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Scientific Argumentation and Social Compromises: The Difficulty of Codifying Occupational Diseases in France

Marc-Olivier Déplaud¹

Abstract

Policy choices are often regarded as compromises between public authorities and interest groups, even when the use of experts is required because of their technical nature. In this article, we show that expertise cannot be considered as a “passive” resource in the hands of interest groups, but as a relatively autonomous field with specific rules that impacts policy outcomes. Thus, the convergence of positions between some experts and some interest groups needs investigation and explanation. We illustrate this contention through the analysis of the codification of occupational diseases in France. This process involves a deep medical expertise and has sparked a very intense controversy between labour unions and employers’ organizations.

Keywords

Interest groups, expertise, advisory committees, occupational diseases

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Introduction

Political institutions are replete with various standing advisory committees, where representatives of interest groups, experts and senior civil servants take part in making policy outputs. Some of them can be accurately described as “policy communities”, characterized by “a limited number of participants”, “frequent interactions between all members of the community on all matters related to the policy issues”, “consensus, with the ideology, values and broad policy preferences shared by all participants” and a balance of power among members (Rhodes, 1999: 142-144). Rhodes suggests that one group may prevail, but “it must be a positive-sum game if community is to persist”. But many other advisory committees, whose memberships are also stable and interact with each other, would be better described as “arenas” (Bailey, 1970): “policy arenas” may be characterized by a restricted membership and frequent interactions among members, as well as by strong conflicts of interests between participants and great difficulties to reach consensus. The resources of the members may be very unequal, and the “game” they play is more often a zero-sum game than a positive-sum one.

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Yet these arenas are sometimes seen as areas of ritual struggles and judged as uninteresting by some political scientists². However, the study of standing advisory committees may be of great importance for policy analysis if we assume that: 1) “the debate between people who take part in a collective decision [may be] a major stage of this decision” (Urfalino, 1999: 165), and 2) that the prevailing rules of argumentation within standing advisory committees may have some impact on policy choices (Fisher and Forester, 1993). In those committees which are specialized in very technical matters, the representatives of interest groups frequently hire experts, or are experts themselves. Therefore, if we intend to know how decisions are reached in those committees, we must study how experts are engaged in the struggles between the delegates of each interest group.

Experts are generally considered as a “resource” that is mobilized by representatives according to their interests. However, this model, which looks at the experts as a “passive” resource, underestimates the specific interests and values of the experts. As the sociology of professions identifies it, the autonomy claim, especially in diagnosis activity, is a constant feature of professionals when they are consulted as experts (Abbott, 1988: 40-44; Bourdieu, 1976, about scientists). Other studies, inspired by Habermas’ writings about “deliberative democracy” (Habermas, 1996), propose that the presence of experts may favour the emergence of a rational discussion, i.e. a debate where only the arguments’ intrinsic value of the participants would be taken into account. Nevertheless, the social effectiveness of the discourse is dependent on both its institutional environment, and on the social qualities of the speaker (Austin, 1962; Bourdieu, 1991: 107-116). The participants’ social status is particularly important in official situations – such as in advisory committees. What Bourdieu wrote about linguistic competence is also true about expertise: the authority of an expert is greater “when the use of the legitimate language is more imperative, that is, *when the situation is more formal* (and when it is more favourable, therefore, to those who are more or less formally delegated to speak), and when consumers grant more complete recognition to the legitimate language and legitimate competence [emphasis added]” (Bourdieu, 1991: 69). Moreover, the authority of the experts is supposed to be all the more decisive since the advisory committees on which they sit “deal with fairly obscure matters. [...] It is in such largely inconspicuous committees and panels that we might expect fairly decisive weight to accrue to the recommendations of its professional members” (Freidson, 1986: 192). Thus it is critical to study the extent to which experts can impose their specific rules of discussion in these committees and to understand on what grounds their authority is based.

We investigated the activities of a rather obscure standing committee, the Committee of Occupational Diseases, whose mission is to codify occupational diseases in order to improve their financial support by the French public health care system. This

² A political scientist like Mény (1991 : 393) wrote : “These committees may at best bring information or put pressure on the Civil Service. Most of the time, they are only forums for heated exchanges between opponents who repeat their arguments in front of civil servants who may act as referees. Lastly they fall into oblivion as soon as they are created, inasmuch as they were only an institutional answer to a momentary problem.”

advisory committee, which was founded in 1984, is one of the six specialized committees of the High Council for the Prevention of Occupational Risks, which is answerable to the Ministry of Labour³. Its composition is similar to that of many other advisory committees, including:

- a) Some representatives of ministerial departments and public organizations. Most of them are actually civil servants of the Department of Working Conditions of the Ministry of Labour, and in particular of the “Office of Hygiene in Occupational Areas”, which is in charge of the Committee.
- b) Some delegates of interprofessional unions, the most active being the representatives of the General Confederation of Labour (CGT) and of the French and Democratic Confederation of Labour (CFDT).
- c) Some representatives of the employers’ organizations: the Movement of French Firms (the Medef, which used to be called CNPF until 2000), which is represented by two delegates, the General Confederation of Small- and Medium-Sized Firms (CGPME) by one.
- d) Several experts who are said to be “fully qualified”. Five to seven « qualified » persons usually sit at the committee. Most of them are occupational doctors or specialist practitioners in occupational diseases.

When we started our study around 2001, several unions’ and employers’ representatives and experts had been serving on this Committee since its creation in 1984, and the rest for five years or more. They knew each other very well and they had frequent face-to-face or telephone interactions. Despite this, the Committee of Occupational Diseases was an arena of very intense controversy between the representatives of the labour unions and those of the employers, since all increase in the financing of the treatment of occupational diseases entails a rise in employers’ contributions to the public health care system. In order to limit our study, we examined the work of the Committee on chronic low back pain between 1988 and 1998. In the end of the 1980s, the unions claimed that chronic low back pain should be recognized as an occupational disease. The categorization of that pathology gave rise to strong opposition from the employers’ delegates. Indeed, low back pain is a very frequent and very costly disease⁴. The codification of this pathology was the subject of a protracted struggle. At last, in 1999, two “tables of occupational diseases” concerning “chronic affections of

³ This council was founded by the law of 19 December 1976, which resulted from an important mobilization about working conditions, launch both by some interprofessional unions and magistrates (Cam, 1978 ; Lenoir, 1980 ; Piotet, 1988 ; see also the testimony by Juffé, 1980). In fact, this new council gathered committees which has been existing for a long time, such as the Committee of Industrial Hygiene, which was in charge of the codification of occupational diseases.

