Recognition of work-related health conditions is a major issue of health in the workplace. While the relations between the forces involved are arbitrated by those who hold political power, the latter have to consult the scientists and experts who will legitimate or oppose the decisions in question. Of course, the interplay among social players, experts and those in power takes place on a national level, where the laws and their application have framed social interaction throughout the 20th century. But the scale of state is not the only one. The smaller gradations of jurisdiction, professional field or company sector create numerous case laws and controversies.\(^1\) Nation states also position themselves within transnational spaces that can assume two forms. On the one hand, international groupings are inclined to deal with occupation and employment policies. Communities formed in this way may opt for minimalist definitions and for the lowest common denominator, or else they can over-reach and integrate national systems. On the other hand we see another kind of coalescence in which experts and social forces have the initiative. Cutting across states and building themselves mainly outside international institutions, these networks put forward movements of analysis and challenges to legislation and institutions at a transnational level. These two types of transnational dynamic highlight different configurations within which expertise is placed.

Periarticular pathologies offer a particular scope for examining these forms of transnationalism.\(^2\) They share a general pattern whereby new illnesses are recognized only after long and frequently bitter struggles.\(^3\) And yet they neither spring from sudden, dramatic events like accidents at work, nor result from aggressive effects such as

---

those caused by external toxic substances. They have none of the tragic outcomes of the «big killers» such as lead poisoning, silicosis, asbestosis and work-related cancers. They are inconspicuous and have their source in the work itself, in the movements made and the postures adopted by labourers. By virtue of this they are pathologies of everyday activity. Referring to the difficulty of determining what part of these pathologies can be imputed to work, European states have in general avoided letting them feature on lists of illnesses for which compensation can be paid. However, at the point when the European Community placed health at work on its agenda and invited member states to join in elaborating new regulations, it included musculoskeletal disorders among the problems to be dealt with. This topic corresponds to the first part of this article. The second part relates to the 1980s and 90s, when the majority of industrial countries saw a spectacular rise in the incidence of periarticular work-related illness. This phenomenon shook up scientists and experts, social groups and political powers. It took centre-stage among problems of health in the workplace. Thus two types of transnational configuration were drawn up among expertise, power and social forces.


After the signing of the Treaty of Rome had established the European Community on 25 March 1957, European authorities initiated measures in accordance with the document relating to work and employment. A number of articles in the treaty stated the aim of developing collaboration between the different states on various aspects of employment, professional training, social welfare, protection against accidents at work and work-related health conditions, as well as trade union rights (Article 118). The closer alignment of legislative and administrative measures and regulations was intended to promote the harmonisation of social systems and improvements in working conditions (Article 117). At the beginning of 1959, through its department of social security and social services, the Commission embarked on an expert study of systems of prevention and redress. To this end, it solicited the involvement of high-ranking officials selected by each of the governments from their respective ministries of employment: office managers, inspectors and social security administrators who were sometimes joined by medical academics with acknowledged scientific authority in their specialty. While the latter were consulted in order to define and classify the pathologies, the former assumed the dominant role once the systems of health and

---


5 On the basis of Article 55 of the founding treaty, the ECSC had already set up a committee for re-search into workplace hygiene and medicine, within the High Authority’s labour problems division. See D. Spierenburg ans R. Poidevin, Histoire de la Haute Autorité de la Communauté européenne du charbon et de l’acier: une expérience supranationale (Bruxelles, 1993), 448 –449.
safety or compensation came into play, in other words when practical measures had been set up. At an early stage, meetings of experts were held with the task of discovering the frequency and the seriousness of work-related illnesses in order to «set an order of priorities for the problems.» But very quickly, as foreseen, the Commission undertook to orient the policies of the member states in terms of recognition, redress and prevention of work-related health conditions.

From National Specificities towards a Mixed European Project
As stated above, the immediate chief objective involved identifying the situations of the different states in order to «set an order of priorities for the problems.» An initial difficulty arose with the gathering of statistics. In some countries statistics for accidents at work and for work-related health conditions were in 1959 based on files for compensation schemes (Belgium, France, Italy and the Netherlands), whereas in Germany and Luxembourg the data was derived from compulsory registration. Attention was concentrated on comparing the different systems of recognition and compensation for work-related health conditions.

