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Werken aan arbeidsongeschiktheid.
Hoe ambtenaren, medisch experts en gehandicapte werkers arbeidsongeschiktheid in praktijk brachten in de context van de Ongevallenwet (1901-1967)
(met een samenvatting in het Nederlands)

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Introduction

Incapacity for work seems to be a clear phenomenon. It indicates a person is unable to perform labour. Often incapacity for work is associated with a deficiency in the body or a dysfunctional mental state, or it is considered a matter of individual misfortune which inevitably leads to poverty. And thus, the history of social security legislation mainly deals with the ways in which people were compensated by the state for the financial consequences of this incapacity. Disability scholars have, however, claimed that incapacity for work is a social construct and has nothing to do with deficient bodies, but instead is produced by capitalist societies and work environments that fail to recognise the diverse ways in which people perform labour. Despite its contested nature, incapacity for work is a concept that people use. It is measured and quantified. It is the subject of medical training, care and rehabilitation. It offers a ground for receiving benefits. It is a phenomenon which people can embody in full or in part. It can be exaggerated or simulated. Likewise, it can also be a source of sadness, pain or pity. In short, incapacity for work exists as something real. It can, however, be many things arising from actions and practices, and its manifestations have material consequences.

This dissertation provides a fresh look at the ways in which incapacity for work has historically been produced. Taking an ontological multiplicity as a starting point, it analyses the actions and practices that have created and sustained the phenomenon of incapacity for work. It examines how it was enacted not only through social security legislation, but also through the interactions between the officials who implemented policies, the medical experts who testified about the nature, veracity and severity of the incapacity for work, and the individuals whose working capacity was under scrutiny. How did these actors navigate the legal policy provided by social security legislation? How did they apply, change or use it to match their values, knowledge, experiences or interests? What realities of incapacity for work can be traced from these interactions? What practices made these enactments appear or change over time, and what material consequences did they bring about? The answers to these questions reveal what incapacity for work could be historically.

Making up incapacity for work in the Dutch Industrial Injuries Insurance Act

This dissertation takes as its object of research disputes over claim assessments under the first Dutch Industrial Injuries Insurance Act (the *Ongevallenwet*). This act, which was introduced in 1901 and extended in 1921, regulated insurance to cover disability payments following workplace accidents. It provided disabled workers with temporary or permanent benefits to compensate financially for the loss of working capacity due to injury sustained at work. Officers in the service of the Rijksverzekeringsbank, the state in-

surance bank[1] that was charged with the execution of the Act, had to determine whether workers were able to work and whether they were eligible for benefit. The Act stipulated that a worker who was fully incapable of working would receive 70% of their former daily wage. Through examination and observation, officers in the service of the Rijksverzekeringsbank had to estimate a percentage of incapacity for work that corresponded with the *actual abilities* of the worker in question. Disabled workers[2] could lodge an appeal against this decision by the state bank, which was considered by a local council of appeal. Both the worker and the Rijksverzekeringsbank could then lodge another appeal, which was considered by the supreme court, the Central Council of Appeal (*Centrale Raad van Beroep*). In most of these higher appeal cases, physicians were consulted as expert witnesses, embodying a knowledgeable and neutral perspective. In these cases, the dispute centred on the question of the extent to which a worker was incapable of working. And thus, the state bank, the medical experts and the worker all took part in a quest to find the properties of incapacity for work.

Complicated as it was already, this search was, moreover, burdened with constant worries about fraud. In the historiography of the welfare state, the introduction of acts like the Industrial Injuries Insurance Act marks a moment in time in which societies started to take care of the victims of individual misfortune, a process that happened in many European countries at the beginning of the twentieth century.[3] These new forms of state-funded compensation for the loss of income due to disabilities came with a pressing individual responsibility to not abuse this social security arrangement.[4] From

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1 The word 'bank' in the name of the Rijksverzekeringsbank referred to the fact that it was also in charge of collecting premiums and distributing money to beneficiaries. It was not a consumer bank.

2 The historical actors often referred to these persons as victims (*getroffenen*), reflecting a notion of disability as an individual misfortune. In this dissertation I aim to show that this term does not do justice to the complexity of the experiences of disabled workers. I have therefore chosen to use 'disabled workers' as this reflects their position in the context of the Industrial Injuries Insurance Act. They claimed benefits because they were considered by the law to be workers. Although, as we will see later on in this dissertation, class was an important element in the assessment of benefit claims, I have chosen not to use the term labourer, because it suggests that all these people were part of the working class, which was the case for the first version of the Industrial Injuries Insurance Act, but not for the reformed version of the Act, which covered workers in all industries and occupations. There is also much debate about the use of identity-first or person-first language. While person-first language ('persons with disabilities') aims to emphasise that a person is more than their disabilities, identity-first language ('disabled persons') sees disability as a prominent social identifier and aims to reclaim pride in it. Although preferences may differ among individuals and communities, it is currently the prevailing norm within disability studies to use identity-first language, because it reflects the social model of disability.

3 Abram de Swaan, *In Care of State: Health Care, Education and Welfare in Europe and the USA in the Modern Era* (Cambridge: Polity Press 1988).

4 Deborah Stone, *The Disabled State* (Philadelphia, Temple University Press 1984).

the start, there were politicians, doctors, journalists and company owners who worried about the possibility of workers simulating injuries to fraudulently claim benefit. In the Netherlands these worries increased when the Industrial Injuries Insurance Act came into force, and the number of claims kept rising.[5] The Rijksverzekeringsbank therefore was tasked with making sure only the people who were truly incapable of working would receive benefit. But when was a person *truly* incapable of working? In short, disability benefit legislation necessitated classification and norms that could be used to determine which workers were included and which excluded from receiving benefit.

As philosophers of science have shown, classifications are moving targets that interact with our investigations. Ian Hacking has argued that all sorts of labelling processes make up the group of people being described. Because although we think that labels and categorisations describe kinds of people with definite properties, and research helps to gain more knowledge of these characteristics, in practice, classifications are constantly adapted and changed when they are applied.[6] In a similar manner, Annemarie Mol has analysed medical labels as brought into existence through practices. The reality of classifications is *enacted*, as Mol calls it. It is what works as reality that subsequently turns into a reality. Moreover, Mol argues that this 'making up' is not a top-down process; instead, it is done in interactions between regulations, doctors, measurement schemes, patients, instruments etc that refer to each other: there is no ultimate signifier.[7]

When classifications make up the group of people being described, this fundamentally changes the way social security legislation works. While the disability benefit scheme of the Industrial Injuries Insurance Act was intended to avert poverty and help individual workers, the corresponding classifications required to substantiate boundaries determining who was included in a way that not only described the group of workers, but also brought incapacity for work into being.

This 'bringing into being' is central to this dissertation. It examines the historical search for identifying properties of incapacity for work as a process of 'making up' incapacity for work. I have not searched for the true properties of incapacity for work, the quest with which the historical actors were concerned, but instead focus on how this

5 The Rijksverzekeringsbank was charged with the administration of accident statistics. For an overview see: National Archives, The Hague, 2.15.55, Ministerie van Sociale Zaken en Werkgelegenheid: Rijksverzekeringsbank, Inv. No. 336-373, Ongevallenstatistiek 1903-1956. For an overview of the costs, as calculated by the accident fund that managed the income and expenses, see: National Archives The Hague, 2.15.55, Ministerie van Sociale Zaken en Werkgelegenheid: Rijksverzekeringsbank, Inv. No. 375-384, Vijfjarige balans van het Ongevallenfonds 1903-1954.

6 Ian Hacking, *Historical Ontology* (Harvard: Harvard University Press 2002), Ian Hacking, "Making up people", *London Review of Books* 28.16 (2006) 23-26.

7 Annemarie Mol, *The Body Multiple: Ontology in Medical Practice* (Durham: Duke University Press 2002).

search, in fact, produced the incapacity for work it aimed to describe. This dissertation therefore seeks to answer the following research question: How was incapacity for work made up in the execution practices of the Industrial Injuries Insurance Act?[8]

To explain the need for this focus on interaction and practice, I will first discuss the theoretical grounding of this dissertation and the origin of my research question. Then I will reflect on what this new approach to incapacity for work adds to existing research on the history of welfare, medical expertise and disability. I will then describe the practical application of this approach by reflecting on the sources that I use and on the methodology applied.

I THEORY

Materiality in practice

In histories of disability benefit, incapacity for work is usually studied as the result of a malfunctioning body. There is much debate on why societies started to implement social security legislation, but scholars share the assumption that its goal was to avert some of the financial consequences of individual misfortune caused by disability.[9] This seemingly neutral notion of disability resulting from an ill or deficient biological body is an example of what scholars in the field of disability studies call 'the medical model' of disability. The medical model analyses the malfunctioning body as the cause of individual problems. People need help to be cured, fixed or make adjustments so that they can participate in society. This notion of disability is omnipresent in all parts of modern-day society, not just in medicine and health sciences, but also in social policy and social security arrangements.[10] And thus it is small wonder that historians have often analysed the history of the welfare state using a medical model approach to things like disability and incapacity for work. For this dissertation, however, I turn to the field of disability studies to theorise

8 I use 'making up', 'enacting' and 'bringing into being' interchangeably, although I am aware that the connotations of each term may differ slightly. Hacking's use of the term 'making up', for instance, may suggest that there is an agent who intentionally produces incapacity for work in a certain manner, whereas Mol's 'enactment' seems less intentional. In my dissertation, I consider incapacity for work as something that arises in legal practices and interactions between different actors. While these actors may have had all kinds of intentions, I do not view them as part of an overarching plan or aim, but rather as navigations. My focus is on the specific understandings of incapacity for work that emerge in different interactions.