⁴ “Hanging on the different studies and the methods they use, 14 to 45 per cent of the adults say that they suffer from low back pain. The prevalence throughout life is of 60-70 per cent”, according to Carré (1999). According to another study used by the members of the Committee of Occupational Diseases, in 1988 low back pain meant 9 per cent of general surgeries, 8 per cent in radiology, 25 per cent in rheumatology and 30 per cent in physiotherapy in France. They also meant 7 per cent of sick leaves, 12 million unworked days and a medical cost of 1.37 billion Euros each year (Lacronique, 1991). Occupational lumbagos, *i.e.* acute but momentary low back pain, were rather well taken in charge as industrial injuries ; but it was not the same for chronic low back pain. Most of the time, the medical consultants of the health care services denied that the chronicization of low back pain, and thus relapse, could be caused by work.

lumbar discs” were enacted. Nevertheless, they were very restrictive, and they led to the compensation of very few people⁵. We will later on explain the reasons of this restrictive classification⁶.

This study was conducted between November 2001 and June 2002. Due to the technical nature of the debates, it was necessary to develop a familiarity with the requisite legal and medical terminology. For the analysis of the negotiations themselves, we gathered ministerial or personal minutes of the meetings about low back pain between 1988 and 1998 and the scientific studies that the members of the committee used, inasmuch as some of them allowed us to use their private archives. To get more information about the social trajectories of the committee’s members and about the interactions during the meetings, we did thirty-three interviews of an average length of an hour and fifteen minutes: ten with unions’ representatives, five with employers’ delegates, five with civil servants and thirteen with experts and “fully qualified people” (including the President of the Committee). All the people we called accepted to be interviewed. However, two employers’ delegates and one of their experts refused to be recorded, despite our insistence. In addition, unlike the unions’ representatives and the FNATH⁷, the employers’ delegates did not allow us to review their private archives. For that reason a large part of our information stems from the unions representatives, the FNATH and the civil servants, who were intrinsically supporting the unions.

However, we attempted to be careful to not bias our analysis through: first, systematically comparing our oral sources with each other, and the oral sources with the written ones (ministerial and personal minutes of the meetings, and letters of the unions and of the employers’ organizations to the Ministry of Labour), and then, comparing the case of chronic low back pain with other occupational diseases. As several sociological and medical studies⁸ and administrative reports⁹ proved, in France, as in many western countries, most of the occupational diseases are not recognized nor compensated; where they are, the compensation is very low. Far from being an idiosyncratic case, chronic low back pain is a good illustration of the lack of knowledge and of the weak compensation of occupational diseases in many western countries.

⁵ In 1999, only 579 people were compensated thanks to the tables of occupational diseases number 97 and 98, enacted on 15 February 1999. There were 2057 people the following year (Source : CNAMTS, Department of Occupational Risks).

⁶ This paper is a reshaped version of a paper published in French in *La revue française de science politique* (Déplaudé, 2003) and presented at the General Conference of the European Consortium for Political Research at Marburg (Germany), in September 2003. Thanks to Marie-Laure Terrieux for correcting the language of this paper.

⁷ The National Federation of the Victims of Industrial Injuries and of Disabled People (FNATH) is a member of the Committee as a “qualified person”. See below for more information.

⁸ See Thébaud-Mony (1991), Appay and Thébaud-Mony (1997), Henri (2000), Gollac and Volkoff (2000).

⁹ See Dorion and Lenoir (1990), EUROGIP (2000), Masse and Zeggar (2001), Cour des Comptes (2002).

Occupational diseases: a matter of controversy

Far from resulting only from scientific criteria, the codification of occupational diseases is often a site of protracted struggles between unions' and employers' representatives. Thus, we will specify the nature of the struggles and the resources these representatives usually mobilize during the meetings of the Committee of Occupational Diseases.

The economic and social perils of codification

In France, as in most of Western countries, a pathology can be defined as an occupational disease only if it fits very precise criteria. A hundred tables, called "tables of occupational diseases", constitute a list of the pathologies that may be recognized as occupational diseases for the employees of the private sector¹⁰, as well as under what conditions they exist. Before the creation of an "additional" system of compensation in 1993¹¹, the pathologies registered in these tables were the only ones to be indemnified. Therefore, occupational diseases are a specific category of ailment, codified by the law¹².

Each table of occupational diseases consist in one title and three columns (see Appendix):

- a) The first one includes the definition of the pathology, *i.e.* the clinical signs which allow its identification with certainty.
- b) The second one specifies the time limit for compensation, meaning the ultimate deadline between the noticing of the disease and the moment when the worker ceased to be exposed to the risks, which are supposed to favour it.
- c) The last one is a list of the occupations that may provoke the disease in question.

Therefore, any disease that fulfils the conditions inscribed in a table must be considered to be an occupational disease. Neither the general practitioner nor the specialist can declare whether a pathology has an occupational origin or not. He/she only has to confirm that the clinical signs required by the table accompany this pathology, and to fill in the medical certificate that the worker will send with a "declaration of occupational disease" to the local health care service, the CPAM. Afterwards, the medical consultants of the CPAM must verify that the other two conditions (time-limit and list of occupations) are fulfilled. In this case, the ailment that affects the worker is *presumed* to be an occupational disease. In the end, this device

¹⁰ The civil servants benefit from the tables of occupational diseases too, with specific advantages. See Plantey (2001 : 655-665).

¹¹ This device allows the compensation of occupational diseases that are not taken in charge by the tables. But the tables keep a main place in the system of compensation, since the recognition as an occupational disease of a pathology not codified in a table must fulfil very restrictive conditions (yet these conditions were relaxed in 2002).

¹² The tables of occupational diseases are enacted as decrees and are added to the Code of Social Security. After their elaboration by the Committee of Occupational Diseases, they are submitted to the opinion of other advisory committees. Most of the time, the tables that are enacted are identical to the draft adopted by the Committee of Occupational Diseases.

allows the victims automatic compensation, unless their declaration of occupational disease is disputed by the CPAM or by the employer¹³.

This inclusive compensation is granted by the Branch of Industrial Injuries and of Occupational Diseases (called “ATMP branch”) of the national health care service, the CNAMTS. Unlike the other branches of the CNAMTS, which are financed by the contributions of both the workers and the employers, the ATMP branch is financed only by the employers’ contributions. Therefore, any creation of a table of occupational diseases implies a financial transfer from workers to employers¹⁴. The firms’ and unions’ representatives of the Committee of Occupational Diseases are opposed in a very simple way: the firms’ delegates are used to resisting any creation or extension of a table of occupational diseases (since it implies an increase of the contributions of firms to the health care national service), whereas the unions usually hold the opposite position, because the tables allow compensation by the firms themselves and offer the victims a better protection against their employer. Thus the Committee of Occupational Diseases is characterized by an opposition between “two interest blocks”¹⁵, which is deeply entrenched since the stakes are high, as it is illustrated by the case of low-back pain:

“If [the employers’ representatives] fight like cats and dogs about the low-back pain table in order to make a minimum table, it is because they knew that if we did a table that is too lax, it would imply important consequences in terms of surplus of contributions. Hum... Sometimes, we examine some subjects... Well, there was one case, two cases of this disease in France. They are not used to fighting, or they fight on principle, about that! You know, when it deals with musculoskeletal disorders, deafness, asbestos, when it may concern serious diseases like cancer, in these cases they think: it costs a lot!” (Interview with a delegate of the FNATH, 12/03/2001)

If the codification of occupational low back pain provoked strong resistance from the employers’ delegates, it is because they feared that it could cost firms a lot, as we explained above. Their resistance was all the more effective since they could mobilize many more resources than their opponents.