A first comparison highlighted the differences in the majority of measures for recognition, these resulting as much from the variations in systems of insurance as from the diversity of industrial activities. The number of recognized conditions, or groups of conditions, varied between 17 in Belgium and 40 in most of the other countries, with no complete match between the different lists. While for certain health conditions all of the countries specified the kinds of work qualifying for recognition, most of the legislation relating to the others included the simple mention of «all kinds of work.» Only a few pieces of national legislation required minimum periods of time of exposure to the risks, a maximum period of time between ceasing exposure to the risk and the first date on which the condition was observed, or an analysis of the circumstances in which the symptoms arose. The Netherlands appears to have been the country most open to assuming financial responsibility for the conditions that feature on the recognized list, while France combined most of the restrictive requirements. These differences are sometimes stressed because of the inequalities they produce in the provisions guaranteed to workers, and at other times they are minimised as if they were mere differences in terminology. The experts stress that the respective pieces of legislation of six community member states share the same system of list, as recommended by the International Labour Organization, as opposed

---

6 European Commission, meeting of experts from 27 to 29 May 1959, introductory note. Historical Archives of the European Union (EUHA), European University Institute, BAC 6/1977, 245.
8 Commission on work-related health conditions, meeting of experts from 27 to 29 May 1959, EUHA, BAC 6/1977, 245; Recommendation of the Commission to Member States regarding the adoption of a European list of work-related health conditions, Journal Officiel des Communautés No. 80, 31 August 1962.
to the global system, whereby every injury or health condition contracted in the course of exercising an occupation is a work-related condition qualifying for compensation. While the latter system appears more liberal due to its comprehensive nature, it nonetheless leaves it up to the victim to prove the existence of the health condition, a proof that is sometimes difficult to establish.9

The experts quickly came to a conclusion in favour of maintaining the system of classification and of «inclining towards the establishment of a uniform standard classification for the six countries.» They proposed the setting up of an analytical classification of recognized health conditions and substances in the six countries. And rather than maintaining only positions common to all the classifications currently in force, resulting in the formation of a more restricted list than any of those in the six countries, they decided to group together in a single list the greatest possible number of conditions that appeared on the lists of each of the different countries. The aim was to extend to all workers the benefits of being insured against occupational health conditions that were already enjoyed by those in one or more of the EEC countries.10 The aim was to facilitate the free circulation of workers within the Community, and to «guarantee protection of the same kind to all workers in whichever of the member states of the community they are of a mind to take up residence and place of work».11 In this spirit, the experts judged that an over-restrictive classification could bring about serious disadvantages for both the workers and their employers, by referring the disputes to the common law without protecting the protagonists by any insurance.12

The plan for a broad and unified classification raised difficulties as the review and analysis of national tables progressed. At first, experts from the six countries drew up a list of health conditions and noxious substances recognized under at least one of their respective legislations. They wanted to validate the process pursued in each country for recognition «by virtue of the guarantees of which public authorities can avail themselves to proceed».13 They stressed the necessity of regularly updating this set of classifications. Nevertheless the single list (here and there called the «ideal list») appeared restricted in relation to the cases being debated in different countries, and the group of experts judged it useful to put forward a secondary list of health conditions and noxious substances. This second list corresponded to new substances in use, to recent techniques that would be «desirable to introduce into modern legisla-

tion», or to symptoms whose work-related nature was still uncertain. By proposing a subsidiary list of this kind, the group’s aim was to use it as a database of information and documentation that could periodically serve to update the standard list. Moreover, the subsidiary list would prompt the member states to undertake studies of these conditions, to enable compensation under specific forms and to promote efforts of prevention: «It is a well-known phenomenon that putting a health condition or a noxious substance on the list of occupational conditions subject to compensation brings about increased measures of prevention and tends to dissipate the risk.» Thus there took shape the idea of a so-called mixed system consisting of a double list, which the ILO envisaged using to revise its agreement on work-related health conditions.

**The European Recommendation of 1962 and its Outcomes**
The government experts worked under the guidance of the nascent European Commission, whose tasks and structures were in formation. The Commission had a General Department of Social Affairs containing a Department of Social Security and Social Services, which included a Social Security Division. While the structure looks like a Ministry, its role appears to have been more restricted. For the area we are looking at here, it consisted of furnishing studies and organising advisory boards. Before issuing any views, the Commission had to consult the European Economic and Social Committee. Was it supposed to follow this standard procedure in order to bring forward the issue of work-related health conditions? The question was debated among experts designated for this purpose as government representatives, a sign that here knowledge was caught in an interplay of national forces. The German representative thus deemed that taking a position would perhaps exceed the prerogatives of the Commission, and that the harmonisation of the lists should have as its goal only economic and financial objectives. On the contrary, the Commission’s representative proposed and succeeded in transforming the advice into a recommendation, in order to give more weight to the project vis-à-vis the member states. In a working group of representatives from the EEC, the European Atomic Energy Community (Euratom), and the Economic and Social Committee, the proposed recommendation aroused another debate. For some, it would be necessary to tie the drawing up of the lists to a harmonisation of compensation terms for fear of aggravating the differences among member states, and to begin with some preventive action. Others were afraid of doing nothing