9 De Swaan, *In Care of the State* (Cambridge: Polity Press 1988).

10 Rachel Adams, Benjamin Reiss and David Serlin (eds.) *Keywords for Disability Studies* (New York: New York University Press 2015) 1-11, Alan Roulstone and Simon Prideaux, *Understanding Disability Policy* (Bristol: Policy Press 2012) 1-20.

the concept of incapacity for work, and in this field, the medical model is criticised and disability is explicitly considered not to be an individual problem.

Disability studies and the problem of the missing body

Disability studies is a relatively new, yet burgeoning field of inquiry.[11] Stemming from constructivist epistemology and influenced by the cultural turn, scholars have dedicated their research to the deconstruction of modernist notions of excluding categories inscribed on the body. They share a Foucauldian suspicion of practices in which bodies and minds are diagnosed and become subject to medical intervention to make them conform to normative health standards.[12] Disability studies is an interdisciplinary field, but it is mainly literary scholars who have done a great deal of the work with a historical component. Over the past twenty years, more historians have started to engage in the field.[13] In her famous essay in *The American Historical Review*, Catherine Kudlick stresses

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11 Although still predominantly an Anglo-Saxon affair, research on disability in the Netherlands has been limited. Luc Brants, Paul van Trigt and Alice Schippers attribute this to the lack of organised disability activism in the Netherlands. There have been self-advocacy groups since the 1970s, but they are fragmented and have long been organised along the lines of different disabilities. In addition, these groups and associations have mainly acted as spokespeople for service providers and government officials and have not put much emphasis on civil rights, as has been the case in the United States. In 2009, the institute Disability Studies in the Netherlands (*Disability Studies in Nederland*) was established to initiate research on disability studies in the Netherlands. Rooted in the disability rights principle 'nothing about us without us', its mission is to conduct research in which disabled people are strongly involved. Geert van Hove, Alice Schippers, Mieke Cardol and Elisabeth de Schauwer (eds.) *Disability Studies in de Lage Landen* (Antwerpen and Apeldoorn: Garant Uitgevers 2016), Luc Brants, Paul van Trigt and Alice Schippers, 'A Short History of Approaches to Disability in the Netherlands', in: Roy Hanes, Ivan Brown and Nancy Hansen (eds.) *The Routledge History of Disability* (London 2017) 151-162.

12 There are many great examples. This is a very small selection of the invaluable work that has been done: Paul Longmore, *Why I Burned My Book and Other Essays on Disability* (Philadelphia: Temple University Press 2003), Shelley Tremain (ed.), *Foucault and the Government of Disability* (Ann Arbor: University of Michigan Press 2005), Rosemarie Garland-Thomson, *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature* (New York: Columbia University Press 1997), Rosemarie Garland-Thomson, *Staring: How We Look* (Oxford and New York: Oxford University Press 2009). For an overview of current debates in disability studies the Disability Studies Reader is very insightful, see: Lennard Davis (ed.) *The Disability Studies Reader 5th edition* (New York: Routledge 2017).

13 In the last decade, more European historians have entered the field. See for example: Sebastian Barsch, Anne Klein and Pieter Verstraete (eds.), *The Imperfect Historian. Disability Histories in Europe* (Frankfurt am Main 2013), Jenni Kuulia, *Childhood Disability and Social Integration in the Middle Ages. Constructions of Impairments in Thirteenth- and Fourteenth-Century Canonization Processes* (Turnhout: Brepols 2016), Monika Báar and Paul van Trigt (ed.) *Marginalized Groups, Inequalities and the Post-War Welfare State. Whose Welfare?* (London: Routledge 2019), Manon Parry, Corrie Tijsseling and Paul van Trigt, 'Slow, Uncomfortable and Badly Paid. DisPLACE and the Benefits of Disability History', in: Adele Chynoweth, Bernadette Lynch, Klaus Petersen and Sarah Smed (eds.), *Museums and Social Change: Challenging the Unhelpful Museum* (London: Routledge 2020) 149-159, Ninon Dubourg, *Disabled Clerics in the Late Middle Ages. Un/suitable for Divine Service?* (Amsterdam: Amsterdam University Press 2023).

the importance of placing disability centre stage in historical research, using disability as a political category to analyse how society deals with difference.[14] Historians working in the field have not only aimed at bringing the lives of persons with disabilities in the past to light, but are also tracing the cultural origins of present-day notions of disability as a biological and individual concept.[15]

In opposition to the medical model of disability, disability scholars introduced the social model of disability, in which the abnormal, impaired or deviant body is a result of the construction of the normal body. They claim stigma and socio-economic disadvantages cannot be attributed to impairments, but to social attitudes towards deviation and diversity.[16] Moreover, as historical studies have shown, diagnostic categories such as hysteria, deafness or homosexuality were often used to justify inequality and exclusion. What is considered as falling under the label 'disabled' therefore always depends on what counts as normal.

This analysis of how disability was constructed in the past, which considers it to be contingent and culturally constructed, is in fact, rather similar to the way feminist and critical race scholars have conducted research on gender and race. Following debates about the ontology of the body in gender and feminist studies, the argument of the social model of disability has been pushed further by disability rights advocates and scholars, such as Mike Oliver, who stress that the disability has nothing to do with bodily functioning.[17] They let go of a distinction between impairment and disability, and consider the impaired body to be a cultural construct.[18] When following this line of reasoning, incapacity for work does not result from a deficient body, but instead stems from a labour market that only targets normative bodies and corresponding production norms.

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14 Catherine Kudlick, 'Disability History. Why We Need Another "Other"', *The American Historical Review* 108.3 (2003) 763-793.

15 See for a detailed discussion of the field: Michael Rembis, Catherine J. Kudlick and Kim Nielsen, *The Oxford Handbook of Disability History* (Oxford, Oxford University Press 2019), Daniel Blackie and Alexia Moncrieff, "State of the Field: Disability History", *History* 107.377 (2022) 789-811.

16 See for instance, Mike Oliver, *The Politics of Disablement* (Basingtoke: Palgrave McMillan 1990), Lennard Davis, "Constructing Normalcy", in: Lennard Davis (ed.), *The Disability Studies Reader* (New York: Routledge 1997).

17 Mike Oliver, *Understanding Disability, from Theory to Practice* (London: Palgrave MacMillan 1996) 4-5. For a reflection on the implementation of the social model, see: Mike Oliver, "The Social Model of Disability: Thirty Years On", *Disability & Society* 28.7 (2013) 1024-1026.

18 See for instance Shelly Tremain, "Foucault, Government and Critical Disability Studies", in: Shelly Tremain (ed.), *Foucault and the Government of Disability* (Ann Arbor: University of Michigan Press 2005) 1-24, Mairian Corker and Tom Shakespeare, "Mapping the terrain", in: Mairian Corker and Tom Shakespeare (ed.), *Disability/Modernity. Embodying Disability Theory* (London: Bloomsbury 2002) 1-17.

This constructivist foundation of the social model has, however, come under attack for its neglect or rejection of matter. Dan Goodly has claimed that disability studies suffers from 'somatophobia'. He maintains that while rightfully criticising the medical model for its excluding, stigmatising and discriminating tendencies, the social model ignores the existence of illness and impairments.[19] In like manner, Mairian Corker and Tom Shakespeare have argued that the social model has become an all-encompassing excluding theory in itself. The notion that disability is a cultural construct also suppresses diversity, they write, since it neglects the possibility that some impairments are static or even terminal, and disabled persons can in fact experience this as tragic.[20] Impairments constitute a variety of (social) realities, which cannot be ignored or separated from disability.[21] Others have moreover questioned the social model for its lack of room for the possibility to perceive pain, tiredness, hunger or itching as real. A purely constructivist notion of reality leaves no room for these kinds of embodied experience, they claim.[22] This can be linked to debates in disability studies about disability identity. For while the medical model makes disability identity a bodily fact, Simi Linton has emphasised that social conditions have forged people into groups and turned disability into a political identity, an alliance to fight discrimination.[23] However crucial the political impact of this social disability identity, Lennard Davis stresses that this social disability identity is still grounded in a narrative of oppression and perpetuates a binary between nature and culture. Davis sees disability identity as an unstable category, that is constantly in flux.[24] Similarly, Tobin Siebers refers

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19 Dan Goodly, "Dis/entangling Critical Disability Studies", *Disability & Society* 28.5 (2013) 631-644.

20 'Both the medical model and the social model seek to explain disability universally, and end up creating totalizing, meta-historical narratives that exclude important dimensions of disabled people's lives and their knowledge. The global experience of disabled people is too complex to be rendered within one unitary model or set of ideas.' Corker and Shakespeare, "Mapping the Terrain", 15.

21 Ibidem, 1-17.

22 Bill Hughes, "Disability and the Body" in: Colin Barnes, Mike Oliver and Len Barton (eds.) *Disability Studies Today* (Cambridge: Cambridge University Press 2002) 58-76, Bill Hughes and Kevin Paterson, "The Social Model of Disability and the Disappearing Body: Towards a Sociology of Impairment", *Disability & Society* 12.3 (2010) 325-340, Jeannette Pols and Amade M'Charek, "Introduction: Where Are the Missing Bodies? Disability Studies in the Netherlands", *Medische Antropologie* 22:2 (2010) 217-224, Michael Feely, "Disability Studies After the Ontological turn: a Return to the Material World and Material Bodies without a Return to Essentialism", *Disability & Society* 31.7 (2016) 863-883, Michael Rembis, "Challenging the Impairment/Disability Divide. Disability History and the Social Model of Disability", in: Nicholas Watson and Simo Vehmas (eds.) *The Routledge Handbook of Disability Studies 2nd Edition* (New York: Routledge 2019) 377-390.

