferers. However, the diagnosis and treatment did not cure the injury, or remove the pain. Nonetheless, these women pointed out that their injury was unlike any other; a point of which they frequently reminded the researcher and themselves. Their injury was not a common injury, but rather, they had a syndrome! Information indicates that of all the workers in the library, approximately six women have been diagnosed with fibromyalgia rather than RSI - two of these women are on long term disability (Interview L, 1996). In contrast, the

women in the blue collar sector were all clearly diagnosed with RSI and none with fibromyalgia. In other words, the name of the disease, despite the similar symptoms, and the help of the medical professionals, convinces these women of their condition. Nettleton (1995:24) reiterates how "'miners nystagmus', was the product of debates and compromises that were struck between employers, employees, insurance companies, doctors and lawyers". Therefore, she argues, "disease categories are not simply a product of scientific analysis but also the outcome of social and political struggles" (1995: 24). Such a conclusion can be applied to injuries such as RSI or fibromyalgia.

Trade Union and union activism

Some of the differences in the women's perceptions between the two workplaces may be attributable to their unions. For instance, during the 1980s, the union in the white-collar workplace did not give as high a priority to occupational health and safety issues compared to the trade union in the blue-collar workplace (Interview L, 1996: Interview M, 1996). Moreover, the union in the manufacturing company had paid particular attention to ergonomic factors during the mid to late eighties

(Interview M, 1996). Therefore, the level of awareness of the women in the manufacturing company was raised in terms of repetitive tasks and the danger of getting injured by performing such tasks. Indeed, workers in the white-collar workplace noted that they we were not educated: "we did not know about the dangers of repetitive tasks, but they are now much more aware" (Interview #1, 1996). The union in the blue-collar company took a more proactive stance to educate its workers. The library union, however, did not educate its workers in the library regarding repetitive strain injuries and its hazards (Interview L, 1996). However, while one former library union member did state that she was made aware of the injury through the union, this can be explained by the fact that she was one of the officers on the occupational health and safety committee at the time. The difference in levels of awareness between the two workplaces can be attributed, at least, in part to the differing union activities.

The Regulatory Process; Normalizing process

Dreyfus and Rabinow (1983) note that Foucault's concept of normalizing society through the regulatory process turns out to be a powerful and insidious form of

domination. Normalizing practices deploy disciplinary techniques which encourage internalization or promote a "... matrix of individualization" (Smart, 1985: 131). Moreover, the regulatory process teaches one to be an obedient and willing subject - a docile body (Dreyfus and Rabinow, 1983: 133-142). These techniques of disciplining bodies are applied mainly to the working classes (Ibid.). Indeed, Foucault contends that disciplinary control and the creation of docile bodies is connected with the rise of capitalism (Foucault, 1979). Foucault further contends that we live in a culture that is appropriated by expertise, "the same expertise we continually resort to in order to make the individual and community healthy, normal, and productive" (Dreyfus and Rabinow, 1983: 257). Examinations and gathering of data are used in the normalizing process (Foucault, 1977).

The use of examinations and the expertise used to make the individual normal, is exemplified in our study. The women were sent, in some cases, from the company nurse, to (in all but one instance) their family physician, to specialists. One of the women described her trek between specialists:

> ... I was seeing my GP., [then] the carpal tunnel guy, who did the carpal tunnel surgery. ... [The pain] would flare up in one or another place, so I get the specialist for tennis elbow and that helped a lot. ... Then my doctor sent me to Dr. L., the sports medicine guy, he sent me on to physio. So, [then] I get [Dr. L's] assistant ... And that was, like, 2 years later after the pain and the chronic and disability ... (Interview #4, 1996).

Normalizing techniques serve to diffuse contradictions between groups, such as occupational health and safety issues between employers and employees. Indeed, the normalization of society, via disciplinary practices, is used for the rational policing of populations with relative ease. Foucault called this technique of normalization and individualization, bio-power (Discipline and Punish, 1979).

This normalization process can be clearly identified in the manufacturing company with regards to RSI. The presence of a company nurse and access to a company doctor, in fact, serves to normalize workplace injury. The workers' experiences are examined, data are collected and tabulated and an acceptable average is established for that industry. The injury, thus, becomes normalized. Indeed, Bale (1990:255), posits that the role of the state is to neutralize and normalize workplace injuries through the use of legislation, medical

surveillance and its workers compensation system. Indeed, the normalization of workplace disease and injury is used to thwart dissention in the workplace. As long as workers see their injury as an established pattern of the 'norm', they will be accepting of the situation. According to one of the respondents in the manufacturing company:

> You wake up at night and your fingers are asleep and they don't feel right. But doing a job like this, you become accustomed to things like that because it's part of the job. It just happens. It's just the way things are. In a place like this so many of us get hurt. (Interview # 9, 1996).