An unequal balance of power

In the Committee of Occupational Diseases, medical expertise is a crucial resource (this is not only because of the technical nature of the discussions, but also because of the

¹³ In fact, it happens so often that the recognition of occupational diseases can be described, to a large extent, as an obstacle race for the workers. See Thébaud-Mony (1991 : 70-78).

¹⁴ Besides, these tables entail specific advantages for the workers. First, they receive compensation in the case of a temporary disability, as in the case of a non-occupational disease. Secondly, they benefit from free medical care, and, if necessary, of physiotherapy. Thirdly, dismissal by their employer is made more difficult. In the case of a permanent disability or of a demise, themselves or their family are granted a compensation for life. For more precisions, see Lyon-Caen (1996 : 292-314).

¹⁵ According to a phrase of the delegate of the National Federation of the Victims of Industrial Injuries and of Disabled People (FNATH), who is a member of the Committee of Occupational Diseases as a “qualified person” (interview, 12/03/2001). This a spatial opposition too : during the meetings, the members of each block or each “team” sit face to face, at a U-shaped table.

strategy of employers' representatives who are very demanding about the level of expertise, as we will see below). However, not only the unionists but also the civil servants of the department of working conditions possess lower expertise resources than the employers'. In fact, during the meetings of the "occupational low back pain workshop" in 1994-1995, five out of the seven union representatives were doctors, and three out of the two employers' representatives were doctors. If they were occupational physicians, they did not have any specialization in low back pain. It is crucial for each party to have not only experts in occupational diseases, but also in the specific pathology that is discussed in the committee. In this specific context, the Medef¹⁶ devotes significant resources. In fact, it hired two famous professors of rheumatology during the two low back pain workshops in 1991 and 1994-1995¹⁷. Conversely, the unions' representatives had no means to afford experts:

"Our problem with experts is that we have no means to pay them. So there is a discrepancy of means. The employers' delegation can pay its experts, whereas we have no means of paying ours. Our experts must be volunteers, that is a real problem! We are not... it is not equal representation. Should I compare two members of the Committee of Occupational Diseases, I would compare Miss F. who is the director of the Department of Social Welfare of the UIMM, and I, who, until the 31 July, used to be the representative of the CFDT union, there's no comparison at all, see? I am a retired person, I have got a CAP [*i.e.* a vocationally-orientated certificate], that's all! My union will not lift a finger to help me. And it's the same for the others!" (Interview with a CFDT unionist, 03/15/2002)

The unions' representatives benefit from the permanent support of the delegate of the National Federation of the Victims of Industrial Injuries and of Disabled People (FNATH), who is an *ex officio* member of the committee as a "qualified person". Founded in 1921, this association claims 250,000 members. It relies on a network of 87 regional agencies and of 1650 local sections. The FNATH aims at giving advice and support to the victims of industrial injuries and of occupational diseases, and it has acquired an important judicial expertise on the compensation of them. However, like the labour representatives, its financial means are not enough to afford experts.

¹⁶ The Medef is by far the largest employers' organization in France (it claims about one million members). It is a confederation of sector-based federations and of local organizations. Although there is a department of "Social welfare" in the confederation headquarters, most of its resources in this field are owned by one of its oldest and largest federations: the Union of Steel Industry (UIMM). This federation represents about 18,000 firms that hire about two million workers (Bunel, 1995: 83). The UIMM acquired a strong expertise in social welfare, so that the current director of the Department of Social Welfare of the UIMM, represents the Medef not only in the Committee of Occupational Diseases, but also in many other committees of the national healthcare service. The director can use all the resources of her department, such as staff and financial means, which are essential for the payment of external medical experts.

¹⁷ If the Medef can easily recruit experts, it is not only because of its resources: the social proximity of these professors of medicine, who belong to the elite of the medical field, with the employers' delegates makes them probably more prone to accept the role of being an expert for the employers. On the contrary, this may contribute to explain why the unions' representatives meet many difficulties to enrol voluntary professors of medicine. About the position of the professors of medicine in the academic field and, to a larger extent, in the social and political sphere, see Bourdieu (1984: 53-96).

The discrepancy in resources regarding medical expertise is all the more detrimental to the unionists since the Department of the Working Conditions –in particular the Office of Hygiene in Occupational Areas (CT4 Office)– has also very few resources. First, the staff of this office, which is responsible for many more tasks than the Committee of Occupational Diseases, is very limited: in 1995, besides the head of the office, their staff included two lawyers, two engineers, an administrative assistant and two secretaries. As they are forced to work “just in time” (according to a civil servant of the Ministry of Social Affairs, interview, 02/06/2002) [Author’s translation], these agents are often unable to fulfil all their work, so that non-urgent files might have to wait for quite a number of years before being examined, and, sometimes, may even be forgotten. Moreover, the personnel do not have all the skills required by the Committee of Occupational Diseases. Indeed, the construction of a table of occupational diseases requires a specific expertise (e.g., rheumatology for low back pain, pneumology for lung cancers, etc.) and the agents of the ministry, despite their diplomas, do not have the proper skills for this responsibility. When they need independent expertise about a disease, they must appeal to an external expert. But they do not have the necessary budget to pay for it. Moreover, the participation in the Committee of Occupational Diseases implies an important workload:

“It needs time. The bibliography is usually huge. It really needs willingness and time. The work is voluntary. How will a scientist, who is burdened with work, manage to do this as a volunteer?” (Interview with the president of the Committee of Occupational Diseases, 05/07/2002)

The CT4 Office may use the expertise of some public organizations, which are represented at the Committee of Occupational Diseases, and, in particular, of the National Institute of Research and Security for the Prevention of Industrial Injuries and Occupational Diseases (INRS).¹⁸ The doctor who represents the INRS at the committee can do bibliographic research and invite some scientists of the institute to appear at a workshop of the committee asks for it. However, because of the status of the INRS, the civil servants of the ministry cannot mandate the studies required:

“The INRS has an executive board in which the State is only an observer, and in which only the social partners can take decisions [...]. As a consequence, if the executive board of the INRS doesn’t want to study a subject, it won’t be studied, even if we ask.” (Interview with the director of the Department of Working Conditions, 06/12/2002)

¹⁸ The INRS is an association whose executive board is composed, in equal parts, of representatives of the employers’ organizations and of delegates of the interprofessional unions. Financed up to 90 per cent by the employers’ contributions to the National Fund for the Prevention of Industrial Injuries of the national healthcare service, the CNAMTS, it employs 630 people, among which are about 200 scientists. In France, it is the largest research institution in the field of occupational risks. Following several heated debates echoed by the media between 1994 and 1998, which harped on the pressures coming from the employers’ representatives of the executive board in order to prevent some researches from being led or published, because they would have been considered as compromising, the General Inspection of Social Affairs (IGAS) published a very severe report about the INRS in 1999 (Jarry *et al.*, 1999).