23 Simi Linton, *Claiming Disability: Knowledge and Identity* (New York: New York University Press 1998). See for a more in-depth discussion of this social construction of disability identity: Pieter Verstraete, *In the Shadows of Disability. Reconnecting History, Identity and Politics* (Opladen: Barbara Budrich Publishers 2012).

24 Lennard Davis, *Bending Over Backwards. Disability, Dismodernism, and Other Difficult Positions* (New York: New York University Press 2002) 9-32.

to disability identity as a 'complex embodiment' in which bodily and social experiences interact and shape both the body and social frameworks.[25] This tension between material embodiment and cultural constructivism, which Amade M'Charek and Jeanette Pols have called 'the problem of the missing body',[26] poses some difficulties for the analysis of incapacity for work in the historical practice of social security legislation.

Moreover, although these social security arrangements were rooted in the medical model of disability, they do provide vital support and resources and therefore remain crucial for many disabled people. It is important to stress this, especially since the right to disability benefit needs protection. The aura of fraud that surrounds benefits and the accusation that people do not really need them frames benefit recipients as profiteers and is sometimes used to justify the dismantling of welfare arrangements.[27] Furthermore, workers who receive benefit have to constantly prove their incapacity in order to show they need and deserve the benefit. This, therefore, has material consequences for their lives and experiences of disability.

How can we analyse social security arrangements critically, while also making room for the ways in which disabled workers in the past benefited from them? How can we include corporeal experiences, such as fatigue or pain, without perpetuating excluding notions and practices that come with a medical model analysis of disability? I believe that a focus on historical practices is a fruitful way to address these questions.

A praxiographical approach to the history of incapacity for work

While acknowledging the discursive meaning of the body, recently scholars in feminist and gender studies have emphasised the importance of material practices in the performance of gender and race.[28] Similarly, disability theorists such as Rosemarie Garland-Thompson, Alison Kafer and Sami Schalk have tried to overcome a strict nature-culture or medical model-social model divide. Moving away from a focus on representation, language and culture, they instead analyse the relation between meaning and matter. This ontological shift, which is often referred to as 'new materialism', aims at breaking

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25 Tobin Siebers, *Disability Theory* (Ann Arbor: University of Michigan Press, 2008).

26 Pols and M'Charek, "Introduction: Where Are the Missing Bodies?", 217-224.

27 See for fascinating work on this topic in the context of the British Welfare State: Frances Ryan, *Crippled. Austerity and the Demonization of Disabled People* (London: Verso Books 2020), Gareth Millward, *Sick Note. The History of the British Welfare State* (Oxford: Oxford University Press 2022).

28 See for instance: Rosi Braidotti, *Nomadic Subjects: Embodiment and Sexual Difference in Contemporary Feminist Theory* (New York: Columbia University Press 2011), Rick Dolphijn and Iris van der Tuin, *New Materialism. Interviews and Cartographies* (Open Humanities Press: Ann Arbor 2012). For an exploration of the material turn in body history see: Iris Clever and Willemijn Ruberg, "Beyond Cultural History? The Material Turn, Praxiography, and Body History", *Humanities* 3.4 (2014) 546-566, Roger Cooter and Claudia Stein, *Writing History in the Age of Biomedicine* (London: Yale University Press 2016) 91-111.

down modernist dualisms and has resulted in a variety of fresh, often interdisciplinary, studies in which the focus has been on practices, on the relationality of body and mind, nature and culture, as well as on the role or agency of animals or objects in the making of entities.[29]

An extensive discussion of the varieties of new materialism and individual differences between them is beyond the scope and purpose of this dissertation.[30] For this study I have, however, chosen to engage with praxiography, which I consider a branch from the same tree, and part of this material or practice turn in the humanities and social sciences.[31] Praxiography, as developed by Annemarie Mol, analyses the ontology of the body as 'done' or 'enacted' in practice. In her monograph *The Body Multiple: Ontology in Medical Practice,* Mol states that scholars tend to divide a sick or disabled person's bodily state into illness (experiencing, suffering) or disease (diagnosing, treating). This division leads to perspectivism, whereby medical scientists view the biological truth about a body, and social scientists and humanities scholars examine the embodied experience. The material or lived body is made passive, and vanishes, Mol claims. This is in fact the same problem as with the social model of disability. Building on insights from Actor-Network theory, especially the work of Bruno Latour, Mol argues that there is no definite or final truth about the body.[32] It is close to Hacking's theory of the making up of human kinds, in which classifications are brought into being in the very search for their properties.[33] As Trudy Dehue has similarly described for medical labels, objects are made up of de-

29 Rosemarie Garland-Thomson, "Integrating Disability, Transforming Feminist Theory", *NWSA Journal* 14.3 (2002), 1-32, Rosemarie Garland-Thomson, "Feminist Disability Studies", *Signs* 30.2 (2005) 1557-1587, Rosemarie Garland-Thomson, "Misfits: A Feminist Materialist Disability Concept", *Hypatia* 26.3 (2011) 591-609, Eli Clare, *Brilliant Imperfection. Grappling with Cure* (Durham: Duke University Press 2017), Alison Kafer, *Feminist, Queer*, *Crip* (Bloomington: Indiana University Press 2013), Semi Schalk, *Bodyminds Reimagined: (Dis)ability, Race, and Gender in Black Women's Speculative Fiction* (Durham: Duke University Press 2018), David T. Mitchell, Susan Antebi and Sharon L. Snyder (eds.) *The Matter of Disability: Materiality, Biopolitics, Crip Affect* (Ann Arbor: University of Michigan Press 2019).

30 The Critical Posthumanisms Network offers a 'Geneology of the Posthuman' that is very insightful. See: https://criticalposthumanism.net/ (accessed on 13 July, 2023).

31 Clever and Ruberg, "Beyond Cultural History?", 546-566.

32 In her book she analyses the ways in which doctors, patients, nurses, instruments and practices mutually produce arteriosclerosis. She focuses on the ways in which different actors involved, talked about a variety of things (human tissue under the microscope, experiences of pain, having difficulties walking) while they assumed they discussed arteriosclerosis as a singularity. Arteriosclerosis is multiple, she claims, it is always something different in relation to different objects, people, and practices. Moreover, when doctors and patients describe or examine arteriosclerosis, they intervene with the disease, they interact with it and thus produce it. Mol, *The Body Multiple*.

33 Hacking, *Historical Ontology*, Hacking, "Making up people", 23-26.

scriptions, and have no definite properties. There is no ultimate signifier.[34] Mol claims we ought to focus on how different realities are made to cohere, and are managed to form a seemingly natural unity (a *virtual common object* as she calls it). What matters here is the dynamic and the interaction that temporarily establish the body in context. It is explicitly not a matter of different perspectives on the body, but a body multiple. Mol writes:

> *'If practices are foregrounded there is no longer a single passive object in the middle, waiting to be seen from the point of view of seemingly endless series of perspectives. Instead, objects come into being – and disappear – with the practices in which they are manipulated.'*[35]

By using the term 'enactment', Mol emphasises that illness is not so much a cultural construct, but something that finds a temporal ontology in material practice.[36] Mol's focus on practices, functions as a way to bring materiality back into the analysis of bodies and illness, while overcoming an essentialist binary divide between nature and culture.[37]

Historian Geertje Mak has shown that Mol's aim '(…) to study the multiplication of a single disease and the coordination of this multitude into singularity' is applicable to historical research as well. In her book *Doubting Sex. Inscriptions, Bodies and Selves in Nineteenth-century Hermaphrodite Case Histories*, Mak analyses historical cases of persons whose sex was doubted, and focusses on the ways in which people were assigned a sex.[38] She traces how knowledge of the body was produced, and highlights that medical logic did not precede practice, but instead followed from interaction with medical objects, social norms in everyday life, as well as the tactics, bodies and stories of the persons whose sex was under scrutiny. In Mak's analysis, cultural and medical en-

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34 Trudy Dehue, *De Depressie-epidemie. Over de Plicht het Lot in Eigen Hand te Nemen* (Amsterdam: Atlas Contact 2008), Trudy Dehue, *Betere Mensen. Over Gezondheid als Keuze en Koopwaar* (Amsterdam: Atlas Contact 2014).

35 Mol, *The Body Multiple*, 5.

36 For Mol the body is never constituted: 'My argument is that there need not be a "doer behind the deed", but that the "doer" is variably constructed in and through the deed. (…) Performing identities is not a question of ideas and imaginations devoid of materiality (…). A lot of *things* are involved.' Mol, *The Body Multiple,* 38-39.

37 Similarly, in previous work, Mol also discussed the ways in which various natural and social sciences have analysed what a woman is. She concludes that the search for the true nature of a woman, as done by sciences, in fact shapes the woman into a singular object. Annemarie Mol, "Wie Weet Wat een Vrouw is… Over de Verschillen en de Verhoudingen Tussen de Wetenschappen", *Tijdschrift voor Vrouwenstudies* 6.21 (1985) 10-22.

38 She writes: '[i]nstead of criticising a social, legal and cultural system that does not allow for gender categories outside the male and female dichotomy and which is implicitly heterosexual I decided to doubt the category of sex itself.' Mak, *Doubting Sex*, 2.

actments coexist and interact with each other, and this is why there is no such thing as a stable category of sex. She thus adds to praxiography a historical focus on the mutual relationship between different rationales, while also analysing how enactments occurred, changed and disappeared over time.[39]

By rationales, she means the tacit reasoning, the implicit logics, inherent in the practices that determined the assignment of a person's sex.[40]

Mak has successfully used praxiography to analyse gender/sex in history[41] and Amade M'Charek and Irene van Oorschot have done the same to analyse ethnicity/race in contemporary legal practices.[42] Annemieke van Drenth has, moreover, applied praxiography as a methodology to analyse the enactment of 'idiocy' in children in nineteenth-century research and care practices. She integrates an analysis of case files, questionnaires and medical handbooks to show how these children were designated a special status as being mentally disabled.[43] Apart from her work, the possibilities of praxiography for disability history have hardly been explored.[44]

In this dissertation I use praxiography in a similar, historical way to Mak and Van Drenth. Their work helped me to evaluate the multiplicity of incapacity for work and analyse the practical conditions in which it was historically enacted. This means that I consider incapacity for work as the result of interactions between government officials, medical experts and workers that took place within legal procedures, claim examination practices under the Industrial Injuries Insurance Act, and scientific discourses, as well

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39 Ibidem, 111.