However, in the white collar workplace fewer women viewed their injury as solely work-related. Instead, the women were more willing to blame non-work-related factors. One of the women in fact stated that her condition "was caused by stress" (Interview #5, 1996). While another commented that:

> ... [T]o me, [it is caused by] using my hands a lot, my left hand a lot and doing heavy things with it. Because it's affected by the same thing, like vacuuming, and carrying grocery bags (Interview #2, 1996).

Hence, they would not report their injuries to the workers compensation board, an important step in the normalization of a workplace injury. Of course, if an injury is not seen

as work-related, there is no need to normalize the situation within the context of work, as workplace dissention is not likely to develop over something that is not seen as work-related.

The workers' perception that their injury is not solely caused by tasks performed in the workplace is advanced, albeit unintentionally, by members of the medical establishment. Medical personnel have a great influence over issues relating to women's health and hence their lives (Sanford and Donovan, 1984). These medical personnel diagnose the injuries as being something other than work-related. For example, some of the women from the library were diagnosed with fibromyalgia. However, fibromyalgia, is not seen as a work-related condition, hence the workers' compensation board does not recognize it as work-related. The problem, though, is that fibromyalgia exhibits symptoms similar to, or the same as, RSI type conditions. Indeed, the literature (Littlejohn, 1989; Ewan et al., 1991; Hopkins, 1989) suggests that both RSI and fibromyalgia are one and the same condition. The difference is that RSI related injuries are recognized by the workers' compensation board as work-related and thus compensable. Fibromyalgia, on the other hand is not, and therefore

injuries related to it are taken beyond the purview of work-relatedness and beyond compensation. Yet, it is contended that both conditions are one and the same except for their nomenclature. Nevertheless, the women with fibromyalgia emphatically denied that their condition was a repetitive strain injury. In the words of one of the library respondents: "It is not the same thing ... it's not an injury it's a syndrome" (Interview #5, 1996). While another library worker noted that "fibromyalgia is a sleeping disorder, predominantly [suffered by] women" (Interview #4, 1996). Thus, if a physician diagnoses the symptoms to be fibromyalgia, rather than RSI, all connections to the workplace are obscured. Especially, when an anti-depressant is prescribed, to help you sleep and take the pain away. The end result is that the focus on work-relatedness is subverted - intentionally or unintentionally - and in its place is inserted a more individualistic cause of the worker's injury.

Such views have been internalized by many of the women in the library to the point that most were not willing to accept their injury as solely caused by their employment: "because the thing is that I do things at home too" (Interview #1, 1996). In other words, the women

accepted an argument which steered their attention away from recognizing their injury as work-related and accepted as normal the fact that it was an individual problem. Hence, the idea that RSI is not solely a work-related injury is being normalized by these women.

An explanation for how this can occur is provided by Nettleton (1995). Nettleton (1995:26), contends that medical knowledge is socially created and that "social relations contribute to the creation of disease, [while] the language of disease serves to conceal the nature of social relations". In other words, in comparison to labour, the state and capital, the medical profession plays a large role in establishing the work-relatedness of disease. What is of importance here, Nettleton notes, is the manner in which medicine is used rather than its content. As soon as workers link their injuries/diseases to the workplace, the need is established to normalize the injury/disease within the context of work. However, when medical explanations confirm traditional social values or beliefs (i.e. non-work-relatedness), they are readily accepted as an individual health problem rather than an occupational health problem (Nettleton, 1995). Furthermore, the fact that the WCB made it difficult for

the women workers in the library to get compensation added to their perception that their problem was not truly work-related. However, this is not to take away from the fact that their injury was being normalized nonetheless. Moreover, those women in the library who did insist that their injury was work-related, and reported it to the compensation board, experienced significant difficulty in getting their injury recognized as a workplace injury. As one library worker reported:

> My doctor knew it was work-related, so we filed for WCB. Although I had to really document, extremely. I had to prove and I had to document the number of slips. You know, I wrote little charts and graphs to show that [flipping through the slips] had been a real key [in] causing this particular thing. It took months before they awarded [me] (Interview #4, 1996).

