

RSI/WMSD in the context of the symbolic meeting between patients and medical experts at the INSS/SP

As LER/DORT no contexto do encontro simbólico entre pacientes e médicos peritos do INSS/SP

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Resumo

Este artigo discute aspectos da relação médico-paciente no contexto do encontro simbólico entre portadores de LER/DORT e médicos peritos do Instituto Nacional de Seguro Social de São Paulo (INSS/SP). A pesquisa empírica que serviu de base à discussão foi de abordagem qualitativa e utilizou como instrumento para obtenção dos dados a entrevista em profundidade, com roteiros distintos para médicos peritos e pacientes. Foram realizadas 9 entrevistas, 6 com pacientes e 3 com médicos peritos. Análise de conteúdo foi aplicada ao material empírico segundo a referência conceitual das representações sociais. As narrativas dos portadores de LER/DORT, as narrativas dos médicos sobre o trabalho pericial e as narrativas de ambos acerca das consultas periciais possibilitaram explorar o encontro simbólico, não necessariamente factual, da consulta pericial. A relação médico-paciente que se estabelece nesse encontro simbólico é extremamente peculiar, pois está direcionada à avaliação do processo saúde-doença do paciente, com base em premissas do direito previdenciário, fator que descaracteriza a relação médico-paciente assentada no imaginário social como espaço de cuidado e confiança. Como consequência, portadores de LER/DORT e peritos, no momento do encontro, estão em diferentes escalas de poder: aqueles são avaliados e estes avaliam a validade da queixa segundo os padrões do INSS/SP. Por isso, apresentam narrativas sobre as consultas permeadas pela tensão relativa às expectativas e necessidades quanto aos resultados.

Palavras-chave: Pesquisa Qualitativa; Relações Médico-Paciente; LER/DORT; Transtornos Traumáticos Cumulativos.

Abstract

This paper discusses aspects of the physician-patient relationship in the context of the symbolic meeting between patients with RSI/WMSD and medical experts at the Brazilian National Institute for Social Security of São Paulo (INSS/SP). The empirical research which grounded the discussion had a qualitative approach and it used as instrument for obtaining data the in-depth interview, with different scripts for medical experts and patients. We conducted 9 interviews, 6 with patients and 3 with medical experts. Content analysis was applied to the empirical material according to the conceptual framework of social representations. The narratives of patients about RSI/WMSD, the narratives of medical experts about medical evaluation, and the narratives of both about INSS/SP medical consultations allowed exploring the symbolic meeting that occurred between them. The physician-patient relationship established in this symbolic meeting is extremely peculiar, since it is aimed at assessing the health-disease process of the patient, based on the premises of social insurance law, factor that mischaracterize this kind of relationship, established on the social imaginary as a space for care and trust. As a consequence, patients with RSI/WMSD and medical experts, at the meeting time, are in different power scales: the former are assessed and the latter assess the validity of complaint according to the standards of the INSS/SP. Hence, they present narratives about the consultations permeated by the tension related to the expectations and needs with regard to the results.

Keywords: Qualitative Research; Physician-Patient Relationships; RSI/WMSD; Cumulative Trauma Disorders.

Introduction

RSI/WMSD: brief history and recognition by the Brazilian social security system

The “onset” and identification of repetitive strain injuries (RSI) initially took place in Japan among keypunches (1950s) and Australia (1970s) in jobs marked by static overload (Maeno, 2001). In Brazil, in the 1980s, there was a high incidence of tendinitis among bank employees and officials of the Federal Revenue whose main task was typing. This fact required an accurate medical investigation and it was found that work organization factors, such as excessive amount of tasks and incentive and reward systems led to physical and mental overload. Then, a mobilization of data processing workers emerged in order to raise awareness of this kind of illness, and it was acknowledged by the Ministry of Social Security, which named it “typist’s tenosynovitis” (Couto, 2000; Maeno, 2001). However, only in the late 1990s the classification of RSI as a *work-related illness* was established, when the National Institute for Social Security (INSS) decided to replace the term RSI by work-related musculoskeletal disorders (WMSD). As Verthein and Minayo-Gomez (2000a, 2000b) pointed out, this change was the result of a discussion among various society sectors (health professionals, labor unions, and researchers/academy) about this illness process through the contributions of social psychology, epidemiology, and ergonomics.

RSI/WMSD represent a group of work-related musculoskeletal disorders with a multicausal origin, complex and insidious regarding its onset and evolution. Its emergence combines biomechanical factors of activity, such as tension/friction on tendons, inadequate postures at the workplace, exposure to extreme temperatures, and other psychosocial factors, such as work organization and dynamics, for instance, monotonous tasks, lack of control over the activity, individual perception about career, and relationship with the work team. It is a clinical syndrome characterized by pain, especially in the neck, shoulder girdle, and upper limbs, accompanied or not by objective injuries in tendons, muscles, and peripheral nerves (Dias, 2001; Neves, 2006; Ruiz et al., 2003; Settini and Silvestre, 1998).