40 Ibidem, 2.

41 For the use of praxiography to analyse gender in current medical practice, see J.R. Latham, "(Re)making sex: A Praxiography of the Gender Clinic", *Feminist Theory* 18.2 (2017) 177–204.

42 Amade M'Charek, "Fragile Differences, Relational Effects: Stories About the Materiality of Race and Sex", *European Journal of Women's Studies* 17.4 (2010) 307-322, Amade M'Charek, "Beyond Fact or Fiction: On the Materiality of Race in Practice", *Cultural Anthropology* 28.3 (2013) 420-442, Amade M'Charek and Irene van Oorschot, "What About Race?", in: Anders Blok, Ignacio Farías and Celia Roberts (eds.) *The Routledge Companion to Actor-Network Theory* (London: Routledge 2020) 235-245, Irene van Oorschot and Amade M'Charek, "Keeping Race at Bay: Familial DNA Research, the 'Turkish Community,' and the Pragmatics of Multiple Collectives in Investigative Practice", *Biosocieties* 16.4 (2021) 553-573.

43 Annemieke van Drenth, "Sensorial Experiences and Childhood: Nineteenth-Century Care for Children with Idiocy", *Paedagogica Historica* 51.5 (2015) 560-578, Annemieke van Drenth, "The 'Truth' About Idiocy: Revisiting Files of Children in the Dutch 'School for Idiots' in the Nineteenth Century', *Journal of the History of Education* 45.4 (2016) 477-491.

44 Vasilis Galis, "Enacting Disability: How Can Science and Technology Studies Inform Disability Studies?" *Disability & Society* 26.7 (2010) 825-838, Paul van Trigt, "Ordering Disability. How Can Modernity Theory Inform Disability History?", *International Journal for History, Culture and Modernity* 7 (2019) 423-442, Nathanje Dijkstra, 'The Incapacity to Work as Moving Target. Exploring the Possibilities of Praxiography for Analysing Realities of Disability in History', *Tijdschrift voor Gender Studies* 25.1 (2022) 59-78.

as through the use of techniques and materialities (such as measuring instruments, foot-dragging gait, weariness, or as we shall see, somersaults). A praxiographic approach takes into account the reciprocity of cultural and medical notions of illness as well as physical pain and experiences of inability. This offers a new perspective on legal procedures and everyday application, and allows discourses to be analysed together with ideas and practices. Thus, it provides theoretical grounding for how incapacity for work came into being in situated practices engendered by disability benefit legislation. By looking at incapacity for work as a site of interaction between workers, doctors, medical norms, procedures, bodies and examination techniques, we can challenge perceptions of disability as either a biological truth or a cultural construct. As we shall see, in practice, incapacity for work was 'made up' beyond these dichotomies and brought into being in multiple ways. Incapacity for work could be the result of a calculation, put into percentages. It was also a symptom of newly diagnosed diseases, such as the pulmonary condition silicosis. Sometimes it was the degree to which the joint of the left ring finger could be bent, or the number of cigarettes that could be rolled in a minute. In Chapter 4 we will see how workers enacted incapacity for work as a daily experience. In their accounts they not only analysed their incapacity for work as a lack of energy or the inability to meet production norms, but also showed how this stood in relation to the exhausting or frustrating administrative tasks that became part of their lives once they started claiming benefit. Simple mistakes could lead to a reduction in the amount of benefit, and forms that were filled in incorrectly or were lost in the post could make a worker deemed fully capable of working. Moreover, workers who committed themselves to rehabilitation programmes stated that while this improved the functionality of the injured body part, it added to feelings of anxiety or exhaustion. Here, in the statements of workers, social policy, bodily functioning, the filing in of forms, rehabilitation exercises, the postal service and feelings of anxiety or fatigue together make up incapacity for work as an everyday experience that was tied not just to the workplace, but to the claim assessment. This was something different than, for instance, the incapacity for work as a matter of calculation based on comparison of the functioning of injured body parts, which was a common way for doctors to measure incapacity for work.

Praxiography pushes the researcher to refrain from 'solving' or explaining away the diversity in enactments of incapacity for work. In this vein, I aim to bring to light how that diversity existed in contradicting practices, coexisting elements of different logics, arising from a diversity of experiences and complex or messy everyday interactions, from medical knowledge, bureaucratic procedures and measurement scales. Moreover, praxiography provides an analytic framework to interpret modes of cooperation and interaction with practices that have been analysed by disability scholars as being excluding or stigmatising, such as medicalisation.

The fact that incapacity for work can be many things does not mean that it can simply be anything. As Mol has stressed, the body is more than one, but less than many.[45] The same goes for incapacity for work. There were historical or physical limits to the ways in which incapacity for work could be enacted. For instance, incapacity for work, in this specific period of time, was never enacted as the inability to pick up the children from school and no longer be a good dad or find the right work-life balance. Nor have I come across a case in which workers claimed that they were unable to develop their management skills in a professional setting. This shows how incapacity for work was tied to things like gender norms, to what qualified as work (differences between care and work, paid and unpaid activities, part-time and full-time positions[46]), or to the meaning and value of 'professional leadership'

Moreover, the Industrial Injuries Insurance Act itself set the parameters within which incapacity for work could be enacted. Before 1921, for instance, workers were not insured against occupational diseases. Incapacity for work could, therefore, not be enacted as the inability to earn an income due to a lung disease sustained at work. As we shall see, in 1955 this could very well be the case. But not for migrant workers who made up the workforce in the Dutch mines before they closed in 1974, and who were not considered incapacitated for this lung disease, because they did not held Dutch nationality and worked on short-term contracts. Enactments of incapacity for work are therefore always situated and related to practices concerning nationality, and as we will see later on in this dissertation, also age and class.

This dissertation focusses on what was done in legal practices. Drawing on historical source material, it brings to the fore a variety of enactments. I do not aim to be exhaustive, but by bringing to the fore a variety of enactments I aim to show what enactment of 'incapacity for work' was prominent and what material and cultural consequences it enabled in the specific context of the claim assessment under the Dutch Industrial Injuries Insurance Act. While Mike Oliver feared that by critiquing the social model of disability, disability studies would lose its political value, I believe that far from depoliticising the study of disability history, this focus on practice enhances the reflection of disability politics.[47] Despite the fact that the enactments described in this dissertation are rooted in specific historical contexts, this study lays the foundation for a new analysis of social security legislation, one that makes us think about the different types of cate-

45 Mol, *The Body Multiple*.

46 See for recent (feminist) discussion of what counts as work in the Dutch context: Marguerite van den Berg, *Werk is Geen Oplossing* (Amsterdam: Amsterdam University Press 2021), Anja Meulenbelt, *Alle Moeders Werken Al* (Amsterdam: Mazirel Press 2021), Lynn Berger, *Ik Werk Al (Ik Krijg Er Allen Niet Voor Betaald)* (Amsterdam: de Correspondent 2023).

47 Oliver, "The Social Model of Disability", 1024-1026.

gories it creates and transforms, and the (unintended) social and material consequences that come with these categorisations. Based on these insights and knowledge, scholars and activists can further reflect on the design of social security systems and on which enactments of incapacity for work can be considered just, fair, social or democratic, or which ones create better lives for disabled people.[48]

In short, this practice-focussed study on incapacity for work in the historical context of disability benefit legislation in the Netherlands bridges disciplinary boundaries between the social history of the welfare state, medical history and disability studies. Through its detailed analysis, this dissertation contributes to our understanding of incapacity for work as a multifaceted, yet vital phenomenon that intersects with notions of work, disability, citizenship and expertise. It yields new insights into the complex relationships between disability and society, the relevance of which extends beyond the Dutch case and the time period covered by this research, as I will now discuss.

II HISTORIOGRAPHY

Disability and citizenship in the welfare state

Disability benefit in the Netherlands is mostly studied from a top-down economic and political perspective that concentrates on the design of welfare policy and legal history. The main focus has been on the post-war period, emphasising the development of a sustainable welfare system. Political historians have described in detail the political situation that resulted in changes in social security legislation, analysing disability benefit as a political affair.[49] Sociologists such as Abram de Swaan have dedicated much work

48 Like Annemarie Mol, we should be aware of the difficulties of what she calls ‘ontological politics’. She writes: ‘Alternative realities don’t simply co-exist side by side, but are also found inside one another. But this is a situation that does not easily fit our traditional notions of politics. Which means that new conceptions of politics need to be crafted. But which ones? What kind of politics is implied here—or required?’ Annemarie Mol, “Ontological Politics. A Word and Some Questions” in: John Law, John Hassard (eds) *Actor Network Theory and After* (Oxford: Blackwell 1999) 74–89. Although the answers to these questions are not straightforward, it is clear to me that the adapted social model of disability I propose, with its focus on practice, involves an extensive critical analysis of essentialism and the medical model. By showing how incapacity for work is made to hang together, it reveals the historical boundaries and hierarchies that have played a role. As Pieter Verstraete has pointed out, it is important to ‘invite historians of disability to look for those quiet places where new forms of life can express themselves. Not so much to be poured into the bottleneck of existing truths, but to open up new ways of relating to the world, to each other and to oneself’, and I argue that a focus on practices helps with this. Verstraete, *In the Shadows of Disability*, 120-121.