17 In the case of France, Alain Chatriot has shown the importance of an organisation of a similar kind. See A. Chatriot, *La démocratie sociale à la française. L’expérience du Conseil national économique 1924–1940* (Paris, 2002).
by following this analysis and took the contrary view that only the establishment of a
common list of work-related health conditions could make it possible to embark upon
common policies of compensation and prevention.\(^{19}\) They carried the decision and
the proposal resulted in a recommendation.

On 23 July 1962, the EEC Commission recommended that the member states
should adopt a standard European list of health-related conditions and substances
that could give rise to them. Based on the presumption of origin, this list included
«health conditions or substances featuring on one or more current national lists, the
member states being in a position to adopt this list according to the procedure in force
in each country.» It was presented as a first step towards the harmonisation of legal
and statutory prescriptions in the matter of protection against work-related health
conditions and compensation for their consequences. The succeeding steps could
then focus on conditions for attribution and levels of benefit. Alongside the standard
list, the recommendation timidly put forward the idea of a subsidiary list. First of all,
it invited the six member states to open up a right to compensation for the health con-
ditions that did not feature on their national lists, or else those susceptible to over-
restrictive stipulations (proceedings, deadlines, symptoms) but whose work-related
origin was adequately established. Next, the document advocated the establishment of
a subsidiary list of health conditions that were officially not recognized, but made
available for information. Its proposed function was to encourage pooling research.
By separating this subsidiary list from the right to compensation, the Commission
held back from setting up a second sphere of pathologies likely to be recognized. It
therefore did not fully institute the envisaged mixed system. Another limit to initial
ambitions concerned the restrictive stipulations imposed by national regulations on
responsible over recognized health conditions. While preliminary proceedings
had repeatedly expressed the wish for the reduction or elimination of those clauses
(deadlines, circumstances, working conditions, symptoms),\(^{20}\) this demand was not
expressly formulated in the recommendation.

In the course of the years that followed, the Commission devoted the larger part of
its meetings and proceedings to the outcomes of the recommendation within the dif-
ferent member states. In 1963, the Federal Republic of Germany indicated significant
progress by becoming the third European country, and the first in the EEC, to adopt a
mixed system. In 1964, the Commission explicitly advocated this system, which,
alongside the primary legislation arising from the classification list, accepted «that
the proof of the work-related origin of a symptom may be introduced in cases not
foreseen by the list.»\(^{21}\) The Netherlands, too, quickly distinguished itself by announ-

---

20 European Commission, meeting of experts from 27 to 29 May 1959, introductory note. EUHA,
21 EEC, Commission, Recommendation regarding the European List of Work-Related Health
Conditions, communication from M. Levi Sandri, Brussels, 3 March 1964, EUHA, BAC 6/1977,
251.
ing its intention to grant workers the right to compensation for all health conditions, whether work-related or not. In the four other member states, research and development studies were set in motion. France added two health conditions to its list and put the study of several others on the agenda, on the basis of the European list. Italy, too, slightly extended its list, along with Luxembourg, which showed itself to be more enterprising (eight new health conditions, which is to say a quarter of the total) and very interested in the German mixed system. Community momentum met with some explicit reticence. Italy feared that a mixed system would furnish «pretexts for unjustified claims» and was preoccupied with seeking out a more precise formula. For its part, Germany defined its mixed system «in very judicious terms» at the suggestion of the insurance organisations, by disqualifying ratified health conditions (their definition shifted from «als Berufskrankheit» to «wie eine Berufskrankheit») and in particular, by avoiding recognition of symptoms of ageing and physical wear and tear as work-related health conditions. More adeptly, France praised its social legislation that was supposed to allow victims to assert their rights. One single case duly upheld, the ministerial delegate explained, was enough to put another condition on the list. This picture contradicted French experience, characterized by an almost systematic refusal to compensate cases relating to health conditions not recognized on the list.