This set of factors makes its anatomic diagnosis difficult to perform and the connection to work is put into question, since the emergence of pathology is a social process, lacking absolute proof (Dias, 2001; Ruiz et al., 2003). Given the complexity for diagnosing the RSI/WMSD, the Ministry of Health drafted a handbook to guide procedures, which clearly states that the precise anatomical diagnosis of RSI/WMSD is difficult to be made, particularly in subacute and chronic cases, and its connection to work is questionable, even when there is epidemiological and anatomical evidence (Brasil, 2005)¹.

In face of this situation, according to Dias (2001, p. 427-428), [...] the society expects the physician to interpret, check, or reject the legitimacy of the arguments and facts. Thus, the clinician must face uncertainty, evaluating the cause and disability based on the legal and bureaucratic organization, something which is by no means an easy task.

RSI/WMSD and the social representations field

Faced with the finding that the relationship between disease, the job market, and daily life activities is close and complex, some scholars have dedicated themselves to the study of social representations of patients with RSIs/WMSDs. In these researches, the reference to disease (pathology) stands out as a substrate for the constitution of a social phenomenon (illness) affecting all walks of life, since the recognition and experience of illness are intersubjectively constructed in collective spaces (workplace, community, health professionals, family), having a guiding role in order to plan the disease with regard to treatment adherence, claiming actions, etc.

Thus, among other aspects, the studies described the impact of physical limitations posed by the disease in the professional, social, and family realms of the affected individuals, which can generate an identity crisis. For women, for instance, they highlighted the impossibility of caring for children and carrying out their usual household chores, not only as an acquired condition, but also in order to recognize the need for fulfilling these activities in the family context. For men, they pointed out the issue

of “uselessness” and social devaluation related to the loss of physical strength to fulfill tasks at home and at work, as well as in the community, besides the impact on the role of financially providing for his family when on sick leave or unemployed due to the disease (Almeida and Codo, 1995; Batista et al., 1998; Neves, 2006; Verthein and Minayo-Gomez, 2000b).

RSI/WMSD change the daily life reality of subjects and they have impacts on the identity of affected people, promoting (re)significations of their conceptions and positions with regard to the health-illness process (Merlo et al., 2003). This accommodation and (re)signification process is reflected on these people’s repertoire of social representations.

[...] due to changes posed by the disease, what the individual recognized as her/his identity no longer holds, because it is no longer reset by the social environment. Sudden loss of the references which maintained their previous identity makes it necessary that this individual actively seeks out new references that allow her/him to recognize her/himself (Almeida and Codo, 1995, p. 152).

Given these findings of researches with a qualitative approach about the RSI/WMSD, we see how fruitful has been the social representations framework. From the perspective of Moscovici (1978), social representations constitute a practical way to increase knowledge, socially constructed in order to make sense of daily life reality. Among other things, social representation plays the role of turning the strange into familiar, putting into practice a process in which the individual expands the categorization of an object which, previously, was unknown to her/him, including it into her/his repertoire (Gomes et al., 2002). Social representations guide behaviors in the collective space and they enable an objective logical apprehension of behaviors, opinions, and aspirations, allowing us to understand “why some problems stand out in a society” (Herzlich, 1991, p. 28).

Another relevant aspect emerging from studies with a qualitative approach about the problem is the issue of social invisibility attributed to the RSI/WMSD, a fact which partly stems from the characte-

¹ When establishing the causative link (relationship between the labor activity and the worker’s disease), the worker should stop doing her/his job, in order to receive clinical treatment for her/his condition, and, then, return to her/his job or adapt to another occupation (Brasil, 2005).

ristic that the main symptom of RSI/WMSD is pain, undetectable by means of usual exams and difficult to prove through physical examinations performed by a physician (Almeida and Codo, 1995; Batista et al., 1998; Gravina, 2000; Neves, 2006). A painful sensation has an individual and subjective nature, but it finds expression and meaning in the collective space, validating its manifestations that need to make sense for the “other”, who is also included in the context, otherwise, it will not be acknowledged (Sarti, 2001). The lack of evidence about illness eventually make the problem invisible and stigmatize the people suffering from it, regarded as healthy male/female workers who, yet, do not correspond to the socially motivated demand for work performance within the public and private realm.

The complexity for validating the symptom pain and the fact that further exams not always indicate an injury sign make patients feel anxious and believe to be suffering from a strictly mental disease (Settimi and Silvestre, 1998).