49 Willem de Vries, *De Invloed van Werkgevers en Werknemers op de Totstandkoming van de Eerste Sociale Verzekeringswet in Nederland* (Deventer: Kluwer 1970), Frits Noordam, “Sociale Verzekeringen 1890-

to answering the question of why societies started to take an interest in compensating for individual misfortune.[50] Taken together, this results in a narrative about laws that were driven by solidarity, bureaucracy or governmentality, that changed in response to socio-economic circumstances, and led to the development of a unique system in which the aim was to ensure treatment of the weak and wounded and compensation for lost income.

Scholars have not just praised social interventions. There is a vast body of literature on the problems of the welfare state, ranging from a focus on economic consequences to critique of the bureaucracy that came with it. Disability historians have, moreover, analysed the ways in which (neoliberal) political ideas and values found their way into post-war and present-day welfare policy.[51] Berteke Waaldijk has argued that historians should pay more attention to the ambivalences of social policies, for instance to the effect they had on notions of care and individual responsibility for one's own working life.[52] In the work of Greg Eghighian on German social policies, welfare bureaucracy is critically analysed as intervening in everyday lives of civilians, leading disabled workers to regard themselves as victims of the national workforce and creating a social entitlement state.[53] Apart from the work of Eghighian, the socio-cultural consequences of disability benefit have received scant attention.

Moreover, in welfare historiography and the narrative of disability benefit as the product of a social configuration and as a means to avert individual misfortune, incapacity for work is analysed as stemming from an impaired body, but is not theorised as such. In this dissertation, I scrutinise the ways in which social policy was transformed in day-to-day practices, and how it affected the ways in which workers capable of working were

1950", in: Jacques van Gerwen and Marco van Leeuwen (eds.) *Studies over Zekerheidsarrangementen. Risico's, Risicobestrijding en Verzekeringen in Nederland vanaf de Middeleeuwen* (Amsterdam: Nederlandsch Economisch Historisch Archief 1998) 570-604, Anton Rommelse, *Een Geschiedenis van het Arbeidsongeschiktheidsbeleid in Nederland* (Leiden: Leiden University 2011), Jos Bergham, Ad Nagelkerke, Kees Boos, Reunoud Doeschot en Gijs Vonk (ed.) *Honderd Jaar Sociale zekerheid in Nederland* (Delft: Eburon 2003), Ton Kappelhof, '"Omdat Het Historisch Gegroeid is". De Londense Commissie-Van Rhijn en de Ontwikkeling van de Sociale Verzekeringen in Nederland (1937-1952)', *Tijdschrift voor Sociale en Economische Geschiedenis* 1.2 (2004) 71-91.

50 Abram de Swaan, *In Care of the State: Health Care, Education and Welfare in Europe and the USA in the Modern Era* (Cambridge: Polity Press 1988), Marcel Hoogenboom, *Standenstrijd en Zekerheid. Een Geschiedenis van Oude Orde en Sociale Zorg in Nederland* (Amsterdam: Boom 2004).

51 Monika Báar and Paul van Trigt (ed.) *Marginalized Groups, Inequalities and the Post-War Welfare State. Whose Welfare?* (London: Routledge 2019).

52 Berteke Waaldijk, "Personeel van Sociale Instituties. Over het Verband Tussen Vrouwenbeweging en Maatschappelijk werk", *BMGN- Low Countries Historical Review* 130.2 (2015) 44-69.

53 Greg Eghighian, *Making Security Social: Disability, Insurance, and the Birth of the Social Entitlement State in Germany* (University of Michigan Press: Ann Arbor 2000).

distinguished from incapacitated workers. The Industrial Injuries Insurance Act did not provide clear instructions on what 'incapacity for work' ought to be. The Act, moreover, was substantially reformed in 1921 to make more workers eligible for benefit, but also to bring the Act in line with the ways in which it was already being applied in practice. The Industrial Injuries Insurance Act and 'incapacity for work' mutually transformed each other. By considering the Act an actor in the making up of incapacity for work, this dissertation provides a bottom-up approach to the operationalisation of social security legislation.

Furthermore, through employing a bottom-up approach, this research sheds a new light on larger themes such as the relationship between the state and the citizen, medicalisation and the gatekeeping power of doctors, as well as changing ideas about work, good citizenship and the meaning of disability in a capitalist society. Often these subjects have been analysed as a top-down matter, focussing on political deliberations, medical insights or social policy alone. By bringing to the fore the ways in which these themes found their effect in practice, this dissertation adds to their understanding and, in some cases, proposes a different periodisation. For instance, by examining the intersection of citizenship and rehabilitation in the enactment of incapacity for work, this research offers new insights into the ways in which the Rijksverzekeringsbank encouraged disabled workers to be 'good citizens'. With the introduction of the Industrial Injuries Insurance Act, incapacity for work was extracted from the realm of employer-employee relations and turned into an issue in which the disabled citizen had to deal with the state. By offering rehabilitation measures and vocational training, workers were encouraged to overcome their incapacities, making ability to work a form of civic duty. This shift has been observed by others; they have placed it in the post-World War II period and tied it to the extension of welfare arrangements.[54] Here I claim that this shift can already be traced back to the beginning of the twentieth century, with the introduction of the first form of social security legislation in connection with extended opportunities for rehabilitation. Through analyses like these, this dissertation provides concrete interpretations and material relations that go beyond abstract top-down narratives.

Histories of medicalisation

Alongside the welfare historiography, the analysis of disability benefit as an example of medicalisation takes up an important place. Doctors played a key role in all kinds of disability insurance schemes in welfare states, but while in most countries the claim

54 Leo van Bergen, "'Revalidatie Vóór Rente.' Medische Zorg en de WAO" In: Karel Peter Companje (ed.) *Tussen Volksverzekering en Vrije Markt. Verzekering van Zorg op het Snijvlak van Sociale Verzekering en Gezondheidszorg 1880-2006* (Amsterdam: Aksant 2008) 537-558, Paul van Trigt, *Blind in een Gidsland. Over de Bejegening van Mensen met een Visuele Beperking in de Nederlandse Verzorgingsmaatschappij, 1920-1990* (Hilversum: Verloren 2013).

assessment and medical examination were separated, in the Netherlands they were combined and performed by medically trained government officials in the service of the Rijksverzekeringsbank. Moreover, when workers lodged an appeal against the decision of the Rijksverzekeringsbank, it was doctors who were consulted as experts on the working capacity of the labourer in question.[55] Much medical-historical work is dedicated to why and how doctors gained the position of gatekeeper in all kinds of social arrangements. Scholars have pointed out the ways in which doctors gained authority to make decisions in a variety of social inquiries.[56] Recent scholarship on the history of expertise, moreover, has shown that medical authority is not just a reflection of better knowledge of sick and healthy bodies, but results from a much more complicated negotiation between the supply and demand of social questions and medical answers.[57] Medical historians have focussed on the ways in which medicine and the state became entangled in the twentieth century, how social questions were answered in medical terms, how certain social behaviours and interactions were pathologised, and how this affected the medical profession. In these histories the power to define what counts as illness has been critically analysed, and has often resulted in an emphasis on the ways expertise, knowledge and power were performed and negotiated in interaction with social policy.[58] It is, however, widely acknowledged that the "receiving" end of this expertise, the persons who were diagnosed, classified and considered eligible for benefit, deserve more attention.[59]

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55 As opposed to the German situation in which medical examination and claim assessment were separated.

56 See for instance: Karel Velle, *De Nieuwe Biechtvaders: de Sociale Geschiedenis van de Arts in België* (Leuven: Kritak 1991), David Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge: Cambridge University Press 1983) David Armstrong, "The Invention of Patient-centred Medicine", *Social Theory & Health* 9 (2011) 410-418, George Ikkos and Nick Bouras (ed.) *Mind, State and Society Social History of Psychiatry and Mental Health in Britain 1960–2010* (New York: Cambridge University Press 2021).

57 Ludmilla Jordanova, "The Social Construction of Medical Knowledge", in: Frank Huisman and John Harley Warner (ed.), *Locating Medical History: The Stories and Their Meanings* (Baltimore: Johns Hopkins University Press 2004), 338-363, Joris Vandendriessche, Evert Peeters and Kaat Wils (eds.) *Scientists' Expertise as performance: Between State and Society, 1860–1960* (London: Routledge 2015).

58 Klasien Horstman, *Verzekerd leven. Artsen en Levensverzekeringsmaatschappijen 1880-1920* (Amsterdam: Babylon-De Geus 1996), Peter Conrad, *The Medicalization of Society On the Transformation of Human Conditions into Treatable Disorders* (Baltimore: John Hopkins University Press 2007), Harry Oosterhuis, "Mental Health and Civic Virtue: Psychiatry, Self-development and Citizenship in the Netherlands, 1870-2005", in: Frank Huisman and Harry Oosterhuis (eds.) *Health and Citizenship: Political Cultures of Health in Modern Europe* (London: Routledge 2015) 155-172, Frank Huisman, "Expertise and Trust in Dutch Individual Health Care", in: Joris Vandendriessche, Evert Peeters and Kaat Wils (eds.), *Scientists' Expertise as Performance: Between State and Society 1860-1960* (London: Routledge 2015) 173-190.