Despite these divergent national applications of the recommendation, the European authorities still wanted to move forward. On 20 July 1966, the Commission came up with a new recommendation regarding the adoption of a European list of work-related health conditions. The restrictive stipulations for recognition were also the object of proposed reform. A proposed recommendation invited member states to «eliminate from their legislation any restrictive stipulations concerning compensation for workers afflicted by a work-related health condition», in particular «limitations in terms of proceedings, symptoms or specific periods of exposure to the risks.» This information would allow a doctor to evaluate the relationship between the work done and the work-related health condition. The mixed system was complemented by a list of exceptions maintaining stipulations for certain work-related health conditions. However, the authors of the proposal had no illusions; they recognized that «the distance between it and certain national legislations is very great, to the extent

---

22 Directorate of social affairs, minutes of the meeting on the follow-up to the Recommendation by member-state governments, Luxembourg, 14 November 1963 to 9 December 1963, EUHA, BAC 6/1977, 251.
25 EEC, European Atomic Energy Community, Economic and Social Committee, minutes of the deliberations on the opinion regarding the «Projet de recommandation aux États membres concernant les conditions d’indemnisation des victimes de maladies professionnelles», 52nd plenary session held on the 23 and 24 February 1966, Brussels, 11 March 1966, EUHA, CES — 001636.
that one might well fear difficulties of application.» In other words, they questioned the chances of its uniform realisation. Pragmatically, the Economic and Social Council made a number of concrete suggestions with the aim of promoting limited rapprochements: incorporating a list of exceptions within the recommendation, setting up a medical expertise in the workplace under certain circumstances, reinforcing the prevention of work-related health conditions.

All these reactions sketched out a European perspective that rested on national reforms and carried weight with varying degrees of effectiveness on the policies of individual states.

Periarticular Ailments: a European Overview

While failing to be representative of work-related health conditions overall, the case of periarticular ailments illustrates the evolution of policies within the member states of the EEC in the wake of the recommendation and, more widely, the strength of the European impetus.

After 1959 the Commission undertook in-depth studies on four categories of health conditions: silicosis, lead-poisoning, cancers, and lastly, rheumatism and arthritic conditions. Initially surprising, the choice of this last group was justified by the widespread nature of these pathologies and the significance of their direct consequences and complications. Moreover, the Commission’s representative observed, the Commission could not content itself with harmonising existing national legislations, but had to improve working conditions and protection for workers. These studies would make it possible to envisage the inclusion of rheumatism, arthritic conditions, work-related cramps and inflammation in the classifications of work-related health conditions. In fact, the point of departure was particularly restricted. In 1960, the first inventory revealed some recognized pathologies here and there. Four countries recognized vibrations from tools as a source of health complaints. Luxembourg and Germany accepted chronic disorders of the periarticular bursae (bursitis) and fractures of the spinal column as a consequence of strain. Moreover, Germany identified disturbances to tendon and muscle sheaths resulting from excessive overuse and nerve paralyses under conditions of repeated pressure. At the very time they prepared the Recommendation, the experts broadened and specified the repertoire of the standard list and its subsidiary. They envisaged including within the former, conditions provoked by vibrations, periarticular forms of bursitis caused by continuous pressure, tendinitis provoked by overuse, lesions to the spinal column (apophyses) likewise pro-

26 In a sign of strong resistance, a quarter of those voting at the CES judged that «the Recommendation would bring about such an overturning of certain current legislation is that it seems to them to be inapplicable.»

27 EEC, Commission, Directorate of Social Security and Social Services, Work-Related Health Conditions, Special Studies, minutes of the meeting of experts in Brussels from 4 February 1960, 15/2/1960, EUHA, BAC 6/1977, 246; Centre for Contemporary Archives, Fontainebleau. art. 970162, 06.
voked by overuse, nerve paralysis and lastly, inflammations of the knee or elbow. The proposed subsidiary list foresaw the inclusion of work-related cramps: «The best-known work-related cramp is writer’s cramp, which nowadays has become extremely rare due to the increasingly widespread use of typewriters. Nevertheless, other work-related cramps are possible, compelling the subject to switch to another occupation.»

This inventory was confirmed in the two lists accompanying the Recommendation, which from then on served as reference points for the different national ministries.