Considering that the medical consultation represents a pragmatic demonstration of the physician-patient relationship which requires an interaction, always between two people, marked by privacy, intimacy, and trust, the limits of its existence as paid work end up being forgotten (Caprara and Lins, 1999), and it becomes imperative that researches address the RSI/WMSD in the context where this relationship takes place. However, this approach was not found in the literature concerning the theme of RSI/WMSD, as well as in the literature about the physician-patient relationship. This way, using the social representations framework, this paper aims to discuss the “symbolic meeting” involved in the relationship between patients with the disease and medical experts at the INSS/SP in terms of tensions deriving from different expectations and acknowledgements of these categories of subjects.

Since it is an intersubjective meeting, the medical consultation takes place in an environment promoting the expression of feelings, even when it involves a context where the professional is detached from the patient (Fernandes, 1993). In this study, however, the perceptions involving feelings, opinions, and attitudes of both (patients and medical experts) have not been accessed through the

observation of expert medical consultations, but by means of the narratives of medical experts and patients with RSI/WMSD who experienced concrete situations of INSS medical consultation for defining their diagnosis. Thus, representativeness of the “symbolic meeting” was guaranteed by previous experience for both categories of subjects, which, by being invited to remember situations they went through, (re)signified and (re)positioned themselves in face of them. For analyzing this “symbolic meeting”, we used the social representations framework. For patients with RSI/WMSD, as well as for medical experts, who construct representations of themselves and the “other” through the expert medical consultation context, here understood as a singular context, the theoretical framework provided by the inclusion of subjects’ practical knowledge reasoning into the social representations framework is of great importance in the occupational health field (Sato, 1996).

Methodology

This paper represents a summary of a deeper study about the meanings attributed to RSI/WMSD by patients and medical experts at the INSS/SP (Siqueira, 2007). The summary undertaken here aimed to analyze the representations of both categories of subjects (patients with RSI/WMSD and social security medical experts) about illness due to these diseases and the expert medical consultation context, a moment named “symbolic meeting” among these subjects.

The deeper research was based on the approach through the qualitative methodology according to the social representations framework. As we understand that in a qualitative research the study object is human being, constructor of a symbolic universe which guides her/his social behavior (Becker, 2007), the decision of using this kind of methodology may be justified because this study sought to apprehend the meaning of what has been experienced by the research subjects (medical experts at the INSS/SP and patients with RSI/WMSD), in order to, by approaching the reality of the “other”, dive into the symbolic universe of *wanting to say* things to these subjects.

In the production of empirical data, we used the in-depth interview technique. It proved to be adequate by allowing the resumption of the subjectivity dimension, since the speech of respondents reveals systems of values, beliefs, norms, it is significant even without the intention to mean something (Bourdieu et al., 1999). Thus, the speech of somebody may be representative and report the ways how social groups understand, mean, realize, and act in certain historical, social, and cultural contexts.

As for the research subjects, there is a need to explain that they carry the status of “special individuals”. The workers with RSIs/WMSDs were patients at the Reference Center for Occupational Health in the State of São Paulo (CEREST/SP), hence, they had access to a unique instrumentation to treat the disease when compared to other patients. The medical examiners hold expert medical jobs at the INSS/SP, due to the recognition that this work conducted by the institution has gained over the decades, initially in performing medical examinations and other administrative tasks.

We conducted 6 interviews with patients with RSI/WMSD, 5 of them were women and 1 was a man, and 3 interviews were conducted with medical experts at the INSS/SP. The interviews followed different scripts for the two groups. The script designed for patients was structured in order to survey the history of illness due to RSI/WMSD, its impact on daily work and social life to provide a better understanding of the respondent’s attitude towards the experience of expert medical consultations. Regarding the examiners, the script was designed through the perspective of apprehending their conceptions of RSI/WMSD, considering her/his work as medical experts at the INSS, then, the meeting with patients during expert medical consultations was addressed.

As for participation in the study, we invited patients at the outpatient unit for RSI/WMSD of CEREST/SP, who are included in the Treatment and Rehabilitation Program (TRP) and according to the following criteria: age group from 31 to 55 years and working at the services sector; with regard to the illness profile due to RSI/WMSD (Gutierrez, 2004; Neves, 2006), having undergone an expert medical examination at the INSS/SP at least once between 2004 and 2005 (historic period of changes in the medical

structure of the INSS and the study period chosen).

The patients with RSI/WMSD were invited to participate by means of direct contact during the TRP sessions. They accepted the invitation and 5 women and 1 man participated in the research, with no dropouts during the interviews, which were conducted at CEREST/SP, whose direction provided an exclusive physical space, a location known by respondents and with an easy access.