59 Among others, Roy Porter has pointed out that medical history is too 'physician-centered'. His plea to correct one-sided medical historical narratives by adding stories of sick persons in the past (after all 'it takes two to make a medical encounter'), has gained a lot of interest. However, since it is mostly

While taking into account the differences in power between doctors and workers, this dissertation shows that rather than being divided into opposing parties, these different actors engaged in the making up of incapacity for work constantly interacted with each other. Their interests, desires and perspectives overlapped to a certain extent. Ideas about the proper execution of social policy were, for instance, not in opposition with the desire of workers to receive benefit, since the aim of the Rijksverzekeringsbank was to meet the needs of disabled workers. Likewise, the arguments of medical experts were formed through interactions with workers, and disabled workers also changed, used and adapted practices and ideas about work and social policy to their advantage. That is not to say that interests did not conflict. But this research shows that the actors involved dealt with all sorts of contradictory assignments, tasks, goals, values and ideas. For instance, doctors who were granted the task to make expert statements about a labourer's working capacity had to change or adapt their medical knowledge to fit a legal context that came with its own eligibility criteria. Moreover, insights into a person's working capacity could only be gained through cooperation with the worker under examination, while at the same time doctors had to maintain a neutral position and had to make sure that their assessment was based on the worker's actual capabilities, and not on exaggerated or understated experiences of pains or impairments. These medical experts complained they lacked the experience and knowledge to do so, but they performed the examination anyway, and navigated the contradictory tasks to fulfil their assignment. Thus, the conflict was often not divided along the lines of opposing parties, but included internal struggles as well. A focus on practices highlights these intricacies of incapacity determination, revealing how power and interests shifted with each interaction.

Experiences of disability

As described above, disability scholars have criticised the medicalisation of a diversity of bodies and have analysed disability as a social affair, defined by normative values and not as an individual identity inscribed on the body.[60] Sarah F. Rose has, for instance, shown

doctors' perspectives that have made it to paper and have been preserved as part of institutional or academic archives, sources that provide for insights in patient's perspectives are scant, resulting in historical underrepresentation. See: Roy Porter, 'The Patient's View: Doing Medical History From Below', *Theory & Society* 14.2 (1985) 175-198, Eberhard Wolff, 'Perspectives on Patients' history: Methodological Considerations on the Example of Recent German-speaking Literature', *Canadian Bulletin of Medical History* 15.1 (1998) 207-228, Flurin Condrau, 'The Patient's View Meets the Clinical Gaze', *Social History of Medicine* 20.3 (2007) 525-540, Richard A. McKay, ' "Patient Zero": The Absence of a Patient's View of the Early North American AIDS Epidemic', *Bulletin of the History of Medicine* 88.1 (2014) 161-194.

60 Paul Longmore and Lauri Umansky, *The New Disability History: American Perspectives* (New York: New York University Press 2001), Rosemarie Garland-Thomson, *Extraordinary Bodies. Figuring Physical*

that the Industrial Revolution and its ramifications were a catalyst for the construction of incapacity for work. She has written an American history of disability and the workplace in terms not of individual misfortune but of social exclusion instead.[61] This shift in the analysis of incapacity for work has been valuable, but, again, puts much emphasis on the discourses and practices of government officials and employers. As David Turner and Daniel Blackie have pointed out, workers were not passive bystanders in matters of industrialisation and social policy, but were instead 'active agents of economic change'.[62]

Similarly, by also analysing disabled workers as actors in the production of incapacity for work, this dissertation illuminates the ways in which disabled workers negotiated social policy and the associated examination practices. It therewith breaks with a narrative of disabled people as being silent recipients of benefit, or as passive victims of repressive attitudes and measures. Taking into account the ways in which disabled workers analysed their own incapacity for work, this dissertation highlights their room for manoeuvre. It shows that workers used and shifted rationales of incapacity for work provided by law or medicine, while also bringing forward their own experiences of dealing with workplace discrimination and notions of productivity, as well as with fatigue, pain or poverty. In doing so, this dissertation for instance demonstrates that the push to make the workplace more adaptable to fit a variety of work modes is not just a recent disability rights or feminist approach. Instead, I found that this plea to adapt the workplace instead of the worker already played a role in experiences of incapacity for work at the beginning of the twentieth century.

It should be noted that differences in power were indeed evident. This is why I take actual social barriers into account. But by also acknowledging the forms of agency that workers had, this dissertation aims to nuance the social model of disability and analyses the making up of incapacity for work as a context-based and shared enterprise.

III SOURCES AND METHODS

Incapacity for work in higher appeal cases

As described above, the focus on practice stems from a desire to take into account material interest and bodily experiences related to disability and incapacity for work. This

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Disability in American Culture and Literature (New York: Columbia University Press 1997).

61 Sarah F. Rose, *No Right to Be Idle. The Invention of Disability, 1840s-1930s* (Chapel Hill: University of North Carolina Press 2017).

62 David Turner and Daniel Blackie, *Disability in the Industrial Revolution. Physical Impairment in the British Coalmining, 1780-1880* (Manchester: Manchester University Press 2018).

means that it is not just discourse that is at the forefront of the historical analysis, but an analysis of what actors did and how they engaged with disputes over the severity and veracity of incapacity for work.

These disputes, and the ways in which they were navigated, can be found in higher appeal cases considering incapacity for work in the context of the Industrial Injuries Insurance Act between 1901 and 1967. In these cases, workers or the Rijksverzekeringsbank had lodged an appeal against the decision of one of the local councils of appeal, questioning the established incapacity for work. The Central Council of Appeal that dealt with these cases was the supreme administrative court, which handled disputes regarding the application of social security legislation, including the Industrial Injuries Insurance Act. The higher appeal cases do not just provide the most detailed and complete body of sources available on this topic; they are especially useful for the present research because they mark a moment in which different enactments of incapacity for work were made to form a singularity. In the higher appeal cases, the boundaries between capacity and incapacity for work were negotiated by the three groups of actors, namely by the Rijksverzekeringsbank, by medical experts and by the workers. In these sources a variety of including and excluding practices come to the fore, and the statements made by the actors involved express a variety of versions of incapacity for work. In addition, the Industrial Injuries Insurance Act was designed so that casuistry would inform, correct and shape the execution practice. Higher appeal cases thus form an excellent site to study the interaction between social security legislation and incapacity for work.

While it would have made sense to also use claim reports drawn up by the Rijksverzekeringsbank, unfortunately these have all been destroyed. The same goes for most of the jurisprudence of appeal cases considered by local councils of appeal. I was therefore not able to trace the case histories back to the initial claim examination.[63] But while medical or claim reports deal with the analysis of government officials or doctors, in legal records workers also took the stand. This provides unique insights into the acts, ideas and role of workers in the making up of incapacity for work, which has usually remained undiscussed due to a lack of sources.[64]

63 In 1902 seventeen councils of appeal were established, each with their own geographical jurisdiction. In 1907 this number was lowered to seven councils and in 1955 and 1957 three more councils were added. This meant that over time, most of the archives corresponding to the councils had been moved from one place another at least once. In 1992 the councils were abolished. Through ministerial decree in 1991, the case files were qualified for destruction seven years after the case was closed. This decree, in combination with the moving of archives has resulted in a very limited, fragmented and disorganized collection of available material.

64 Eddy Houwaart and Wout de Boer, for example, have chosen not to include the perspectives of disabled workers in their analysis of claim assessments. Eddy Houwaart and Wout de Boer (eds.) *Geschiktheid Gewogen: Claimbeoordeling en Arbeidsongeschiktheid in Nederland 1901-2005* (Hoofddorp: TNO 2006) 21-22.

The archives of the Central Council of Appeal contain all the verdicts from 1901 to 1967. This includes witness reports and an occasional letter of appeal. As there were between 100 and 1,500 cases per year, the size of the archive did not allow me to analyse every single case. Therefore I decided to take samples. I collected all higher appeal cases for the years 1905, 1915, 1925, 1935, 1945, 1955 and 1965 (see appendix I).[65] I confined myself to the cases that dealt with the veracity and severity of a worker's incapacity for work, and left out the cases that considered the widow's pension, premiums or disputes over the legal definition of the term "accident". In the higher appeal cases I analysed, the Rijksverzekeringsbank, medical and other expert witnesses and workers took the floor, and their evidence regarding the claim for benefit was noted in the verdict. As they had to arrive at a solution, the need to make sense of what incapacity for work actually was, became pressing, and these records show a detailed description of what was done and claimed to get to that point.

While I consider enactments of incapacity for work in the specific context of higher appeal cases, I did use complementary source material in the form of medical journal articles, handbooks with instructions for the application of the Industrial Injuries Insurance Act and documents from the archive of the Rijksverzekeringsbank. To be specific, I consulted the *Tijdschrift voor Ongevallen-Genees*kunde (*Journal for Accident Medicine),* which was later renamed the *Geneeskundig Tijdschrift der Rijksverzekerings-bank* (*Medical Journal of the Rijksverzekeringsbank*, published between 1916 and 1942), medical and legal handbooks on the application of the Industrial Injuries Insurance Act, and all articles in the *Nederlandsch Tijdschrift voor Geneeskunde* (*Dutch Journal for Medicine*) that dealt with examination practices of the Industrial Injuries Insurance Act between 1901 and 1967. This literature allowed me to see the interaction between the medical and legal contexts in which medical experts navigated. Moreover, it provided an understanding of the professional norms, values and official instructions which government officials brought to court. To also gain insight into the values, norms and ideas with which workers came to the courtroom, I used the handful of letters of appeal from workers preserved in the archives of the Central Council of Appeal.

On numbers, sampling and representativeness

There are a few remarks to be made regarding this source material. First of all, it is important to note that these are the cases in which the Rijksverzekeringsbank and workers

65 From every sample year I recorded how many cases considered disputes about incapacity to work, as opposed to cases in which a worker had died, or in which the amount of premium that a company should pay was debated. Moreover, I noted who lodged the appeal and who was found in favour. This information can be found in appendix I.

disagreed about the veracity and severity of incapacity for work. These sources do not give a clear indication of what workers did when they accepted or agreed with the decision of the Rijksverzekeringsbank. This analysis of the making up of incapacity for work is therefore specifically situated in the context of the appeal cases. Since this dissertation analyses incapacity for work as relational and depending on specific contexts and interactions, it does not aim to make claims about a definite construction of incapacity for work produced by the Industrial Injuries Insurance Act. Instead, it aims to bring to the fore a variety of enactments of incapacity for work, and for this purpose the variety of practices, ideas and debates that can be found in these higher appeal cases are invaluable.