The onus was placed on the individual to show the work-relatedness of her condition. This, in spite of the fact that Ontario Chief Justice, Sir William Meredith's historic proposals,[18] which established the legal limits of workers'

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[18] With the rise of industrialism, at the turn of the century, there was concurrently an alarming increase in industrial accidents in Ontario. Indeed, accident compensation became the central issue in 1910. As a result, in 1914, the Ontario legislature passed the Workmen's Compensation Act. Chief Justice Meredith played a pivotal role in getting this Act proposed and passed (Piva, 1975).

compensation, guaranteed workers protection against loss of wages due to occupational disease or injury, irrespective of fault; while, in return injured workers gave up their right to sue their employers, which relied on the workers' ability to prove negligence on the part of their employer (Elgie, 1989; Piva, 1975). By refusing to accept the work-relatedness of an injury, despite contrary evidence as presented in the literature by experts (Tanaka et al., 1994; Tanaka et al., 1995), the Workers' Compensation Board effectively bypassed its guarantee to workers and diffused the issue in terms of normalizing occupational injuries.

It is prudent to place Foucault's concept of normalizing practices within the broader context of political economy and occupational health. Doyal (1981) argues that employers within a capitalist economy tend to place more priority on making profits than on the health of their workers. She states that it is "in the economic interest of employers not to inquire whether their workers are at risk from accident, disease or death" (Doyal, 1981: 69). A similar argument is advanced by Doern (1977). He contends that the regulatory process, in relation to occupational health and safety, depends on a number of variables among which we need to consider: "the market

economy and the production cycle; the role of organized labour, federalism, and the scientific and laymen's approaches to evidence and causal knowledge" (Doern, 1977: 1). Essentially he maintains that the need for profit tends to displace the need to consider the health and safety of workers, which is all contingent on the interplay of the various competing interests.

It is assumed, in such situations, that the state and trade unions will come to the aid of the workers and protect their health. Hence, protective occupational health and safety legislation setting minimum standards which employers must abide by are put in place. In fact, Doyal (1981) states that work in general is assumed to be safe and not dangerous to one's health. Yet, health and safety "safeguards are not operating very effectively" (Ibid.). Therefore, she continues, it is necessary for workers to keep an eye out for their own health and safety since their employer is not likely to do so (Ibid.). In order to do so, workers must depend on their own awareness of workplace hazards and industrial disease. But, Doyal contends that "medical and legal knowledge is concentrated in the hands of 'experts' and as a consequence workers have to rely on their unions both to obtain such information,

and also to initiate any necessary action" (Ibid.). Meekosha and Jakubowicz (1991) indicate those who have key interests in the recognition of RSI as work-related: employers, the state, trade unions, and the medical profession among others. They conclude that:

> [the] struggle for social and legal recognition of [RSI] was aided by some parts of the medical profession concerned with the damaging effects of technology, [while] the compensation nexus elicited significant alternative medical assessments which focused primarily on the notion of hysteria (Meekosha and Jakubowicz, 1991: 34).

Hysteria is a concept connected to an individual's mental state. This view that RSI is in people's heads is still very prevalent and current (Voiss, 1995). The argument lays blame on the victim by arguing that those who claim to suffer from RSI type symptoms are essentially malingerers or hysterical. The problem with relying on this view is that it is based on an expert's testimony used in a court case which established jurisprudence for workers' compensation in the United States. Such a view would obviously be affected by the social mediation referred to by Nettleton (1995). In other words, the reliability of the testimony must be questioned. Therefore, if trade unions need to rely on the knowledge produced by experts, one can argue that occupational health

and safety issues can be 'manufactured' to the extent that experts have differing opinions on issues which are, in reality, essentially the same (Hopkins, 1989; Littlejohn, 1989; Voiss, 1995). On the other hand, such arguments can be used to negate any concerns labour may have, leaving workers with little or no protection. Thus, a workplace injury can be made to look like an individual problem simply by giving a different diagnosis for a similar set of symptoms, which are produced under similar circumstances - fibromyalgia and RSI, for example. It depends on the economic circumstances and the strength of the workplace union whether workers can expect protection from occupational dangers in the workplace.

Hopkins (1989: 250) argues that the incidence of workplace disease "is only socially recognized as [noteworthy] if it is observed and reported". He further notes that "the processes of observation and reporting are crucial in understanding [the phenomenon]" (Ibid.). Moreover, having an insight into the social construction of disease "is particularly important in accounting for apparent differences in the incidence of the problem" (Ibid.). Indeed, disease can be defined, and defined away as Smith (1987) has skilfully demonstrated in her account

of the black lung movement in the United States. Additionally, Nugent (1987), like Nettleton (1995), points to the role the medical profession plays in defining a disease. As Hopkins (1989: 251) notes, "the way in which [a] problem [is] diagnosed and [is] recorded" are important factors to consider since such practices can obscure the true nature and incidence of workplace disease or injury. Furthermore, the way in which the disease is reported influences statistical recording procedures and can play a "major part in preventing the widespread recognition of [a] problem" (Hopkins, 1989: 252).