Contact with the INSS was provided by the coordination of CEREST/SP. The Regional Superintendent’s Office of the INSS/SP indicated 3 male medical experts who agreed to participate in the study. For doctors, a single criterion for participation was adopted: length of professional practice as medical experts for, at least, two years, enough to become familiar with service routines and contact with socially insured people.

The research was conducted according to the parameters of Resolution 196/96, from the National Council of Research Ethics, and it was approved by the Research Ethics Committee of the School of Medicine of the University of São Paulo (USP) and its Clinics Hospital (Protocol 1,043/2005). Participants received a Free and Informed Consent Term (FICT). The interviews were subject to approval and signing of the FICT by participants. The reports, with an average length of 105 minutes, were audio-recorded and transcribed later on. In order to ensure respondents’ anonymity (medical examiners and patients with RSIs/WMSDs), their names have been changed.

The process for analyzing empirical data obtained from the interviews considered the following procedures: full reading of each interview, establishment of thematic categories, organization, and analysis of the material according to thematic categories, as well as comparison of contents from the categories to the current literature on the general theme and the analytical framework (Gomes et al., 2005). Resorting to the analytical framework of social representations was justified by the dynamism of patients’ values and practices within the context of illness due to RSI/WMSD and by the experience of expert medical examinations at the INSS; regarding the medical examiners, experts at the INSS, this option was justified by the experience of expert medical work.

Results and Discussion

Characterization of subjects

Table 1 - Characterization of patients with RSIs/WMSDs²

Respondent	Sex	Age	Education level	Occupation	INSS benefit
Jairo	Male	38 years	Incomplete High School	Typographical printer	B91, Accident assistance
Maria Fernanda	Female	48 years	Incomplete High School	Administrative assistant	Uncertain benefit status
Maria Lúcia	Female	38 years	Incomplete High School	Supermarket cashier	B31, Disease assistance
Marília	Female	35 years	Incomplete High School	Cleaning assistant	B31, Disease assistance
Nice	Female	54 years	Complete Higher Education	Bank employee	B 91, Accident assistance
Priscila	Female	35 years	Complete Higher Education	Administrative assistant	B31, Disease assistance

Table 2 - Characterization of medical experts at the INSS/SP

Respondent	Sex	Specialization	Experience with expert medical examination
João	Male	Cardiology	24 years
Marcos	Male	Endocrinology	20 years
Sandro	Male	Medical clinic/surgery	30 years

The recognition of disease by patients and agreement/disagreement in the context of medical evaluation

For the patients with RSI/WMSD, the worsening of symptoms (pain, numbness, loss of strength) was key for seeking treatment, usually encouraged by workmates. In addition, lack of knowledge about the pathology impact on their life and work stood out.

Back in 2003, I started feeling something on my arm, the left arm... only after one year I searched for a doctor. I did not want to go to the service... those things, we prefer to work than taking care of our health, you know, then, after 18 months, after a workmate talked too much, indeed, she said, go to the hospital, your shoulder is very swollen, this is not normal. So, I said, yeah, I am going to go there. Such pain is not normal. (Marília, 35 years)

The patients with RSI/WMSD also classified their work as repetitive and “tiresome” for the body, a factor they associated to sick leave. Besides, they thought that the job required constant mental con-

centration and that they were under pressure on jobs, exerted by workmates, the immediate boss, or the employer. Thus, the findings of literature were corroborated, pointing out that the context of RSI/WMSD is grounded on an organization of labor activity based on pressure for productivity, under low pay and poor work conditions, where workers had little control over the production methods (Sato, 1996; Batista et al., 1998; Neves, 2006).

That is what happens to us at the hospital, at the time of calculating the debt bills, [...] wow, I have to comply with 3 procedures with regard to an only patient, and every procedure requires you to move to another screen, you have to get out of that screen, enter the password again, access another screen. Thus, you cannot assign it to the night shift colleague, he does not accept you assign one debt bill to him, no, he does not accept, indeed. This has already been said, but our boss do not interfere, we have already complained, I have already said, I am tired of talking about it. (Maria Fernanda, 48 years)

² The names of participants, both patients and medical experts, have been changed to ensure confidentiality when using data provided by them.

[...] however, when I started working there, there was no bank of hours and we just worked for 15 days, the year-end holidays, opening and closing, we pick up the rice package, we pick up the package with 6 liters of soda, milk carton, and I, I am very, as people say, I am a person who works very fast. [...] So, I worked very fast and there we, there is that row, the customers are always in a hurry, we cannot talk, they think we are taking time. (Maria Lúcia, 38 years)

It is also worth noticing that patients with RSI/WMSD reported in detail the obstacles for defining diagnosis and accessing treatment, related to the unpreparedness of professionals at the health care system (public and private) for providing a proper anamnesis of the clinical condition, a factor which postponed the onset of treatment and the request for sick leave. According to them, the correct procedure was observed in public services with professionals specialized in occupational health.