This ties in with the reasoning behind my decision to take samples. Sampling is not uncommon in historical research. Often historians reflect on whether or not this affects the representativeness of the outcome of their research.[66] This dissertation, however, proposes to look at practices as being situated, analysing incapacity for work as a context-specific enterprise. By taking samples, I was able to analyse the interaction between social policy and execution practices over a larger span of time, and take into account the changes between the first and the second version of the Industrial Injuries Insurance Act. My aim is not to provide an exhaustive or complete history of incapacity for work, if such a thing exists. Instead, my analysis of selected case studies aims to thoroughly describe some of the ways in which incapacity for work was made up in practice, allowing me to also take into account changes over time. The cases consulted provide ample material to meet that purpose.

It is however, important to note that the number of cases per year vary considerably. As Table 1 in appendix I shows, 1935 was a "peak year" with 1,547 appeals, while the number of cases fell in the final years in which the Industrial Injuries Insurance Act was in force, with only 103 cases in 1965. There are multiple possible explanations for this fluctuation. The accident statistics of the Rijksverzekeringsbank show that the number of workplace accidents dropped over the course of the twentieth century, which could be due to technological innovation, workplace safety measures, changing nature of work, or increased awareness of workplace safety.[67] I believe that the fluctuation in numbers of cases is also connected to the fact that the legislator had intentionally left the definition of incapacity for work open and did not provide many guidelines for the claim assessment, so that the Rijksverzekeringsbank would have the freedom to come up with its

66 Tony Wrigley, "Sampling in Historical Research", in: Tony Wrigley, *Nineteenth-Century Society. Essays In the Use of Quantitative Methods for the Study of Social Data* (Cambridge: Cambridge University Press 1997) 146-190, Paul M.M. Klep (ed.) *Steekproeven uit massale archiefbestanden ter wille van historisch belang* (The Hague: Koninklijke Vereniging van Archivarissen 1997).

67 National Archive, The Hague, 2.15.55, Ministerie van Sociale Zaken en Werkgelegenheid: Rijksverzekeringsbank, Inv. No. 336-373, Ongevallenstatistiek 1903-1956.

own organisational structure, which would then be corrected where necessary by the Central Council of Appeal.[68] Debates about eligibility and ways to measure incapacity for work were fought out in the courtroom. This makes it such an interesting source for this dissertation. But it also made the decisions of the Rijksverzekeringsbank prone to a lot of appeals, whose number would then vary due to all kinds of factors. For instance, since the scope of the Industrial Injuries Insurance Act was extended in 1921 and more workers became eligible for benefit, it makes sense that the number of claims increased. In particular, some, but not all, occupational diseases were now considered 'workplace accidents' by law, which resulted in a lot of higher appeal cases dealing with that matter. I am not able to provide a solid or conclusive explanation for the exact fluctuations,[69] but for this dissertation it is important to keep in mind that the appeal cases functioned as an arena in which the search for the properties of incapacity for work took place. And in this dynamic all kinds of cultural, legal and political circumstances played a role, and become central to the situated analysis of incapacity for work.

This situatedness is also related to the legal nature of the sources. The verdicts are written down by a clerk in a structured manner that corresponds with the rules and customs applied for legal documents. It describes the legal matter, the appeal and the defence (if pleaded). Then it continues with the 'considering' section (*het overwegende*), in which the statements by the witnesses are described. It ends with the deliberations and the decision of the council. The documents only discuss what was stated, and it is important to note that the verdicts only provide the information that the court found relevant. It is very rare for a physical gesture to be described, for instance only when a worker showed their injured hand to the council. There is no mention of other kinds of behaviour, nor are there visual descriptions or references to expressed emotions. Bruno Latour and Irene van Oorschot have shown that the compilation of the documents and files can, in itself, be analysed as practices in legal case-making, enacting administrative and criminal law respectively. They take the law in itself as the object of study and analyse how the process of legal decision-making is done in court and other legal practices.[70] In

68 Joost van Genabeek, "Opbouw: de Periode 1901-1920", in: Eddy Houwaart and Wout de Boer (eds.) *Geschiktheid Gewogen: Claimbeoordeling en Arbeidsongeschiktheid in Nederland 1901-2005* (Hoofddorp: TNO 2006) 78-94.

69 There are many economic, social, political and legal variables that could have impacted this. Greg Eghegian has, for instance, argued that in the interbellum German welfare state a claim culture emerged which resulted in a social entitlement state, thus providing a cultural explanation for the rise of appeal cases. Greg Eghighian, *Making Security Social: Disability, Insurance, and the Birth of the Social Entitlement State in Germany* (University of Michigan Press: Ann Arbor 2000).

70 Bruna Latour, *The Making of Law – Ethnography of the Conseil d'Etat* (Cambridge: Polity Press 2009), Irene van Oorschot, *The Law Multiple. Judgement and Knowledge in Legal Practice* (Cambridge: Cambridge University Press 2021)

this dissertation though, it is not the law, but enactments of incapacity for work that I study.[71] The court functions as the place, the arena, in which enactments of incapacity for work are navigated to become a singular phenomenon which can be real or simulated, or which a person can fully or partially embody. There is something at stake here, incapacity for work is negotiated, and this makes the higher appeal cases so valuable for this dissertation. I therefore used these legal documents to distil practices from them. I consider the described examinations and analyses as a given. When a psychiatrist claims they observed a worker in a swimming pool, I do not question whether this psychiatrist had been physically in that pool, neither do I analyse this as a form of tactics that reveals an agenda. Instead, I use this information as a way to gain insight into what incapacity for work he enacted with this observation. To what understanding of incapacity for work did he adhere when observing a swimming worker? By reading verdicts in such a manner, and by focussing on a variety of enactments that are derived from the statements made in court, these verdicts, however limited, provide insights into the making up of incapacity for work that cannot be found anywhere else. Lastly, I would like to point out that the case files I used are only partially available for inspection by the public. To honour the European General Data Protection Regulation and the privacy of the persons involved, I have given the workers pseudonyms.[72]

IV STRUCTURE

This dissertation highlights the ways in which incapacity was *made up* by the three parties involved in these cases, namely the Rijksverzekeringsbank, the expert witnesses and the workers. The first chapter deals with the ways in which the Rijksverzekeringsbank implemented the first version of the Industrial Injuries Insurance Act (1901-1921). It shows that the legislator had left the definition of incapacity for work open for interpretation in

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71 I analyse a different process. Sociolegalists Ron Levi and Mariana Valverde explain in their discussion of ANT and the work of Latour : "It is admitted that each of the actants could also be analyzed as itself a network; that is, as the temporary product of some other ongoing process (…) In other words, the distinction between actor and network is not an ontological one, but rather one that has to be made by the analyst, purely for the sake of focusing on *this* network." Ron Levi and Mariana Valverde, "Studying Law by Association: Bruno Latour Goes to the Conseil d'État", *Law & Social Inquiry* 33.3 (2008) 805-825.

72 The archive of the Central Council of Appeal that holds the documents of the cases between 1903 and 1939 is available for consultation in the Dutch National Archives in the Hague. For the time period 1939-1967 these are open for research purposes only and available upon special request at the current Central Council of Appeal in Utrecht. The practice of pseudonymization is in correspondence with the research data management requirements of the Dutch Scientific Organization (NWO), as well as with the ethical research policy as drawn up and applied by the Humanities Faculty of Utrecht University.

practice, but required that it should be measured and put into percentages. The practical circumstances, for instance the time pressure under which the director of the Rijksverzekeringsbank had to come up with an organisational structure for the claim procedure, as well as the decision to let medically trained officers perform both the medical examination and the claim examination, together formed the practices in which incapacity for work was made up as a calculation based on the severity of the bodily injury. Moreover, distrust of workers and worries about fraud can also be considered a practice in which incapacity for work was made up. The Rijksverzekeringsbank and workers together adhered to the idea that workers might fake their injuries. Distrust towards workers had already been a prominent factor in the liability cases that, prior to the implementation of the Act, had been a way for workers to receive some form of compensation in case of workplace accidents. In higher appeals, workers stressed their trustworthiness and tried to prove their good moral conduct, while the Rijksverzekeringsbank discussed intensively how to test this, enacting incapacity for work as a morality issue.

The second chapter considers the changes in the new version of the Industrial Injuries Insurance Act (1921-1967) and its implementation by the Rijksverzekeringsbank. The reformed Act was there to make more people eligible for benefit, and moreover focussed on the relationality of incapacity for work, stressing that there should be a fit between the bodily functioning and the workplace in which the worker had performed their job. This chapter shows that, in practice, this resulted in a strong focus on rehabilitation. The changes in the Act, combined with the availability of medical-technical measures and therapy, interacted with notions of work as a purifying experience and civic duty. Together, this suggested incapacity for work as a temporal state, something the worker should adapt to and strive to overcome.

Chapter 3 then focusses on the statements of expert witness. It shows how medical doctors who were invited to act as expert witnesses continuously shifted between a clinical and juridical context. I analyse their use of the labels 'traumatic neurosis' (which was used for medically unexplained impairments) and 'silicosis' (a newly identified lung disease), and show how in these specific cases incapacity for work became both a symptom and the origin of the disease. These medical labels and incapacity for work were co-created. In that process the Industrial Injuries Insurance Act became a pathogen, and incapacity for work was enacted as illness.