Our study indicates that a social construction of RSI can be demonstrated. The very fact that the same set of symptoms, suffered by white and blue collar workers alike, are given different labels by various medical experts (for instance: neurologists, orthopaedic surgeons and the like) indicates considerable confusion, intentional or not, among the medical experts. The literature indicates a substantial dichotomy between those who adhere to a psychological thesis and those who adhere to an organic thesis - hence, the different diagnoses for the same set of symptoms. Interestingly, the women in this study diagnosed with fibromyalgia (a sleeping disorder), were all from the

white collar workplace, whereas those from the blue collar workplace without exception had been diagnosed with RSI. As mentioned, studies demonstrate that the symptoms of fibromyalgia are remarkably similar to the symptoms of RSI and that the two are developed under similar circumstances (Waylonis et al., 1994; Littlejohn, 1989; Hopkins, 1989). Indeed, these studies also show that those diagnosed with fibromyalgia do repetitive tasks under stressful and tight time constraints, mostly in office settings. Thus, it is argued, the progression of these symptoms coincide with repetitive job tasks and hence it can be hypothesized that these symptoms are, in fact, job related. Thus, even if it should be the case that fibromyalgia is not the same as RSI, evidence indicates that the condition can be perceived as work-related. The women in our research sample, however, seem to be caught between competing discourses on this point.

Furthermore, confusion also exists among those who see RSI as an organic pathology; they cannot come to a consensus as to how the symptoms actually developed. One set of physicians claims that some of the women suffered from a sleeping disorder - fibromyalgia - and treated them accordingly. Another set of physicians treated the women

for inflamed or constricted tendons, thus RSI. It is clear, then, that disputing discourses are evolving over symptoms which have a number of similarities. Indeed, medical experts who diagnose RSI type symptoms as fibromyalgia add to the obscurity of invisible dangers which coincide with continuous repetitive tasks in the workplace. Unfortunately, the women in the library seem to be caught between these competing discourses.

The question raised, of course, is why do the women in the blue-collar sector see RSI as solely a work-related injury while the women in the white-collar sector tend not to? One can speculate that the difference is explained by the varying impact of union education in the two workplaces. The union at the manufacturing company focused more on ergonomics and attempted to raise the awareness of its members, whereas the union at the library tended to focus less on occupational health and safety factors (Interviews with union officials, 1996). Thus we can speculate that, the women at the manufacturing company were educated and thus predisposed to the idea that RSI was a work-related issue. The awareness of the women in the library, however, was not yet raised to that level.

This speculation, though, is not that apparent when observing the collected data. Indeed, the women in both workplaces contended that the union had no involvement at all with bringing RSI, as a workplace problem, to their attention. The women at the manufacturing company found that in most cases the connection between their injury and the workplace was made by their physician: "It was my doctor that explained it to me" (Interview #6, 1996). Another noted that her initial suspicion about her condition was peaked by watching a television show: "so I went to see my own doctor ... [He] told me then what was wrong with me. He told me I had to have carpal tunnel syndrome" (Interview #10, 1996). Thus, it can be argued that the manufacturing company women did not experience the union as playing a significant role in occupational health and safety matters at the individual level. Indeed, the union did not hold official occupational health and safety classes during the mid to late 1980s (Interview M, 1996). However, they did have significant involvement with an Occupational Health Centre regarding ergonomics during this time (Interview M, 1996). Moreover, occupational health and safety committees were educated in related matters. At that point it depended on the committee whether employees

were informed or educated. Furthermore, occupational health and safety was foremost on the agenda of the union during the 1980s, and together with the employer, the union was very safety conscious (Interview M, 1996). This could also explain the presence of medical facilities on the premises, which would suggest that the union's involvement in these matters was more at a company level and not so easily perceived at the individual worker level.

The union at the library noted that the membership learned about RSI by word of mouth (Interview L, 1996). Like the union at the manufacturing company, it too, did not hold official occupational health and safety classes for their membership (Interview L, 1986). Health and safety issues, though important, were not first and foremost on their agenda during the mid-to-late 1980s. This apparent lack of interest in occupational health and safety by the union in the library, is evident in that most of the women library workers did not recognize their condition as work-related. For those who did recognize it as work-related, the issue was brought to their attention through different channels. One of the women learned about RSI conditions and the workplace because she was an occupational health and safety officer on the committee.