[...] I went to P. Hospital, and people working there asked the Work Accident Communication (WAC) to the company, but this procedure was very disorganized, the hospital asked the WAC and the company just did not provide it. So, as the company did not provide it, they [hospital] said this: Look, you do not have the WAC, this is an occupational accident, you have an occupational disease; the manager [company] told me: if you have an occupational disease, you will have a sick leave. Thus, I spent a day back and forth, at the hospital, I thought that someone would provide me a sick leave... I went home crying, the hardest thing is a doctor recognizing that we are sick, especially at the emergency room. (Maria Lúcia, 38 years)

[...] I searched for the doctor of the labor union and reported I had a problem, severe pain on my arm, [...] then, he referred me for some exams, he referred me to another health care unit, also connected to [the Unique Health System], here, downtown. Then, I underwent examinations, i.e. X-rays, and I went to the health care unit, but I was not assisted, because I lived in Ribeirão Pires, I had to arrive at 4 a.m. at the unit to wait in a nearly 2 km row. [...] Then, I went back to the doctor after 3 working days, and she [the doctor at the Reference Center] came and

said that I cannot have a sick leave. You worked at the company for only 3 days. Then, soon I realized I had a sick leave. (Jairo, 38 years)

As already described in the literature (Barbosa et al. 2007; Merlo et al., 2003; Verthein and Minayo-Gomez, 2000a), when patients with RSI/WMSD realize the fact of being ill, they reveal the negative impact of disease on their lives, mainly related to the loss of autonomy for working and fulfilling everyday life activities, the continued dependence on medicines, and the “invisibility” posed by the absence of apparent signs of illness.

The RSI makes you get older, the RSI makes your mind get older. Sometimes, your body is not well, thus, you look at it and think it is normal, but your body is old within, because you have inflamed nerves. (Maria Lúcia, 38 years)

However, I cannot lift some weight. If I lift some weight, I feel pain for 2, 3, 4, days, the whole week, I have to take an anti-inflammatory drug. I mean, I have to take an anti-inflammatory drug all the time, when weather changes, I feel it, my shoulder hurts, my wrist hurts. (Priscila, 35 years)

When I hear of a printing company, [...] then, my heart races. It is like I was making a living out of that, as if I was working with that, the work was very demanding, but I never thought it would hurt me. [...] But it was like a candy, very tasty, that someone gives you and then takes back [...]. (Jairo, 38 years)

[...] I live with my husband's family, in the same yard, my sister-in-law said that I have nothing, that I am pretending, [...] that I just have nothing. (Maria Lúcia, 38 years)

Considering the context experienced by patients within the organizational structure of the INSS/SP, it is worth emphasizing that recognizing illness and getting close to the biomedical rationale in terms of diagnosis, treatment, and prognosis became important factors for moving in the institutional space and for defining the subjects' position with regard to expert medical examination. The respondent Jairo explained that his sick leave due to RSI/WMSD was different from another due to a fracture.

Well, the difference is that when you have a problem related to fracture, you are just anxious to get back

to work, those who have a sick leave do not want to be away [...]. Regarding a RSI/WMSD, I think, the difference is that when you are about to leave, you just do not take it anymore, you just cannot breathe. (Jairo, 38 years)

As pointed out by other studies about RSI/WMSD, the patients faced difficulties to enjoy the right to leave and, also, to obtain the right benefit for her/his illness (Almeida and Codo, 1995; Verthein and Minayo-Gomes, 2000a). Besides, they reported that the contact with the bureaucracy of the INSS/SP and its officials was marked by difficulties and misunderstandings with regard to appointments, clarification of doubts, and, especially, benefit classification, a relevant factor in labor and social insurance law.

In the case of RSI/WMSD, the benefits usually granted are Disease assistance (B31) or Accident assistance (B91). Disease assistance (B31) is the benefit granted to the insured person who is unable to work due to a disease or accident for more than 15 consecutive days. Disease assistance is not a right granted to those who, at the time of joining social insurance, have already acquired a disease or injury which may entitle them to the benefit, except when the disability results from the worsening of this disease or injury. Accident assistance (B91) is the benefit granted to the insured person who is unable to work due to an accident at work or an occupational disease (Brasil, 2010)³.