The European action did not make do with the publication of the Recommendation. While the Commission’s new investigations into workplace accidents and work-related health conditions were pursued along the route of compensation, the lists continued to refer to the development of national systems. Moreover, these lists developed and became more detailed. In 1969, a nomenclature of approximately 300 pages compiled detailed notes on the health conditions that featured on the standard list and confirmed the earlier categories.

This transnational dynamic of the EEC shaped the national legislations and health systems. Thus France embarked on a progressive recognition of peri-articular disorders to come closer to the European list and to respond to the workers’ protest that developed after 1968.

2. The 1980s: A Transnational Modification of Analyses

During the 1980s, a new way of regarding periarticular disorders had taken shape. While the number of cases recognized by compensation organizations saw a substantial increase in several developed countries, experts in occupational health challenged the earlier definitions that judged every pathology as specific. Beyond work-related specifies, they aimed to discover whatever in the changing face of work might explain this kind of epidemic. In the majority of developed countries, this period was marked by crisis and a challenge to industrial systems and the adoption of new forms of organisation whose configurations varied according to the different sectors: the computerisation of administrative and checking operations, the development of fluid manufacturing models and flexible work patterns, the outsourcing by businesses of a part of their operations hitherto carried out internally.

These changes and the pressures of growing unemployment undermined occupational trajectories that enabled the majority of wage earners to take on less demanding kinds of work as they got older. In addition to these structural reforms, there was, in the short term, an increase in employers’ overheads and, in the long term, a pursuit of fragmentation of the production process and repetitive operations. At the root of scientific perspectives on

31 Askenazy et al., Organisation.
work, one repeatedly encounters a social commitment on the part of certain experts – doctors, researchers – who were closer to trade unions than to the ministerial authorities. The international circulation of questions and references between Europe and the Americas played a fundamental role, while national or international authorities lagged behind these developments.

*Something of an Epidemic from 1980–2000*

For many developed countries, the degree of scientific attention was a reflection of cases actually registered. Indeed, the 1980s saw a proliferation of reported or recognized cases of disorders relating to the different joints of the hand and the wrist, the elbow, the shoulder or the knee. While these pathologies were already known and their occupational character sometimes established, what was new about the phenomenon was above all the greatly increased incidence of cases.

In France, the statistics indicate an exponential increase in the number of declared and recognized cases, which installed periarticular pathologies in the front rank of work-related health disorders. These figures merit some commentary. Until the recognition of the knee complaints among construction workers in 1972 none of the numerous existing cases could be compensated. Recognition was broadened in 1982 and 1991 to a cluster of disorders affecting the joints of the arms and legs, for every kind of work activity giving rise to physical overuse. These modifications prompted an enormous increase in recognized cases. To this we can add changes in the behaviour of doctors, patients and more broadly all the actors implicated in the treatment of occupational health. Lastly, the figures are much lower than in reality because of the significant phenomenon of under-reporting that has been brought to light in numerous studies carried out both by scientific researchers and by high-level civil servants.

<table>
<thead>
<tr>
<th>France: numbers of recognized periarticular health complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>-----------</td>
</tr>
<tr>
<td><strong>Cases</strong></td>
</tr>
</tbody>
</table>

Source: CNAMTS, France


The French dynamic is not an exceptional case. A great number of developed countries show a significant growth in the number of reported cases of periarticular disorders. Generalisations are difficult within the European context, since member states have maintained notable differences in terms of listing recognized work-related health conditions, and in defining what constitutes work-related health conditions, as well as the modalities of how these are declared and recognized. In the course of the present decade, since 2000, musculoskeletal disorders (MSDs) make up more than two thirds of work-related conditions in six countries that include France and Spain, while others such as Germany and Denmark have relatively low proportions. Some countries, among them Sweden, Belgium and the Netherlands have seen their levels go down to less than a third of recognized cases, while in Italy this same level represents an increase. Nonetheless, these pathologies have risen in number within a European context from the 1980s on, and by the early 2000s they were still the chief health problem of workers.  