She notes: "I'm pretty careful. I've been a health and safety committee [member] all along. ... and my boss was quite supportive, we, in fact, bought wrist rests for all the computers in the department" (Interview #4, 1996). While the other respondent was told by her husband that she probably suffered from RSI:

> He brought it to my attention. When I was, one day, just sitting there trying to work. And, I mentioned to him what it felt like and then ... he thought, you know, it might be carpal tunnel (Interview #3, 1996).

It must also be remembered that at the time that RSI related problems became more prevalent in Ontario (from the mid 1980s onward) most employers and many workers were not very familiar with the effect of repetitive work tasks.

Normalizing workplace injuries does not mean that the workforce simply accepts workplace injuries as part of the job. What it does mean is that workers perceive injury on the job as a normal condition of work. Worker comments testify to this fact:

> [M]y hands would get very puffy and very sore. **But I just took it as being part of the job** and lifting, whatnot. You know I can't go down to the nurse every day. You know, I work as much as I can, I do as much as I can until finally, there'll be so many restrictions or something that they won't have anything for me. What am I

> to do? Find myself right out of a job. (Interview #13, 1996; emphasis added)

Indeed, the mere fact that experts are continually brought in to compartmentalize and tabulate our experiences, demonstrates the manner in which workplace disease and injuries have become regulated - that is, normalized. For instance, all of the women interviewed at the manufacturing company had gone at least once to the nurse, apart from their physicians and other specialists. Indeed, the procedure at the plant is set up in such a way that injured workers have to go to the nurse's station. Even if you go to your doctor first, a visit to the nurse's station is considered prudent because then "they [the company] know" (Interview #14, 1996). Other women noted the tediousness of having "to go to my doctor and then I have to get a note and then I have to see the nurse and then I have to get ice" (Interview #7, 1996). One of the women saw getting injured as inevitable:

> ... I suspected it was repetitive strain injury ... I mean, it makes sense. ... no matter what job we do in here, it's always the same thing over and over again. Most of the time I used airguns, on most of the jobs that I've worked on in here. So, I guess it's going to happen sooner or later. It's [a worry], nobody wants that kind of surgery and it's, you know, it's the whole thing: the doctor's appointments, the x-rays, the

> tests that they do, everything that you have to go through (Interview #9, 1996)

Meekosha and Jakubowicz (1991: 22) argue that we need to understand RSI in terms of "industrial injury as a site of power, through which broader social struggles are given physical form in the body of the injured worker". Thus, normalizing workplace injuries, tends to diffuse the point of impact, the site of power, the clash between labour and capital as expressed in occupational disease and injury inscribed on the body. It no longer is seen as contentious if the workplace injury falls within accepted norms, under the given circumstances.

However, this begs the question: Do workers accept the idea that getting injured in the workplace is to be expected and part of the job? The question seems to almost suggest that the workers have developed a false consciousness in a Marxian sense. However, the answer to the question, based on the data in this study, must be yes - the idea is accepted. The overall organization of the structure of paid employment includes for workers the idea that they may be injured. Only when injuries become life-threatening do workers become more adamant about changing the work process, and only then when they are encouraged to

do so by outside forces (cf. Judkins, 1986; Smith, 1987; Rosner and Markowitz, 1991; Fox, 1991). The workers are enmeshed in a process of normalization that regulates workplace injuries. The fact that such injuries are reported to the Workers Compensation Board - a regulatory government agency - the fact that physicians and other medical specialists are called in to assess and/or comment on the condition points to the normalization of workplace injuries. In other words experts are asked to evaluate and compartmentalize the issue, which Foucault argues is part of the regulatory process.

Moreover, individualization and normalizing practices tend to direct workers into accepting the idea of workplace disease and injuries. The unions further this process by following the normalizing regulations and avenues of redress. Government legislation dictates that occupational health and safety officers must represent workers on occupational health and safety committees. The fact that such officers get training and are educated in occupational health and safety issues (i.e. they become experts) demonstrates the extent to which unions become part of the normalizing procedures. They too become part of the normalization process of workplace injuries and the

defusing of labour resistance to changes in the organization of production. Changes are not easy to achieve. As one of the women interviewed recounted:

> I really do think that people shouldn't be made to feel funny because their job might be causing them an injury. I mean, the hardest thing to do is to come forward and say, you know, this is what I think and you have to go against everybody. Because your employers don't want you to go to compensation because they don't want to pay compensation, because they're fined ... I think we're now becoming more aware of the repetitive strain injury, which is good. And I think that there has to be more information on it. (Interview #3, 1996).