[...] they had to provide the WAC to me, it was not a Disease assistance. The lawyer had already talked to me. This is not a Disease assistance, but a Disease assistance due to accident at work. It is the B91, so, the Social Insurance made a big mistake and it has always classified me as B31. I said it was B91 here. If they provided the WAC to me, the Social Insurance has to address it as a WAC, right? They received a WAC, are they unable to tell the difference? But okay, this is another case. That is why I left. I left on 11/07/2002. (Priscila, 35 years)

Analyzing the reports, we noticed that the professional class of patients influenced on the bureaucratic procedure of entering the INSS. Nice, bank employee, had her sick leave allowance sent by the company to the INSS/SP; the other respondents had to do that on their own.

Because when the bank opened the WAC, it took the document to the INSS, because the bank used to do that. Because the personnel department of [name of the bank], the chief spoke to the office boy, he sent the document, and the INSS scheduled the expert medical examination. (Nice, 54 years)

Regarding narratives about the meeting with medical experts at the INSS/SP during medical evaluation, among all respondents stood out the expectation of their “disease status” assessment, as well as a sensation that they would receive a similar treatment to that on the part of assistant physicians. Lack of knowledge about the place for expert medical examination and the physician who would meet them raised uncertainty and anxiety at the consultation time.

The expert medical examination, at first, took place at different locations. It was like a test, I regarded it as a test to confirm whether I actually had the problem or not. The worst test is that designed for proving that you are sick. Thus, there was a lot of documents, everything, everything, everything; even what you are just unable to obtain is asked by the medical experts. (Jairo, 38 years)

[...] I am enrolled in the Brás Leme unit and they referred me to the accredited clinics, nearby, all of them in Santana, but if I met you today, I would meet another physician the next time. (Nice, 54 years)

Anxiety and lack of confidence were also connected, in patients’ reports, to the lack of control over aspects related to the expert medical consultation, especially the physical examination. In cases of RSI/WMSD, the physical examination should be adopted as conduct, because the supportive exams (X-rays,

³ According to Brazilian legislation from the Ministry of Social Security, the communication of an accident at work or an occupational disease will be made to the Social Security in a specific form named Work Accident Communication (WAC). The grant of Disease assistance due to accident does not require a minimum period of contribution. While receiving Disease assistance due to accident at work or occupational disease, the worker is regarded as having a sick leave allowance and she/he enjoys stability for 12 months after returning to work activities.

magnetic resonance imaging, etc.) do not ensure clarity with regard to the harm degree or ability to work (Dias, 2001). Regarding the physical examination during the expert medical consultation, the reports point out longing related to fear of pain, lack of control over the procedure, and the absence of physical signs that can be identified by the medical experts, needed to confirm illness, allowing an interpretation on the part of the professional that the patients could be “simulating” their disease status. These findings have also been pointed out by other studies (Batista et al., 1998; Verthein and Minayo-Gomes, 2000b), something which reinforces the idea that illness due to RSIs/WMSDs implies (re)significations which go beyond the subjects’ physical health sphere, bringing up the worker’s right dimension.

No, she (medical examiner) works at Rua Barra Bonita. She did not look at my ultrasound examination when I handed it to her. Then, she asked me an electroneuromyography, and I did it. A few days after, I went back, then, she did not meet me, I did not enter her room, I hand the examination to the secretary. As nothing was found, she discharged me. (Maria Lúcia, 38 years)

Finally, the experience of interacting with medical experts has led patients to adopt a criterion for assessing medical experts according to the polarization between “good physicians” versus “bad physicians”. The “good physicians” would be those offering a “dignified treatment” during the consultation and, especially, those who “believed in the existence of the disease”, acknowledging the disability to work. The “bad physicians”, on the other hand, have been identified as those who do not “believe” in illness, even when the respondent had exams and reports providing evidence.

For instance, I met Dr. N, who was very sympathetic. When I went there, I showed my exams, he had a look at them, he looked at my hand and believed in what I was telling him [...] Thus, this physician was always nice to me. And there was also Dr. L. R., who wanted to retire me, he was rough, you know, but he was good. At least, he treated me with dignity. There was another one, Dr. F., Dr. F. was extremely rough; if you said “good morning, doctor” when entering the room, he just said nothing. He did not

answer and the secretary was always very rude. (Nice, 54 years)

Then he lifted me up [the medical examiner], he was very, very, he took my arm with such violence that I said... I thought to myself, easy, there is no need to do it all! But I should have spoken, sworn the guy, I did not say I should have given him a kick, you know, because he took my arm, lifted it, and threw it backwards [...]. [She felt like] A chicken! A chicken, which you take by the neck, you know, pluck it, and do whatever you want. And then he discharged me. He said it was nothing. (Priscila, 35 years)

The physicians and the universe of medical experts for RSIs/WMSDs

The narratives of medical experts with regard to RSIs/WMSDs were constructed through their memories of contact with this kind of illness in clinical practice, which have chronologically coincided with its recognition as a disease eligible to insurance by the INSS. They experienced the advent of RSI/WMSD, in the 1970s, within the Brazilian social insurance system and pointed out the difficulties posed by them to the expert medical work.