The United States saw an earlier exponential growth in listed cases of peri-articular conditions, from less than 50,000 in 1985 to 300,000 in 1993, by which time they made up 60% of work-related disorders registered in the country. Besides the significant difference in scale, this spectacular increase had great bearing on the weight of attention given to the phenomenon by social and economic leaders. What before had been of concern only a small group of researchers and lawyers became a major issue for trade unions, politicians, the media and government services. Once limited to specific industries such as meat handling, the problem shifted towards a wider group of the labour force: car manufacturing, textiles, electronics, office work and even journalism. In subsequent years a decrease could be seen in the number of cases and their relative seriousness. This was explained by Philippe Askenazy in terms of the effects on risk management within companies because of steps taken by private insurers. In Canada, available statistical comparisons indicate a similar development, and in Quebec, MSDs of the back and of upper and lower limbs amounted to a third of compensation cases every year. Australia witnessed a considerable epidemic. A proliferation of recognized cases occurred in the first half of the 1980s, followed by a comparable reduction. Within national debates, the upsurge was attributed to modifications in regulations and the changes that had taken place in the organisation of work, while the decline was related to an altered perspective on the part of decision-makers, with the medical outlook apt to be sceptical and the courts becoming less favourably inclined towards employees. The way in which courts dealt with contentious cases, both in Australia and North America, exerted strong pressure on the
attitudes of doctors and experts involved in the controversies and on the development of statistical data. Thus, in the majority of countries, the indicators were deliberately distorted and this disarray prompted observers such as those involved in occupational health to re-evaluate their analyses and earlier actions.

International Research Connections

The French example enables us to note the development of a new scientific outlook on this epidemic. In the mid-1980s many professionals in occupational health were surprised to discover numerous cases of employees in several branches of industry afflicted with periarticular disorders. A medical inspector in occupational health found numerous workers in the footwear industry suffering from periarticular disorders of the hands and wrists. A trade union doctor was called in regarding an outbreak of carpal tunnel syndrome in a car factory. Several other researchers stressed the new importance assumed by these health problems within companies. These analyses had a strong hypothesis in common: the growth of periarticular disorders seemed to be connected to the patterns of work as practised in the workplaces studied, whether these were classic Taylorist patterns or new forms of organisation. On this basis, scientific research was undertaken in order to establish firmly the reality of the phenomenon and to better understand its progress. But these steps could not be confined to a strictly French context.

Very quickly, the first researchers to be alerted started to record their work, to compare notes, to publish and to hold meetings. Moreover, even more rapidly than in the course of the preceding decades, these research exchanges assumed an international dimension. A number of researchers observed the growth in international literature of articles on this topic throughout the second half of the 1980s. Among them, those by the American epidemiologist Barbara Silverstein stand out. In a doctoral thesis defended in 1985 at the University of Michigan and published in 1986, she highlighted the role of two risk factors in the development of chronic pathologies: repetitiveness and strain. Moreover, the thesis confirmed the idea of «cumulative trauma disorders» which makes it possible to avoid the dilemma of choice between ideas of injury – linked to the concept of accident – and disease, both of them too restrictive to allow recognition of this kind of pathology. Silverstein finally stressed that disorders of the wrist, her object of study, should no longer be strictly linked to specific occupations, but to the activity carried out by those affected. In a number of other countries, these publications found a clear echo, all the more so for conforming to Anglo-Saxon

canons of scientific legitimacy based on the building of objective statistical data in a manner beyond dispute. Bypassing explanations, demonstration served as proof.

Conferences and meetings made it possible to take the measure of this shift in approach within the international scientific community. Sometimes the meetings acted as a catalyst. Thus, the French ergonomist François Daniellou discovered in 1987, at a conference of the Brazilian Ergonomics Association, that tendinitis can constitute a social problem in Brazil. There, the issue was not musculo-skeletal disorders but the digitadoras, which is to say the young women who did computer keyboarding. The work requirements were very high and these women burned out extremely fast and then they were laid off.41

A similar experience heightened the awareness of the epidemiologist Annette Leclerc, who simultaneously recalls her own development and the first visible signs she saw of research being done in France:

«When I went to the first international conference on the epidemiology of occupational health in 1988, in Stockholm, no one was talking about MSDs of the upper limbs. There were papers on lumbago, but nothing on MSDs. Four years later, at the ‘Premus’ (Prevention of Musculoskeletal Disorders) that was held in 1992, also in Sweden, the topic of MSDs was around. If you look at the list, [on this topic] there was only one paper from a French participant – you can find it in the conference proceedings. A Belgian and a Canadian from Quebec both spoke about MSDs of the upper limbs […]. It struck me as something that was certainly going to come in France. It was already on the way. It existed in countries comparable to France.»42

With such momentum, a Premus conference (International Scientific Conference on Prevention of Work-Related Musculoskeletal Disorders) was organised every three years, usually alternating between the Americas and Europe. While it speeded up changes in perspective, the international circulation of research did not obliterate the differences.43 It rather reinforced transnational links.44