The weak administrative means of the ministry of labour, and its difficulties in obtaining independent expertise, have several important consequences on the performance of the Committee of Occupational Diseases. Firstly, the CT4 office must make the meetings of the committee less frequent (there are no more than four plenary meetings a year) and restrict the number of specialized workshops (no more than three at the same time, according to a rule imposed by the office). As a qualified member of the Committee of Occupational Diseases told us, this “implies a unavoidable slowness on very tricky subjects” (interview, 02/21/2002), which fulfils employers’ interests, as a CFDT unionist denounced:

“This is to the employers’ advantage, as they drag things out, you see? Since the less work there is to do, and the fewer the meetings of the committee, the better it is for them! For them, this commission shouldn’t meet, since the more often it meets, the more it costs them money!” (Interview with a CFDT unionist, 11/20/2002)

Despite the efforts of the agents of the CT4 Office, their weak administrative resources tend to favour, in a tangible manner, the interests of the employers’ representatives. Moreover, in so far as it has not gotten any autonomous expertise, the Ministry of Labour must, to a large extent, leave this work to the employers’ and unions’ delegates. This inevitably favours the employers’ organizations, in particular the Medef, which disposes of many more resources in expertise than the labour unions and the FNATH.

The discrepancy in medical expertise can help explain why the unions’ representatives usually meet numerous difficulties when they ask for the creation or the extension of a table of occupational diseases, especially if it deals with a disease that may be costly for the employers. Yet it might be surprising that these representatives never tried to question such inequalities in the game. Astoundingly, the domination of the employers’ organizations over the Branch of Industrial Injuries and of Occupational Diseases of the CNAMTS¹⁹ induces the unions’ delegates to perceive the existence of an arena like the Committee of Occupational Diseases as a chance:

“It is the only place where labour unions that represent the workers can speak! Now, for instance, there is a commission that re-examines the list of compensations for the IPP – the permanent partial disability –, which is scandalous, this list is scandalous! At the moment, it is being reviewed: there is no representative of the workers who takes part in this revision. They are going to decide what the value of a miner’s lung is... without any social participation, as if it were a scientific issue! [...] So there are two important points in this committee [the Committee of Occupational Diseases]: on the one hand, it is the only place – because many people would like to get rid of the committee, they say, well, it’s crap discussions, it’s useless, they tear each other to pieces because they like it, etc. Right! Hum, Yes! But this is the only place where the workers’ voice can be expressed.” (Interview with a CGT unionist, 03/14/2002)

¹⁹ About this subject, see Pollet and Renard (1995) and Henri (2000 : 122-123). Since the introduction of the equal representation of labour unions and employers’ organizations in the executive boards of the healthcare services, in 1967, until 2000 (when the employers’ representatives announced that they wouldn’t sit anymore in the executive boards of the CNAMTS), the CNPF (now Medef) has always directed the Branch of Industrial Injuries and Occupational Diseases of the CNAMTS.

Aware of the inequalities of power and of their isolation inside their own organizations²⁰, the unions' representatives tend to adopt a pragmatic approach: as a CFDT unionist told us, they endeavour "to break through the system" (interview, 05/17/2002) by obtaining minimum concessions from the employers' representatives. The latter make concessions as long as it allows them to carry on a game that protects their major interests. Their strategy usually consists firstly in rejecting any creation or extension of a table of occupational diseases, and later, in granting a minimum of concessions²¹. So the codification of occupational diseases is above all based on a series of compromises, which are, most of the time, very unfavourable to the interests of the workers.

It might be assumed that the presence of many doctors at the meetings of the Committee of Occupational Diseases, most of whom are occupational physicians and specialist practitioners in this field, should contribute to the balance of power between the employers' organizations and the labour unions, as well as favour less unequal compromises. Nonetheless, the introduction of the specific norms of the medical field tends to consolidate the relations of power instead of modifying them.

The field of industrial relations and the medical field: Structural homologies and their effects

The majority of the members of the Committee of Occupational Diseases are doctors: in the occupational low back pain workshop of 1994-1994, they represented 69 per cent of the persons taking part in the meetings²². In this same workshop, five out of seven union representatives were doctors, and two employers' delegates out of three were doctors. Thanks to their numerical superiority and to their scientific authority, doctors tend to introduce rules of discussion that are specific to the medical field and that ultimately benefit the employer's interests.

The introduction of the specific rules of the medical field

Apart from the professors of rheumatology paid by the CNPF, most of the doctors who take part in the activities of the committee are occupational physicians or specialist practitioners in occupational diseases. But the latter tend to be in a subordinate position in the medical field. As most of them are wage earners, the occupational physicians are at the precise opposite of the dominant economic pole, characterized by an independent or a "liberal" status, of the French medical field. Besides, unlike other

²⁰ "We each of us are rather isolated in our confederations about those fields [occupational risks], because the unions are not very interested in them." (Interview with a CFDT unionist, 05/17/2002)

²¹ The story of the construction of the tables about low back pain is a good illustration of those tactics : "In the beginning, the position of the employers was : there's no table, it's impossible to make a table about low back pain" ; but, later, this position could not be supported any longer : "So they must have thought, in a strategic way, we are going to lock this table at the strictest, so that compensation would be minimal." (Interview with the delegate of the FNATH, 12/03/2001)

²² Source : minutes of the meeting drawn up by the Ministry of Labour.

salaried areas, such as biology or public health, which may benefit from intellectual prestige, due to their activity of scientific research in university hospitals or in centres of public research, most of occupational physicians do not lead any scientific research. Even if some of them become professors in medical universities, they are still strongly dominated in the academic field, because of the relative “indignity” of their speciality²³. Their lack of influence is testified by the weak legitimacy of the practice of occupational medicine. When occupational doctors advocate for the specificity of their area of competence, they rely on their knowledge of “the real world” (according to the words of a retired physician of the coal industry, qualified member of the Committee of Occupational Diseases, interview, 05/12/2002), or, in another words, of their field knowledge:

“What matters, it is being in the field, visiting the guys, in their working place, seeing how they work, what the risks are. Ah, sure, it is not nice for physicians – classical physicians, I mean, you see? There are not the good conditions. Good conditions, it is easy, are when the patient is stark naked in a hospital department, when nobody knows his name nor his age nor his occupation nor where he lives nor his parents nor anything, and we treat him like a... Right, there, it is ideal. But, precisely, occupational medicine is the contrary, the doctor who gets there.” (Interview with a CGT unionist, lecturer in occupational medicine and in professional diseases, 03/14/2002)

This claim for field knowledge is not very legitimate in the medical domain, in which the prestige of an area of competence is often correlated with its degree of specialization and its technical modernity (Ternon, 1994). This entails that the experts paid by the CNPF dictate a large part of the discussions at the Committee of Occupational Diseases, whereas they are not specialized in occupational diseases. For instance, both of the two experts who were requested over low back pain had a long academic and hospital career, and they held a central position in the medical field:²⁴ Because of their career in university hospitals and their numerous publications in medical reviews, these professors felt very concerned with scientific precision and clarity. Conversely, the occupational physicians sometimes argue only on their “experience”:

²³ These professors are often aware that their specialization still meets “difficulties to gain recognition”, according to a CGT unionist, who is a lecturer in occupational medicine and in professional diseases too (interview, 03/14/2002). Occupational medicine is usually the last or the one before last area chosen by the students of medicine who passed the “Internat” (in France, the “Internat” is the competitive exam that the students in medicine must pass in order to learn an area of competence). Source : Centre national des concours d’internat, Paris, France. For more precisions about the profession of occupational physicians in France, see Françoise Piotet (2002).

²⁴ The first of these experts, who was born in 1928, has been a chief of the Department of Rheumatology in a hospital of the smart suburbs of Paris. As honorific president of the French Society of Rheumatology and member of the American College of Rheumatology, he is recognized as one of the best French specialists in low back pain, about which he wrote many papers in French and Anglo-Saxon medical journals. The second one, who was born in 1918, a son and a grandson of physicians, was a chief of the Department of Rheumatology in two hospitals of Paris and its suburbs between 1960 and 1981. From 1981 to 1989, he was the dean of one of the major Faculties of Medicine in Paris. In 1990, he was elected as a member of the prestigious French Academy of Medicine, and he became the Assistant Secretary of this body in 1993.

“There are higher risks in certain occupations, and these risks should not be mistaken with predispositions. We cannot deny the experience of the occupational physicians who identify more low back pains in some occupations.”

“Contrary to what Pr. P. [one of the two professors of rheumatology paid by the CNPF] claims, it is not because an odd-ratio²⁵ is below two that it does not prove anything. The experience of occupational physicians cannot be denied.” (Source: minutes of a meeting of the Committee of Occupational Diseases in 4 June 1991, which were drawn up by a CFDT unionist)

However, these arguments founded on practical knowledge of the working conditions are rather illegitimate in a social space dominated by scientific knowledge. To a large extent, the discussions that take place in the Committee of Occupational Diseases consist in a confrontation of scientific evidence – *i.e.*, essentially papers published by medical reviews. The employers’ representatives are very rigorous on this subject, and one of their favourite strategies is to place the claims of the unionists under different kinds of “tests”²⁶ justified by scientific considerations:

“The favourite argument of T. [the physician who represents the CGPME] is: let us be careful not to use any study! When he says “any”, in particular there is what is edited by the *Archives des maladies professionnelles*, which are not always accurate, but they remain rather adequate French works, aren’t they? Then, according to T., that’s bullshit! [...] T. systematically demolishes *Les documents pour le médecin du travail* – he throws them before having read them with his own eyes. He can’t bear the *Archives*. So, we must... His scientific requirements are very... very important.” (Interview with a CGT unionist, 03/26/2002)

Therefore, the studies that have not been selected by journals whose scientific committees are renowned for their rigor are rejected (according to this point of view, English language journals are deemed as more reliable than French-speaking ones). For instance, an important research study led by the CFDT miners’ union in 1991-1992 about low-back pains of the employees of the Houillères du Bassin de Lorraine was not considered to be of any value; the employers’ representatives and their experts looked at the CFDT union member, a skilled worker in coal mines who took part in the study and presented its results to the members of the committee, quite condescendingly:

“[This unionist] was a very kind man, he is full of militant devotion. All the same, the CFDT union would be better with a expert.” (Interview with one of the Medef delegates, who was a head doctor in an important private firm, 05/28/2002)

“The Medef’s experts... they wouldn’t tell him, you don’t know anything about low back pain.” (Interview with a physician of the INRS, 02/14/2002) [Author’s translation].

These requirements make it more difficult for the unions to produce evidence. Furthermore, according to the employers’ delegation, a “fact” may be only proved by a great number of studies. Lastly, even if the unionists have succeeded in fulfilling these

²⁵ The odd-ratio of a pathology for a group of persons exposed to a particular risk is the ratio between the frequency of the pathology in this group and its frequency in a group that is supposed to be not exposed.

²⁶ We borrowed this term from Luc Boltanski and Laurent Thévenot (1997 : 161-185).

conditions, the employers' delegates require that all the studies that have been selected show high odd-ratios, and that they do not contradict each other. But, in epidemiology, the diversity of the methods and of the groups which are studied, on the one hand, and the biases which may occur in the analysis, on the other, make it very easy to find contradictory works that show odd-ratios close to 1 (which are considered non significant). If the union representatives succeed in producing evidence, they are attacked for having used studies which do not take into account French specificities:

"We must see the French working conditions... hence the problem raised by foreign studies. As for the miners, for example, the working conditions are not the same as they are abroad." (Interview with a Medef delegate, 02/01/2002)

So the position of the employers' delegates in the Committee of Occupational Diseases is to assert themselves as agents protecting scientific "truth" and "virtue". Consequently a table of occupational diseases cannot be built on the basis of doubtful knowledge:

"In this committee [...] we had to fight so that the decisions should be taken not only on a technical and scientific basis, but also on a social basis. We had to explain that the scientific bases are always more timorous than social knowledge, since, in the end, if you want to get scientific knowledge, you must always examine the elements, demonstrate them, etc. By the way, it explains that the scientists who are invited, most of the time, when they are facing T. [the CGPME delegate], who scrapes all the stuff of humanism, of good intentions, all that, because they comes like that, the experts! They come with fine ideas, you see, they will contribute to progress! T. snipes at them, he does scouring, all right, he strips the varnish, the coats: then he strips humanism, he strips good intentions, he strips positive uncertainties, and then, that's it, he goes up to the certainties! Well, if we had not gone further, the tables would be much less advanced than they are today." (Interview with a CGT unionist, 03/26/2002)

As they claim to be very meticulous about the production of evidence and as they require scientific "certainties", the employers' delegates can justify the multiplication in the number of "tests" that the unionists must pass. Actually, by ceaselessly asking for "additional studies", they are able not only to reduce the extension of the table of occupational diseases, but they can also get the discussions to go round in circles:

"The game is easy to understand. For the employers' organizations, the aim is to let the situation deteriorate, and to make it last as long as possible. Because as we quibble— I am speaking in a rather... caricatural way, because after a while, we quibble. In the beginning, we discuss, quite seriously, then, after some time, there is no use discussing any longer. But during this time, they get quite a deal out of this! Because the table will not be created, the table will not be modified, and so there will not be any declaration and compensation of victims." (Interview with the delegate of the FNATH, 12/03/2001)

If the constraint of scientific argumentation is so important within the Committee of Occupational Diseases, it is because some of its members continually fall back on this norm. Though some doctors and some unionists argue for a less strict interpretation of this it, they cannot object to its principle. The existence of people, who are supposed to be "neutral", like the president of the committee and the "qualified

members”, also compels the members of the committee to abide by the rules of scientific discussion²⁷.