It is interesting, I was thinking in 1974, I was doing an expert medical examination, I remember a case, in Santo Amaro, of a person who worked, who was already working with typing back then [...] he was complaining of numbness, tingling, and joint pain, these symptoms especially affected the fingers. And the physical examination was completely negative, thus, the patient had his benefit denied. About 5, 6 months after, I remember that the person returned with an impressive sequel, back then we did not talk of RSI, there was no RSI [...] I was so impressed that I did not know what could have happened to that person, which disease was that [...]. (Dr. Marcos)

The medical experts expressed an understanding of the disease related to the labor force exploitation and its social problem characteristic requiring medical attention.

It’s an epidemic, indeed, it has to be studied, it has to be fought. (Dr. Marcos)

In fact, the RSI/WMSD is currently a very serious problem in developed societies, having in mind the

progressive increase in its incidence. (Dr. João)

The physicians' representations of the expert medical work involving the RSIs/WMSDs were structured through three terms used for expert medical assessment: the difference between the expert medical work and that of an assistant physician, the peculiarities of expert medical assessment of the RSIs/WMSDs and the causal nexus problem. Respondents argued that the INSS is an insurance company and that the expert medical role is different from that of assistant physicians: while the latter work to establish diagnoses and treat diseases, the former (the medical examiners) should check the ability to work. These different roles constitute an argument for the clash with patients in the context of meeting during expert medical examination.

First, I think it is not the primary function of the medical experts to diagnose. Thus, he confirms the diagnosis through data brought by the patient, so to speak [...]. Then, the actual role of a medical experts is assessing disability to work. (Dr. Sandro)

In the case of expert medical examination at the Social Insurance, an administrative medical examination, where the institution is the authority requesting the medical experts data to inform not about illness, but about whether the insured person is able or not to work; if she/he is not able to work, she/he enjoys the benefits she/he are entitled to. Thus, expert medical examination is just a medical procedure, a forensic medical action for providing the institution with elements to decide whether granting the benefit or not. (Dr. Marcos)

When encouraged to talk about the particularities for implementing the medical evaluation for RSI/WMSD, only one respondent explicitly recognized that this consists of a unique medical examination, however, despite the negative answer from the others, this prerogative was implicit in their reports.

[...] in fact, it is a different medical examination. Because if the individual has hypertension, hypertension, until I prove otherwise, establishing a connection between hypertension and labor is very difficult, it is an exceptional situation. Now, with regard to tendonitis, no! Tendinitis has a high percentage, it actually has a relation to work. So, it is a different medical examination, there is a

need for an occupational anamnesis, we have to know the professional background of this insured person. (Dr. João)

I regard it as a normal medical examination, I think that when I am facing it as a special medical examination, I have some bias, indeed. Now, it is known as a biggest discussion points. (Dr. Sandro)

Just as for patients with RSIs/WMSDs, the physical examination issue permeated the group's narratives. Medical experts pointed out the physical examination as a required assessment tool, putting further exams on the background.

I think that it is the most important [physical examination]. I think the physician may provide an expert medical examination without any further examination, however, he should never provide an expert medical examination having only a further exam as a basis. (Dr. Sandro)

Thus, about that [...] the diagnosis of RSI is a clinical diagnosis, it does not depend on a further exam. Now, the medical expert examiner, he may occasionally use this further exam to bridge a gap in the clinical examination. (Dr. João)

Along with the physical examination aspect, we also addressed, regarding the peculiarities of medical evaluation for RSI/WMSD, the issue of simulation, or "appreciation" of symptoms by patients during the expert medical consultation, in order to obtain the benefit. According to the experience of respondents, those who "simulate" represent only a small portion of the insured people.

I could tell you that most people do not do that. But there are a certain amount of people who already arrive here, let us say, with the purpose of doing that, often the person knows she/he has not the right, but she/he tries to "gain" the right. The higher the unemployment rate, the greater the individual's tension and the greater the number of those who actually have a disability or those who do not have the right, but try to gain it. (Dr. Sandro)

Regarding the establishment of the causative link, the medical experts were against this assignment, because they believed it should be implemented on a limited level, due to difficulties posed by daily work, and also because it represents a further

conflict issue, if not the main, with regard to the patients with RSI/WMSD.