---

41 François Daniellou, ergonomist, University of Bordeaux, interview with the author, 9 October 2006.
42 Annette Leclerc, epidemiologist, Unit 88 at INSERM (National Institute for Health and Medical Research), interview with the author, 10 April 2006.
43 Karen Messing, biologist, University of Quebec in Montreal, interview with the author, 6 May 2008, Tours.
44 After scientific exchanges, the Quebecoise Vézina Nicole went to France to complete her thesis in ergonomics, Le travail en ambiance froide dans la découpe de volailles, doctoral thesis in ergonomics, University of Paris XIII, 1987 (supervised by Antoine Laville).
Scientists were not the only ones to notice the proliferation of periarticular disorders. The role of actors in the field was decisive for the production of new analyses. This invites us to reflect on the modes of production of social knowledge, from the initiative of destabilising reports to the process of legitimation, and on the social shifts accompanying this process.

The American case, whose pioneering role in scientific terms we have seen above, can serve as a point of departure. The challenging split between occupational health conditions and accidents at work had been taken up in the courts before being consolidated at the University of Michigan. There is evidence of this in the appearance of the generic term «cumulative trauma disorders» to describe a variety of periarticular conditions (carpal tunnel syndrome, tendinitis, tenosynovitis, Raynaud’s disease, etc) arising from repetitive work. This term arrived on the legal scene in the course of the 1970s, in relation to compensation for workers suffering from back pain. Indeed, up until then, as in France in the discrete instances of Sécurité sociale and the Ministère du travail, the compensation rules recognized only pathologies arising at a specific time and in a specific place, according to the pattern of an accident. They resulted in the recurrent rejection of cases such as those brought against General Motors in 1975 for pathologies presented as the results of «everyday life». The doctrine of cumulative trauma was introduced by litigants, trade unionists and lawyers in order to have MSDs regarded as progressively developing disorders linked to prolonged exposure. This formulation reflected a search for terms appropriate to legal discussion. In the courts, this interpretation began to be accepted in Michigan and California in 1977–1978, and then spread to other states. As reinforcement for these fragile successes, trade unionists approached academics. One official from the United Food and Commercial Workers Union made contact with ergonomists at the University of Michigan, an institution influential in the US in the field of occupational health, to study the rise of carpal tunnel syndromes in a slaughterhouse. The laboratory there likewise co-operated with the United Auto Workers Union with regard to different pathologies of the hand and wrist. It was on this fertile terrain, similarly in cooperation with trade unions, Silverstein carried out the research she advanced in 1985. Some years later, her husband, who was deeply involved in this committed research, would be given a senior role in the US Occupational Safety and Health Administration.

Quebec has seen comparable cooperation between researchers and trade unionists. In the late 1970s, the University of Montreal entered into research and training agreements with several trade unions. In the 1980s, trade union demand pushed the academics’ research in the direction of groups of workers rarely studied, such as cleaners and slaughterhouse workers. A few years later, the development of case law...
brought with it other lines of enquiry. Under increased pressure from state health insurance funds, companies began to challenge occupational health cases that decades before they had recognized without demur. The expertise of ergonomists was no longer enough in the face of employers’ lawyers. A joint mobilization of trade unionists and academics – lawyers and ergonomists – was necessary to re-establish a balance of power in the courts and have a proportion of MSDs recognized as occupational disorders. In France, early research also played an essential role through its militancy and commitment. Among the first doctors and researchers to develop an awareness of the issues in the 1980s were individuals experienced in research or training who cooperated with trade unions and were therefore particularly sensitive to «the eruption of trade union demand.» In western France, doctors involved in occupational health formed an association to carry out regional investigations into work-related risks and occupational health. This dual cooperation between committed experts on the one hand, and on the other hand between them and trade unions greatly contributed to a convergence of perspectives on scientific controversies.

Thus, in all these national cases, the impetus for new kinds of analysis and fights for recognition was at the very least shared with trade union forces. Such a level of cooperation between researchers and trade union representatives is neither systematic nor continuous: trade union awareness on the subject fluctuates with time, while very different points of view can be expressed among the scientists. But this kind of cooperation is to be found at the heart of paradigmatic shifts such as the one relating to periarticular disorders. This cooperation drew strongly on earlier links, like those existing in France ever since the 1960s between ergonomists and certain trade unions, for both research and training. Likewise, it derived from the gains made through an opposition to work that involved repetitive and restrictive movements. It displaced the nature of the issue, from improvement in working conditions to health care policies.