Chapter 7

Conclusion

In this study I have attempted to account for the perceptions and feelings of women workers with repetitive strain injury. The need to integrate the views and perceptions of workers, and particularly of women workers, into the occupational health and safety literature served as the rationale for the research. Given the literature on repetitive strain injury as an occupational health issue, the increasingly large number of people affected by the disease, and the fact that women's occupations are most prone to development of the injury, it is important to study these occupations. The theoretical analysis focused on Foucault's concept of normalization, and feminist concepts of patriarchal ideology and the double day of labour, to provide explanations for the findings from our interview data. However, because of the exploratory nature of the study, the conclusions are tentative and suggestive at best. In order to confirm the findings, a more comprehensive research design is required. Nevertheless,

having said that, the conclusions are interesting and compelling.

By letting the women speak about their injury, what they felt caused it and the problems encountered with it, we addressed directly a major problem with the present occupational health and safety literature - namely, a shortage of research that integrates the subject's views into occupational health investigations. Therefore, the aim of this research was to let the women speak for themselves, in other words to give them a voice. Interview data collected from the women workers in the manufacturing plant demonstrated that they perceived their injury and its attendant problems as work-related and a normal part of work, while all but one of the women at the library either did not see their injury as work-related, or saw their paid work as only aggravating their condition. Those few women who did not see the injury as work-related believed it to be, at best, somewhat aggravated by their employment. Instead, these women were persuaded by their medical doctor that the cause of the injury was an individual problem. In other words, most of the women in this study saw their injury as a work-related problem.

Such evidence, however, is strongly suggestive of a process of normalization. Indeed, most of the women accepted that getting injured on the job is normal and do not resist this view. In fact, none of the women hold the view that their injury could be prevented by reshaping the way in which their work was performed. They are unwilling to see it as the responsibility of their respective employers to provide for changes that would remove the main cause of their injury, namely repetitive work tasks. Furthermore, the process of examinations by family or company medical doctors and by other medical specialists, so that the women can be diagnosed and a name can be put to what ails them, as well as, the managing of injury through the compensation system, are all examples of the means by which people become normalized (Foucault, 1979). Resistance and opposition are blunted within a system that creates normalized subjects; workers accept their injury as part of the working conditions under which they must toil to earn wages to survive. In this manner the activities of the work process are seldom challenged. Indeed, any changes to the work environment in our study did not remove the repetitive nature of the employment duties but only reduced the exposure to them, either by moving the employee

or, in the manufacturing plant, instituting job rotation. While these changes did provide some relief, they did nothing to **prevent** the injuries - the repetitive tasks remained in place.

At this juncture limits to Foucault's notion of normalization should be noted. Although the normalization process can serve to diffuse work place dissention in terms of individuals accepting willingly their workplace injury, the normalization process does not wholly eradicate workers resistance. Therefore, what is needed is for agents of power, such as an individual worker, to resist that which causes the workplace injury or disease to be accepted as normal. This can take the form of resisting the state, prevailing medical opinion, union practices and capital. For example, in the case of asbestos the process of normalization did not adequately provide for dispersement of discontent and agents of bio-power were able to go beyond the normalizing of workplace health and safety issues, which served to ban the use of asbestos (Kleist, 1986; Murray, 1988). It also indicates the multiple sites of power in a Foucauldian sense, in that there were a number of agents who were involved in achieving the eradication of this substance.

Those women who do not see their injury as work-related but instead understood their condition to be of an individual nature, in fact a sleeping disorder - fibromyalgia, become cases caught up in the social construction of disease debate. Repetitive strain injury is still a disputed condition within the medical profession. Many medical professionals believe that what is termed RSI, is in fact fibromyalgia. What was interesting about the women diagnosed with fibromyalgia is that initially one woman had perceived her injury to be work-related, until a physician diagnosed her as suffering from fibromyalgia. In fact, the symptoms and pain described by the women diagnosed with fibromyalgia correspond to those of the RSI sufferers. It is suggested that many RSI sufferers are being diagnosed (consciously or not) by medical professionals with maladies that are not so immediately related to paid work causes, such as, for example, fibromyalgia. This, it follows, makes resistance to work conditions all the more difficult since the workers' injuries are divided across a number of differing ailments. Their injury becomes caught up in a debate within the medical community; a community of experts will determine just what condition they suffer from, and its

attendant causes. The perceptions and views of the worker subject do not, therefore, enter into the construction.