The debates of the Committee of Occupational Diseases can be characterized by the introduction of rules of discussion followed in the medical field. However, the constraints of scientific argumentation do not really alter the pre-existing relations of power: indeed, the employers’ delegates accept this constraint as long as it enables them to give no more than minimal concessions to the unions. This norm also compels the unionists to restrict their claims to what “science” allows them to say, and it makes the formation of compromises that favour employers’ interests easier.

The primacy of the clinical eye

As we have argued, the predominance of the professors of rheumatology during the meetings of the Committee of Occupational Diseases that dealt with low back pain could be explained by their dominant position in the medical field, compared to that of occupational physicians and practitioners. Nevertheless, it is also related to the way tables of occupational diseases are generated. Indeed, the creation of a table requires that its three columns to be filled in (see the examples of tables given above). Among these three columns, the first one (clinical definition of the pathology) and the third one (list of occupations) are the ones that are subject to the longest debates. But the discussions about the first column are the most crucial ones. Though a table of occupational diseases may be modified later, it is much more difficult to change the first column than the third one: whereas the third column may be changed without changing the first one, the contrary is nearly impossible²⁸. Therefore, obtaining a restrictive definition of the pathology which appears in the first column, is the easiest way for the employers’ delegates to “lock” a table of occupational diseases.

But the creation of the first column does not require the same skills as the third one: the former requires the skills of a clinical specialist, the latter the skills of occupational physicians. The structure of the tables favours the clinical specialists, even though, due to the division of medical labour, they usually have a very little knowledge of occupational risks.

²⁷ Jon Elster (1991) noticed that point. Since its creation, the Committee of Occupational Diseases has always been presided by a scientist: first, from 1984 to 1996, by a famous toxicologist, who founded the first Emergency Poison Unit in France, then by the director of a laboratory at the Centre of Atomic Energy (CEA) in France. The president of the committee endeavours to compel the members of the meetings to obey the rules of reasoned discussion, where all “heated debate” or all “provocation” must be avoided. This explains that the decisions of the president of the committee, which are usually a compromise between the unionists and the employers’ delegates, as we said above, are not subjected to a vote: a device that belongs to the “civic city”, according to the terms of Boltanski and Thévenot (1997), cannot be used to conclude a discussion that is claimed to be scientific.

²⁸ Changing the definition of the pathology amounts to say it is not the same pathology : so the list of occupations, which was adequate to the first definition, may not be to the second one.

THE CLINICAL DISCUSSION

Since a clear clinical description of the pathology was required, the composition of the first column of the table about low back pain implied intricate problems. It is very difficult to objectify low back pains. They are not necessarily related to spinal lesions: somebody may suffer a lot from low-back pain without any spinal lesions, whereas someone else may have important lesions without suffering. This allowed the employers' delegation to argue from the outset that low back pain could not be codified in a table of occupational diseases²⁹. The professors of rheumatology also advocated this position:

“Pr. A. (CNPf expert) specifies that there may not be an anatomic lesion in all the cases of low back pain. The X-rays are often negative. [...] Low back pain is rarely a lesion, but more usually a symptom.

Consequently, he thinks that the construction of a table cannot be considered, since the criteria cannot be established easily.” (Source: minutes of the meeting of 22 June 1994, drawn up by the ministry of labour)

As the physicians cannot base their diagnosis on “objective” anatomic lesions, they must trust the patient and their “subjective” expression of pain. This leads to the possibility of charging the plaintiffs with cheating in order to receive compensation from the Branch of Industrial Injuries and Occupational Diseases:

“Some doctors told us, you know, the radio, and even the scanner, do not always bring a solution, you see? It means that sometimes, we see spines completely distorted, and people do not suffer from them, but other people have correct spines, where you do not see anything, and they suffer. And they suffer, really! I think that they are not always storytellers, or people who cheat. [...] This is T.'s old story [the CGPME delegate], how many times did he tell us about cheats! How many times did he tell: I don't want to compensate for cheats! Anyway, the victim of an industrial injury or of an occupational disease is often seen as a person who tries to take advantage of the system. [...] This is the old story we have got used to, you see.” (Interview with the FNATH delegate, 12/03/2001)

Therefore, the union representatives endeavoured to bring the employers' experts to distinguish the pathologies that could be defined in an “objective” way, to distinguish “what exists” (clinically speaking) from “what it does not”:

“We saw that there was no progress, you see, that it could not make progress. So we talked again to know what to do with it, and progressively we discovered that the logics of expertise, in the employers' side, compelled them to define things. Because the strategy of [the CGPME delegate] is to intimidate the experts, to block everything, so that he never tells us... he never shows his cards! On the contrary, the experts who were there did not want to be taken for fools [...]! So those specialists could not have the same logics as [the CGPME delegate], because they were to be doctors, experts. So progressively we succeeded in... titillating them, by saying: – Wait! You say that low back

²⁹ At a meeting in March 1991, the CNPF delegate argued : “A table must be built on an lesion. Is low back pain a lesion ? It is a major legal point.” (According to the minutes drawn up by a CFDT unionist. Underlined by the unionist himself).

pain... but what exists? Sciatica exists, does it not? Such are the debates at the committee, you see! Then: – Of course! But wait... And then we go on discussing, and then, little by little, we brought them to write that sciatica existed. [...] We made them entrench in their logic, by saying: – Wait, if it exists, you refer to your great masters in rheumatology, they described symptoms, they described a disease, so, if they described it, it is a delimited pathology, so we can put it in the table!” (Interview with a CGT unionist, 26/03/2002)

As they were constrained to by their status as “renowned professors of medicine”, the CNPF experts could not, in a committee in which most of the members were doctors, deny some “facts” that were taken for granted in their scientific community without losing their scientific credibility. Besides, these professors were less involved than employers’ delegates in the Committee of Occupational Diseases. They were paid to give their point of view on a single pathology – low back pain –; they were not the regular experts representing the employers’ organizations. So the cost of the loss of their scientific integrity would not have been compensated by the momentary benefits of their status as employers’ experts³⁰. At a meeting of the second workshop, in January 1995, one of them admitted that contrary to low back pain, which is not a delimited pathology, sciatica might be recognized as an occupational disease:

“Pr. A. specifies that occupational low back pain raises great difficulties of classification. Indeed, the classification of low back pains did not make progress at the international level, and the classification (coming from Quebec) that some people use is not satisfying. In these conditions, he thinks that low back pain does not fit the legal frame of occupational diseases.