48 Katherine Lippel, lawyer, University of Toronto, interview with the author, 20 June 2008.
50 Association pour la recherche en épidémiologie et ergonomie de l’Ouest, Private archives.
51 N. Hatzfeld, «Les malades du travail».
3. Conclusion

The first steps towards a European Economic Community policy in the 1960s differ in many respects from the transnational understanding of an epidemic of periarticular disorders in the years from 1980–1990. In the former case, European authorities led a movement towards statutory regulations for member states. They set work in motion with experts of their choice, at specific stages bringing together trade union and employers’ representatives. This initiative from above received its response from the one that was formed from below in the second case. Originating in workplace situations, the latter mobilized trade unionists and researchers who attempted to understand the phenomenon and bring about recognition on an international scale. The two movements derive from two different periods. The building of the European project was marked by strong growth, with a combination of economic and social arguments for the establishment of laws and regulations across the board. The decision to extend to all member states the recognition of health conditions that a single agreement in one state accords to its nationals illustrated the intention to improve social protection and safety at work within the European domain. The second period corresponds to the destabilization of modes of work organization within companies generally described as Fordist. This development found an echo at the level of the European Union, whose successive enlargements enabled particular countries to express their reservations with regard to a Community social model. The epidemic of musculoskeletal disorders, which affected numerous countries, was regarded by ergonomists as being foremost a symptom of disorders caused by patterns of work.

In their own ways, both of these movements raise questions about the role of experts and the relationship between national politics and transnational dynamics. The choice of experts varies according to the task that the states wishes to give them in terms of specific situations, whether it is a matter of exploring a question or making policy decisions. One group of experts designated nationally were ministerial officials and thereby representatives of their countries. However, some of them within the European authorities sometimes went beyond the positions of their institution, as if they were relying on the European project to surmount national obstacles. In their way they were akin in attitude to those scientific networks that were formed at an international level to understand and recognize a new phenomenon.

In general terms, the transnational scale seems to be scope for progress in the assumption of responsibility for work-related health problems, while the national level rather seems to favour its rejection. The case of periarticular disorders shows how barriers set up in the majority of countries in the European community to any form of recognition can be damaged. Nonetheless, the unifying transnational dynamic has a tendency to run out of steam. Attempts to standardize classifications have not

---

resulted in the mixed common system envisaged by the pioneers. The setting in place of this system in the Federal Republic of Germany and the broadened responsibility for health problems in the Netherlands also show that the national dimension is not always synonymous with conservatism. When it is developed outside the institutional context, the transnational mobilization of expertise seems likely to influence policies relating to occupational health. But there too, when it comes to fleshing out this dynamic, international authorities such as the European Agency for Safety and Health at Work, formed in 1994, essentially play an incentive role. In other words, when it comes to policies on occupational health, the mechanisms of national states seem to preserve their powers of decision-making when confronted with international dynamics that endeavour to establish their authority.\footnote{Cf. in this issue, the article by Thomas Cayet, Paul-André Rosental and Marie-Thébaud Sorger on the BIT (International Labour Organisation).}

The Difficult Recognition of Musculoskeletal Disorders between Transnational Expertise, National Powers and Social Actors

The history of periarticular pathologies contains a transnational dimension and harkens back to the labour movements and their socio-political claims. But it was difficult to prove the existence of a causal relationship between work and pathologies. Therefore, many states avoided for a long time to recognize Musculoskeletal Disorders as illnesses for which compensations can be paid. The first part of this article contextualizes the history of the recognition of musculoskeletal illnesses and the first steps on the road to a common European economic policy in the 1960s. At this time, the European Economic Community (EEC) placed health at work on its agenda and invited the member states to elaborate new common regulations, including musculoskeletal disorders among the problems to be dealt with. The second part examines the 1980s and 1990s, a period during which the majority of industrial countries saw a spectacular rise in the incidence of peri-articular work-related illnesses. At this moment, inter- and transnational experts, researchers and trade unionists were in the spotlight. While national states only hesitantly hand over health care political sovereignty rights, transnational dynamics claim the recognition of work-related health problems.
Die schwierige Anerkennung von Skelettmuskelkrankheiten zwischen transnationalem Fachwissen, nationalen Mächten und sozialen Akteuren


Nicolas Hatzfeld
3, rue Delcupe
F–9100 Montreuil
e-mail: Nicolas.hatzfeld@wanadoo.fr