As mentioned above, our interview data suggests a difference in how the library workers perceived their injury compared to those in the manufacturing plant. Most of the women in the library, did not recognize their injury as particularly work-related. However, some did feel that their injury was exacerbated by the work that they performed in their place of employment. On the other hand, all of the women in the manufacturing company, solely attributed the injury to the workplace. In their opinion there was nothing outside of their paid work that they did that could have caused the injury. I suggest that the reason for this may be attributed, in part, to the respective workplace unions. Although there were no obvious educational programs offered by either union local, the manufacturing plant union had a greater influence over the membership's perception of RSI. The union in the manufacturing company placed more importance on work-place injury as a priority in labour management meetings and took a more aggressive stance in this area, which in turn translated into changes in the workplace, such as ergonomic changes and medical facilities. In the library, the mere

fact that occupational health and safety issues were not at the top of the union's list of importance translated into low priority being given to occupational health and safety in the workplace and accordingly no aggressive action in getting injuries addressed as work-place related problems. What this suggests is that unions who are more aggressive in seeking to have occupational health issues addressed within the workplace, whether at a structural level or individual level, may improve the likelihood that workers who suffer an injury will view it as work-related. Such a step would also aid in the compensation to the worker for work-related injuries. This position, however, is speculative and would require more in-depth interviews and research in order to be assured that the differing union stances were relevant in explaining the differing perceptions workers had toward the work-relatedness of their injuries. Yet, it is just such a first step that will be needed to combat the normalizing influences facing workers.

Yet, normalization does not account for the totality of the experiences and perceptions which these women had of their injuries. The interview material reveals the extent of the pain and suffering endured by the

women because of their impairment. However, the pain and suffering **outside** of the workplace was as major a factor as the problems the women faced inside the workplace. In many instances the injury was further aggravated by activities outside of the workplace. Such aggravation cannot be viewed as simply due to normalization since the tasks performed by the women included the extra burden of having to perform domestic labour - a double day of work. In fact, women in both workplaces did not like the idea that the injury hindered their ability to fulfill their mother role. Indeed, separate from the question about the extent to which domestic tasks actually caused or contributed to the injury each woman suffered, is the question why most of the women held strong feelings regarding the interference of the injury with their domestic life and unpaid work.

The women expressed sadness and frustration with their inability to perform what they perceived as a mother's/wife's domestic work because of the pain and restrictions of the injury. Their determination to persist with these work activities, despite the pain, simply aggravated the injury in many cases. How can we account for this? As previously discussed, the patriarchal image of society sets the work of the domestic sphere to be the

domain of women. This view is not necessarily internalized in a similar fashion by all women, as noted by Luxton (1986), however, the perceptions of the women in this sample suggest that it is an ideology that still greatly affects the identity of these women. They perceive their injury to have compromised their identity and ability as a mother/wife since they cannot perform the tasks previously taken for granted. Their attitude is almost apologetic at the limits which the injury puts on their capabilities. Feelings such as these can be accounted for if one remembers that the women must rely on others to help, or do completely, the work they previously performed. Yet, these perceptions of inadequacy do not spill over into the paid workplace: why not? Paid work is seen in relatively non-gendered terms in comparison to the domestic work tasks. Women who perform a double day of work feel compelled to perform the domestic work inspite of any injury. This notion that they must fulfill their household tasks is perpetuated by an ideology of patriarchy. Indeed, domestic work is an important part of women's identity even if they also perform paid labour tasks, as demonstrated by Gannagé (1986). Thus, the evidence collected in this investigation suggests that studies of occupational health and safety

must include the perceptions of women workers, and also that they must analyze the manner in which the domestic and paid work spheres interact to amplify the effect of workplace injury on women's identity.

Emphasizing the importance of occupational health and safety may aid in achieving some workplace change. Changes to the manner in which unions educate their members will also help to break the hold of the normalizing influence of the social structures. Normalization, as a sub-category of bio-power in the context of social structures, is seen in the practices of the agents of bio-power, such as physicians, the company nurse or the workers themselves. Foucault (1980) argues that power exists in action, it is exercised. Thus, power is seen in the steps or actions individuals take or practices individuals follow to achieve their goals. This drive, to accept and follow certain practices obediently, in other words, a disciplined body, may be imposed from within or through external sources. Accordingly, in the context of multiple sites of power, workers are not left powerless, they themselves are agents of bio-power. Hence, it is imperative that workers understand that it should not be considered normal for people to be injured at paid labour.