Conversely, a sciatica of traumatic origin that is not getting better, a sciatica that resulted from an industrial injury might be taken in charge if the compensation received as an industrial injury is not enough.” (According to the ministerial minutes of the meeting of 25 January 1995)

At this, the employers’ delegates ordered their experts to prepare a report. According to this report, two kinds of pathology might be recognized as occupational diseases: sciaticas and crural neuralgias related to a herniated disc. Consequently, an anatomic lesion could identify some low back pain: a herniated disc is a spine distortion that may induce a compression of the roots of certain nerves. If it reaches the sciatic nerve, it can cause sciatica; if it reaches the crural nerve, crural neuralgia. These pathologies are “quite clear diseases”, as one of the employers’ experts noticed in a meeting of May 1995, which led the CGPME delegate to admit, that “if they are related to herniated discs, they might be admitted” (Source: Ministerial minutes of the meeting of 10 May 1995).

³⁰ One of these professors told us that while he was a CNPF expert at the Committee of Occupational Diseases, he had been approached to take part in a public collective expertise about low back pain. He wanted to give up his functions as a CNPF expert and to accept this more prestigious task: “I did not care about CNPF. I could not be at the INSERM [the public research institution that led the collective expertise] and at the Committee of Occupational Diseases as an expert at the same time.” (Interview, 05/15/2002). However, as he could not get the management of the collective expertise, he renounced it and kept on taking part in the meetings of the Committee of Occupational Diseases.

According to the unions, the relative autonomy of the professors of rheumatology from the employers' delegates enabled them to make the talks progress. Nonetheless, we must point out that if the employers' representatives were content with the propositions of their experts, it is due to the fact that sciaticas and crural neuralgias related to a herniated disc represented only a few of the cases of chronic low back pain. In other words, the unionists obtained minimum concessions: they had to be content with "having broken through the system" in accordance with their stated strategy. Moreover, they had to comply with the requirements of the employers' experts to obtain a concession from them: they had to accept that only a pathology that "exists" in a clinical way, meaning a disease that is *always* related to anatomic lesions, could be codified in a table of occupational diseases; this reduced the number of pathologies that could receive compensation considerably. Thus, the creation of the first column of the table sanctioned a very narrow definition of the notion of pathology, which does not take the subjective pain of the patients into account. This definition suited the discourse of both the employers' delegates and the professors of rheumatology, but for different reasons. According to the representatives, this would prevent abuse of the workers, of the "cheats"; while for the professors it would correspond to a traditional – and a rather conservative – conception of the notion of disease, which assumes that only what may be seen with the naked eye or with an adequate device exists³¹. The convergence of points of view between employers' delegates and professors of medicine cannot be explained merely by a supposed common interest, which should result from their common belonging to dominant classes, but by the specific logics of each field and by the homologies of the positions of these actors within each field (the convergence of points of view between union representatives and occupational physicians must be explained in the same way).

THE CONCESSIONS TO OCCUPATIONAL PHYSICIANS AND TO EPIDEMIOLOGY

In January 1995, when the union delegation worked out a new draft of the table of occupational diseases, it included three categories of risks that may favour low back pain: 1) the manual handling of heavy items, 2) vibrations that are transmitted to the whole body, and 3) some working postures (like staying in the same position for long stretches of time). The last category of risks was quickly rejected, because it characterized most occupations. Therefore only the risks linked to the handling of heavy items and to vibrations were kept in the tables. The employers' representatives could not question the first one, since they were acknowledged by many scientific studies and, above all, it would have been obvious. On the contrary, vibrations were a matter of intense controversy.

Indeed, the resources of the unionists were more adequate to this discussion than those which dealt with the clinical definition of the disease. The CGT representative who, as a hospital practitioner and a lecturer in occupational medicine, often speaks on behalf of the unions' delegation, was very well informed about the impact of vibrations on the human body: his Ph.D. thesis dealt with that subject, and he directed a laboratory specialized in spinal anatomy in a hospital of suburban Paris. So this delegate could

³¹ About this point, see Foucault (2000 : 107-124)

demonstrate knowledge of a number of studies about vibrations and their impact on lumbar discs, including many English language works. Moreover, precautionary measures dealing with the dangers of vibrations acknowledged the existence of this risk³², as some members of the committee noticed:

A CFDT member “notices that the amounts of money that several firms have spent to warn from these risks obviously acknowledged to their existence. It is the same thing for the INRS; otherwise this body would not have made so many efforts to improve the protection of farm tractors and to carry out so many studies about this subject... So he is surprised that other studies, in particular cohort studies, may be required, whereas all health care services agree in acknowledging the risks related to vibrations.” (Source: Ministerial minutes of the meeting of 10 May 1995)

“ Dr A. [a qualified member, a retired head doctor in coal industry], referring to his experience in coal industry, notes that the risks related to building machines are an obvious clinical matter. He adds that one argument at least proves that the relationship between those pathologies and vibrations has been known for a long time: it is the implementation of preventive rules by firms, and the studies carried out to settle ergonomic equipments.” (Ministerial minutes of the meeting of 18 September 1995)

Lastly, the unions benefited from the support of INRS doctors. The INRS, which employs renowned specialists in vibrations, has conducted extensive research in this matter for twenty years. In 1987, it was ordered by the health national service, the CNAMTS, to perform an influential study about the impact of occupational constraints on lumbar discs. This study, which took two years to conduct, looked at about 2000 workers. In the first synthesis of this work in 1993 the authors concluded that “serious low back pain, which is identified by a sciatica, is more frequent among groups exposed to manual handling and to vibrations than among reference groups.” The INRS representative at the Committee of Occupational Diseases, who knew about the conclusions of this investigation, invited the occupational physician who directed it to address the committee’s proceedings. At a meeting in June 1994, he claimed that “the culpability of vibrations and of hard physical work in causing serious low back pain has been proved” by his study. At the next meeting, in January 1995, a paper that summed up the conclusions of his research was handed out to all the members of the committee. But the crucial talks began at the following meeting, in May 1995. At once, the professors of rheumatology questioned the impact of vibrations on low back pain. In a study they wrote for this meeting, they asserted that “no physiopathologic argument points to the role of vibrations in causing spinal damage or herniated discs”. They criticized the INRS study, by specifying that it did not use “a clear definition” of the pathology, and that biases probably make more cases of low back pain appear than there should be:

³² The French Agency of Normalization (AFNOR) edited, in 1990, a norm dealing with “the assessment of expositions to vibrations on the whole body” (NF E60-401-2 norm). This norm backed on an international norm (ISO 2631-1) of 1985.