I think that a medical expert at the INSS, this is my personal opinion, should not, at all, address the causative link issue, I think this is a problem involving the employee and the company, it has to do with the Ministry of Labor, with occupational medicine, it has nothing to do with the INSS. (Dr. Sandro)

And there is another situation, RSI/WMSD cases where medical experts, regarding the problem as a tendonitis, does not establish the causative link, because, what is key? Studying that insured person's workplace, that patient. I mean, all physicians who participate in this situation, those who meet this insured person, this patient. (Dr. João)

In order to ground the establishment of the causative link, medical experts sent their reports to describe the concept of *epidemiological technical nexus*⁴, which emerged at the time of the survey, along with the structuring of the benefits granted by the INSS, which they supported.

The epidemiological nexus is another attempt to make the company responsible to prove something. Because, before, when you denied the nexus to the employee, she/he had to justify it. Now, epidemiologically, if she/he performs a risky activity and has a pathology which is often observed in that activity, this establishes the nexus. (Dr. Marcos)

Final remarks

Patients with RSI/WMSD and medical experts at INSS/SP, subjects situated at the poles of an adversarial relationship permeated by suspicions and tensions, had different ideas and, in some points, complementary with regard to illness due to RSI/WMSD and the symbolic meeting represented by the expert medical consultation.

For patients whose representations were cons-

tructed through the experience of illness, the disease was described as a negative event, limiting their autonomy as social subjects and it affects, often in a peremptory manner, the everyday work, the daily life and social activities, forcing them to (re)signify their identities.

In the reports providing access to the social representations of patients, the difficulty to recognize illness and its implications stood out, the complex itinerary in the public and private health care services in order to obtain proper diagnosis and treatment, and, in a marked degree, the obstacles to become recognized as subjects suffering from RSI/WMSD in the work environment, and even in the family environment.

Contact with the INSS/SP was permeated by uncertainty and lack of control over the events related to expert medical consultation, provoking anxiety and tension. In the medical evaluation context, the meeting with the medical experts represented a conflicting situation, because the patients understood that it was a trial about the truth of their arguments and the validity of their condition. In addition, the results of expertise medical examination were decisive for their future. They attributed a great probative value to further exams, able to prove illness in the social space, and, especially, the medical consultation, to the detriment of the physical examination, a moment characterized as involving great exposure and vulnerability. They evaluated medical behavior according to the accreditation received by the medical experts with regard to her/his condition, the "good physician" is that who accredited the disability to work.

Among the medical experts, subject situated at the pole of scientific knowledge and technical judgment, the reports provided access to representations focused on the challenges that the RSI/WMSD posed to the practice medical evaluation by the INSS, in the late 1970s. The complexity of this disease and the technical limitations to obtain the

4 The Social Security Epidemiological Technical Nexus: through the intersection between information from the International Classification of Diseases (ICD-10) and from the code of the National Classification of Economic Activity (NCEA), we point out the existence of a relationship between the injury or condition and the activity conducted by the worker. Through this reference, expert medical examination at the INSS gains another important auxiliary tool for its analysis to conclude about the nature of disability to work observed, whether with a social insurance or an accident nature. The Epidemiological Technical Nexus was implemented by the INSS in April 2007. Available from: <http://www.previdenciasocial.gov.br/conteudoDinamico.php?id=463>. Accessed on: 02/15/2011.

definitive diagnosis and establish the causative link with the labor activity are recurrent aspects in the reports and they are useful to understand the position assumed by the medical experts in face of patients during the medical evaluation. Detailed explanations about the differences between her/his expert medical practice, with regard to the assessment of working capacity, and that of assistant physicians, aimed at the diagnosis and treatment of diseases, make apparent the difficulties posed by the daily work involved in the medical experts and the obstacles to effective communication in the meeting with patients with RSI/WMSD.

As for the peculiarities of medical experts practice, they told about stress, unlike the patients, the importance of physical examination to the detriment of further exams, and they also protested against liability attributed to them in order to establish the causative link. Moreover, the medical experts approved the changes that the INSS was going through at the research time, among which stands out the possibility of introducing the reference to the *Social Security Epidemiological Technical Nexus*, recognized as a breakthrough and probable facilitator of the expert medical practice.

The patients with RSI/WMSD and the medical experts at the INSS/SP had a wide repertoire of representations of the disease and expert medical consultation. Their perceptions were sometimes different, sometimes complementary, and they revealed an aspect of daily illness which is still poorly explored, the interface between these subjects and their conceptions about themselves and the "other", even considering, during this meeting, its symbolic dimension.

We understand that the findings of this research potentiate two kinds of debate. In the institutional realm of the medical structure aimed at social insurance at the INSS, the possibility to contribute to the planning and implementation of change actions related to provide people with RSI/WMSD with assistance and guidance. In the academic realm, pathways are open for further investigations about the relationship between health professionals and patients with RSI/WMSD in the context of assistance and, especially, about the peculiar meeting between medical experts and patients, since this is

a relationship anchored on the relevance of social security law.

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