Indeed, educational programs to deliver this message at union-local levels should be contemplated by trade unions. There is a body of literature which looks at the role of trade unions and occupational health and safety policies in the workplace (see Robinson, 1988; Cassou and Pissaro, 1988; Sass, 1989). Indeed, Robinson (1988) notes that health and safety activities are more apparent in unionized workplaces. Therefore, trade union interest and participation in occupational health and safety issues are paramount for the safety of workers.

Furthermore, it must be recognized that it is the repetitive nature of the work, rather than work in itself, which is the cause of the RSI. If the repetitive tasks were eliminated it would greatly aid in reducing the incidence of this condition. Moreover, the views and perceptions of workers must be integrated into occupational health and safety research. This includes the manner in which a disease comes to be defined or socially constructed. At present medical experts and researchers tend to trivialize and ignore the concerns of the worker and of women. Our evidence suggests that special attention needs to be paid to the concerns of women workers since their injuries are complicated by the double day of work

they perform. This study has contributed in a small, preliminary manner to this by introducing the perceptions of a small sample of women workers. Their lives are being shaped as we speak, by their injury and the demands of the double day of labour.

Appendix A
Interview Schedule

Section A: Workplace

1) How long have you worked for this employer?
2) What is your job title?
3) What are your job duties - describe a typical day at work - what are the tasks you actually perform?
4) How long have you done this job?
5) What is the hourly wage for the job you do?
6) Can you describe the other jobs you have performed while employed by this employer? (For how long for each of these and when?)

Section B: Self-evaluation of the Injury

i) Evolution of Illness: Perceptions of...

Now I would like to ask you a few questions on how you experience your work:

1) Do you experience any discomfort in performing tasks?
2) When at work - is it uncomfortable to perform your duties?
3) When did you first begin to feel this discomfort? Where?
4) Did the discomfort turn into pain? Explain.
5) Did the pain go away at anytime, or did the pain just get worse? Explain.
6) Did this pain happen once before (at another time), or is this the first time?
7) Can you describe this pain?
8) What do you believe your pain is caused by?
9) Do you believe that your pain is caused by your job? If not why?
10) If yes, what is it about your work that is the cause of your pain?
11) Does your injury affect your life at work? Explain.
12) Does your work at home affect your injury?
13) Does your injury affect your life at home?
14) Do you have help at home to cope with the injury?
15) Were you suspecting that you suffered from RSI - if so when did you begin to suspect?

ii) Actions: Addressing the Issue

1) When you first became aware of the pain, did it worry you?
2) What did you do to relieve the pain? Why?
3) What happened next?
4) Was your injury reported to Workers' Compensation?
5) If yes, who filed the claim? If not, why not?
6) Were you away from work with this problem? If yes, how long?

Section C: Miscellaneous

1) What has been your overall impression of how your injury was perceived and dealt with by your doctor/employer/co-workers/workers' compensation/union?
2) Was/is an occupational health and safety officer from the union available to you at any time?
3) Was/is your doctor familiar with RSI? Does she/he consider it to be a legitimate disease?
4) (Since your return to work)Have there been any changes to your job? Explain.
5) Are you an active member in the union?
6) What is your level of participation?
7) Do you know anyone else with your injury?
8) Is there anything I'm overlooking that should be included?

Thank you very much for your time.

Appendix B
Consent Form

The RSI and women's experiences study 1995/1996
Consent Form

I agree to participate in a study on the perceptions of women who suffer from RSI and their experiences with the injury.

This research is being carried out by Pum van Veldhoven for completion of a Masters thesis in Sociology at McMaster University. She will answer any questions I have concerning this study. I understand that she can be contacted at (905) 523-6305 or by message at the Sociology Department, McMaster University (905) 525-9140, ext. 24481. The faculty supervisor for this study is Dr. Robert Storey who may be contacted at the Department of Labour Studies, McMaster University (905) 525-9140, ext. 24693.

The purpose of this study is to learn more about the experiences of women who suffer from RSI. The research is designed to develop an understanding of how women perceived their experiences when they developed RSI and if they felt that their concerns were taken seriously.

I have been assured that all information that I provide will be treated with the utmost confidence. I understand that all identifying information will be removed from the interview material and that this information will be used for research purposes only. No individual will be identified in any way in the research report.

I understand that I may refrain from answering any questions asked in the interview and that I may withdraw from the study at any time. In the event that I withdraw from the study I understand that any notes or tapes pertaining to my interview will be destroyed.

I HAVE READ THE CONSENT FORM AND AGREE TO PARTICIPATE IN THIS RESEARCH.

Name:
Signature:
Date:

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