“We must notice that the aim of the study had been explained to the people who were interviewed, which induces a bias [...]. Indeed, the interviewees had been told about the aim of the study by three posters.” (Ministerial minutes of the meeting of 10 may 1995)

Finally, they expressed doubts about the skills of one of the researchers, by noting that “it seems that the interviewer is not a doctor”. So they rejected the assertion that low back pain may be caused by vibrations, relying on their clinical experience:

“I am a practitioner: I saw thousands of people suffering from low back pain, and I have never seen anybody having low back pain caused by vibrations. I cannot admit that I had a biased population during 35 or 40 years.” (Interview with one of the CNPF experts, 05/25/2002)

However, the employers’ experts could not sustain this point of view for too long, as recounted by a union delegate:

“We succeeded because we had arguments, in particular about building machines, about which they couldn’t argue in depth. P. [one of the employers’ experts] told us: – All right, I’ve got a tractor to cut the grass [and no low back pain]..., he said that! – *He said it?* – Of course, he said that, I was right there, facing him! [...] Then, you see, they could not stand this position for long, since it was too outrageous, even the president of the committee, who was not supposed to have any experience in this matter, knew very well that a man who uses a building engine or a farm tractor or a forestry engine is exposed to vibrations. And then we had levels and measurements! So we could demonstrate that there was a huge ratio between the vibrations of a bus or of a truck and its driver! So it was so outrageous that they could not stand their ground for too long.” (Interview with a CGT unionist, 03/26/2002)

As a consequence of the opposition of the professors of rheumatology, who rejected vibrations as a cause of low back pain, the success of the union position eventually hung on the decision of the president of the committee. The accumulation of scientific data was in their favour. Regardless, they had already given a major concession by accepting a narrow definition of the pathology in the first column of the table. This concession strongly minimized the financial impact of the compensation of an additional category of risks³³. It follows that when the president of the committee decided to maintain vibrations as a cause of risks in the meeting of June 1996, he was not strongly opposed by the employers’ delegates.

Conclusion

Far from being merely technical decisions, the codification of occupational diseases is the result of a series of compromises between representatives of the employers’ organizations and of the labour unions, as the debates about lower back pain illustrate. The codification of Occupational Diseases is usually very restrictive. First, it can be

³³ The table of occupational diseases number 98, which deals with vibrations, led to the compensation of only 117 people in 1999 and 396 in 2000 (Source : CNAMTS, Department of occupational risks).

explained by the weakness of the unions who sit at the Committee of Occupational Diseases in terms of resources, and even of the Ministry of Labour if compared to the resources of the delegates of the employers' organizations and, in particular, of the Medef. But it is also due to the structure of the tables of occupational diseases and above all to the dominance of the scientific medical field in the discussions, since they enable research expertise to prevail over epidemiology and practical knowledge of working conditions. So the unions' delegates tend to content with "micro victories" which require tedious efforts, instead of real progress in the codification of occupational diseases.

Owing to the relative autonomy of the fields of expertise – which can be more or less important –, the primacy of an argumentative frame – here, what we called the "clinical eye" – cannot be explained only by the distribution of resources between the major protagonists in the debates studied: it also requires a study of some structural features of the fields of expertise, and, in particular, of their internal relations of power. Thus an analysis of the uses and of the impact of expertise in the public sphere cannot be only considered as a "passive" resource: expertise is also a field of specific struggles, and the work of political scientists should be to study in which ways they add to the disputes between interest groups about policy choices³⁴.

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³⁴ For instance, Le Baron (2000) studied these struggles between economists and their impact on public policies.

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Appendix

Tableau n° 97 – Régime general

Affections chroniques du rachis lombaire provoquées par des vibrations de basses et moyennes fréquences transmises au corps entier

Date de création: 16 février 1999
(décret du 15 février 1999)

Dernière mise à jour: -

| <i>Désignation de la maladie</i> | <i>Délai de prise en charge</i> | <i>Liste limitative des travaux susceptibles de provoquer ces maladies</i> |
|--|--|--|
| <p>Sciatique par hernie discale L4-L5 ou L5-S1 avec atteinte radiculaire de topographie concordante.</p> <p>Radiculalgie crurale par hernie discale L2-L3 ou L3-L4 ou L4-L5, avec atteinte radiculaire de topographie concordante.</p> | <p>6 mois (sous réserve d'une durée d'exposition de 5 ans)</p> | <p>Travaux exposant habituellement aux vibrations de basses et moyennes fréquences transmises au corps entier:</p> <ul style="list-style-type: none"> - par l'utilisation ou la conduite des engins et véhicules tout terrain: chargeuse, pelleuse, chargeuse-pelleuse, niveleuse, rouleau vibrant, camion tombereau, décapeuse, chariot élévateur, chargeuse sur pneus ou chenilleuse, bouteur, tracteur agricole ou forestier; - par l'utilisation ou la conduite des engins et matériels industriels: chariot automoteur à conducteur porté, portique, pont roulant, grue de chantier, crible, concasseur, broyeur; - par la conduite de tracteur routier et de camion monobloc. |

Tableau n° 98 – Régime general

Affections chroniques du rachis lombaire provoquées par la manutention manuelle de charges Lourdes

Date de création: 16 février 1999
(décret du 15 février 1999)

Dernière mise à jour: -

| <i>Désignation de la maladie</i> | <i>Délai de prise en charge</i> | <i>Liste limitative des travaux susceptibles de provoquer ces maladies</i> |
|--|--|---|
| <p>Sciatique par hernie discale L4-L5 ou L5-S1 avec atteinte radiculaire de topographie concordante.</p> <p>Radiculalgie crurale par hernie discale L2-L3 ou L3-L4 ou L4-L5, avec atteinte radiculaire de topographie concordante.</p> | <p>6 mois (sous réserve d'une durée d'exposition de 5 ans)</p> | <p>Travaux de manutention manuelle habituelle de charges lourdes effectués:</p> <ul style="list-style-type: none"> - dans le fret routier, maritime, ferroviaire, aérien; - dans le bâtiment, le gros œuvre, les travaux publics; - dans les mines et carrières; - dans le ramassage d'ordures ménagères et de déchets industriels; - dans le déménagement, les garde-meubles; - dans les abattoirs et les entreprises d'équarrissage; - dans le chargement et le déchargement en cours de fabrication, dans la livraison, y compris pour le compte d'autrui, le stockage et la répartition des produits industriels et alimentaires, agricoles et forestiers; - dans le cadre des soins médicaux et paramédicaux incluant la manutention de personnes; - dans le cadre du brancardage et du transport des malades; - dans les travaux funéraires |