In the fourth and final chapter, workers take the stand. It becomes clear that workers engaged intensively in the making up of incapacity for work, for instance by actively participating in a debate about expertise. In their statements, workers analysed incapacity for work as something a neutral and knowledgeable expert should decide on. Often they underlined their own lived expertise, adding to this enactment of incapacity for work as the product of knowledge. Alongside this enactment, a different enactment

can be traced, namely the incapacity for work as the impossibility to perform labour. In higher appeal, workers stressed that they were unable to achieve their former productivity, not just because of their injured bodies but more often because of competition, because workplaces that were not adapted to their bodily functioning and sometimes also because of discrimination based on their physical appearance. A third enactment of incapacity for work can also be distinguished. In the statements of workers, their experiences with pain, fatigue, and the pressure caused by rehabilitation measures as well as the general stress that came with the claim assessment added to their reduced capability to work. Like doctors, they identified the claim procedure under the Industrial Injuries Insurance Act as reducing working capacity, while enacting incapacity for work as a holistic and daily experience.

Since the various actors — the officers in service of the Rijksverzekeringsbank, medical experts and disabled workers — have each been analysed within a different historical field of study prior to this dissertation, each chapter starts with a reflection on the historiographic framework relevant to the actors in question. To each of these frameworks a praxiographical analysis of incapacity for work offers something new, such as an alternative chronology of state welfare, a nuanced understanding of medicalisation or a way to write histories of marginalised groups in the past while also making room for negative experiences of disability. In this way I can engage with different debates and consider the advantages of applying a praxiographical approach for different historical narratives.

As noted, I analyse the making up of incapacity for work from three angles, corresponding to the three parties heard in higher appeal cases. Contrary to what this three-part division might suggest, the three parties were not necessarily using opposing rationales or techniques. Neither do their approaches to incapacity for work fully coincide with a difference in their points of view, power position, or interests. They did bring their own norms, practices, expertise and experiences and their occupational, social, medical and political values with them. Sometimes the rationales would overlap, sometimes they did not. As we shall see, the statements of the Rijksverzekeringsbank, medical experts and workers resulted from an intense interaction with each other as well as with the examination practices corresponding to the Industrial Injuries Insurance Act. My aim is to show how incapacity for work was negotiated in practice. This dissertation therefore does not present three sharply divided perspectives on incapacity for work, but instead presents different angles from which the interaction can be analysed. This provides room to consider how socio-political, cultural and material practices mutually produced incapacity for work. It demonstrates that, historically speaking, incapacity for work was by no means a clear phenomenon, but a transformative concept that included practical procedures, calculations, notions of work, good citizenship, poverty, medicalisation, X-ray

photos, pain, pity and frustration. It shows us how social security legislation as such produced the categories it described, and helps us to gain a deeper understanding of the intended and unintended outcomes that affected the material lives of disabled workers.

Chapter 1

Quantification and moral accountability

Incapacity for work enacted by the Rijksverzekeringsbank in the exploratory phase of the industrial injuries insurance act (1901-1921)

This chapter deals with the ways in which incapacity for work was brought into being by the Rijksverzekeringsbank in the context of the first version of the Industrial Injuries Insurance Act. The Rijksverzekeringsbank was a state institution established in 1901 to implement the Act and develop a whole organisational structure to collect premiums and grant benefits. It thus played central role in translating the Industrial Injuries Insurance Act into day-to-day practices and distinguishing between capacitated and incapacitated workers.

Because the Act was the first form of social security legislation in the Netherlands, the Act itself and the organisation of the Rijksverzekeringsbank are usually studied as part of a much broader analysis of the origins of the Dutch welfare state. The focus has been on the “what” and “why” of social security arrangements. ‘Why did people start to form collective arrangements?’ the sociologist Abram de Swaan asks.[73] The scholars Anton Rommelse, Marcel Hoogenboom and others have discussed what constituted the socio-political foundation for the introduction of disability benefit.[74] Historians like Wout de Boer and Eddy Houwaart have examined the organisation of the Industrial Injuries Insurance Act and describe how the Rijksverzekeringsbank and its medical department operated.[75] These studies provide us with invaluable insights into the political and organisational introduction of the Industrial Injuries Insurance Act and with the social, political and economic problems that led to it. What is absent from these studies is a focus on the cultural consequences of social security legislation. Incapacity for work, as such, is not theorised. As a result, scholars somewhat naturally work with a version of incapacity for work that is rather close to how historical actors who designed and advocated social legislation described it. They adhere to incapacity for work as an individual problem, a matter of bodily dysfunction with poverty as a result. It is seen as an individual problem that, because of the numbers involved, had huge socio-economic consequences, and was therefore ‘taken care of’ by societies, but was an individual problem nonetheless. This dissertation, however, takes incapacity for work not as a given. It shifts the attention to the bringing into being of incapacity for work. In this chapter I will therefore move beyond the existing historiography on social security legislation and the welfare state, and analyse the Industrial Injuries Insurance Act and the Rijksverzekeringsbank as actors in the making of incapacity for work.

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73 De Swaan, *In Care of the State*.

74 De Vries, *De Invloed van Werkgevers en Werknemers,* Noordam, “Sociale verzekeringen 1890-1950”, Rommelse, *Een Geschiedenis van het Arbeidsongeschiktheidsbeleid,* Bergham, Nagelkerke, Boos, Doeschot and Vonk (eds.), *Honderd Jaar Sociale Zekerheid,* Hoogenboom, *Standenstrijd en Zekerheid.*

75 Houwaart and de Boer (eds.) *Geschiktheid Gewogen*.

First I will further discuss the historiography on social security legislation, and briefly look at what historians have taken to be the socio-political motivation behind the introduction of disability benefit in the Netherlands. I will show how incapacity for work has mainly been described as the lack of an opportunity to earn a living. Then I will delve into some of the most important articles of the Industrial Injuries Insurance Act itself and show how incapacity for work was introduced in the law. I will illuminate how the legislator had purposely left the definition of incapacity for work open, leaving much room for case-based interpretations while also initiating the process as a matter of estimation. Subsequently, I will analyse two enactments of incapacity for work that I traced in the higher appeal cases between 1901 and 1921. The first is incapacity for work as quantification. The open formulation of Article 22 of the Industrial Injuries Insurance Act in conjunction with a calculation model initiated by the Act, led to the aim to quantify incapacity in terms of percentages.

This calculation was then used in court by both the Rijksverzekeringsbank and the workers to emphasise the legal validity of their perspectives. This ties in with the second enactment, which is incapacity for work as moral accountability. As De Swaan has briefly touched upon, the socio-political idea behind disability benefit legislation, namely that the collective paid for the individual financial consequences of disability, in itself produced a notion of incapacity for work that put great responsibility on the disabled worker to prove not only the legal validity of their claim but also the moral validity.[76] In this part I will show how, in the appeal cases, workers dealt with suspicion of fraud and I will reflect on distrust as a practice in the introduction of disability benefit legislation.

Although there were other enactments of incapacity for work, I found that for this period in time the matters of calculation and individual accountability were the most evident in the source material. As we will see in the discussion of the court cases, both enactments were prominent in this period 1901-1921 in the substantiation of claims about incapacity for work. This shows how the incapacity for work was not just a matter of following the letter of Article 22 of the Industrial Injuries Insurance Act, but instead was the product of interaction with political debates and the organisational structure of the Rijksverzekeringsbank, as well as ideas about the work ethic and morality of workers.

This chapter covers a period that I consider the exploratory phase of the Industrial Injuries Insurance Act and deals with the introduction of the Act. Because it was the first form of social security legislation and the Rijksverzekeringsbank was a brand-new organisation, this period between 1901 and 1921 marks a moment in time in which newly appointed government officials had to translate all kinds of socio-political ideas and values about social security and incapacity for work into day-to-day operationalisation.

76 He connects this to Norbert Elias' notion of civilisation processes. De Swaan, *In Care of the State,* 252-257.

They had to work with unexpected problems and all sorts of growing pains, and deal with medico-legal practices of the higher appeal cases that eventually resulted in a legal reform in 1921. With the newly reformed version of the Industrial Injuries Insurance Act, both the legal definition of incapacity for work and the claim procedure changed substantially. I have therefore decided to divide the analysis of the making up of incapacity for work by the Rijksverzekeringsbank into two chapters. By doing so, I am able to highlight the operational dynamics, the interactions between the legal text of the Act and the everyday practicalities of the execution that together resulted in changing enactments of incapacity for work.

1 SOCIAL RESPONSIBILITIES

Technically speaking the Industrial Injuries Insurance Act was not the first arrangement to insure individuals against the financial consequences of workplace accidents in the Netherlands. Private and corporate initiatives had arranged forms of social security before.[77] However, the Act was the first national act that introduced compulsory insurance of labourers for disability. It was the first time that 'the Dutch state arranged a system in which the collective paid for the individual, and the risk of hazards was shared', as De Swaan put it.[78] This exemplifies the way in which the Industrial Injuries Insurance Act has mostly been studied, namely in its capacity as the first social security law in the Netherlands.

Industrialism, capitalism and growing state intervention

The vast majority of studies of social security legislation in the Netherlands have been conducted by historians in the fields of political and socio-economic history. But the Industrial Injuries Insurance Act has also drawn the attention of sociologists analysing the origins of the Dutch welfare state. While historians have provided detailed analyses of the specific socio-political and economic circumstances in which the Act was introduced, sociologists have focussed on the question why the collective started to take care of individual loss of income due to disability. However different in approach, most scholars have identified industrialisation, the rise of capitalism and the Social Question

77 Joost van Genabeek, *Met Vereende Kracht Risico's Verzacht. De Plaats van Onderlinge Hulp Binnen de Negentiende-eeuwse Particuliere Regelingen van Sociale Zekerheid* (Amsterdam: IISG 1999), Joost van Genabeek, "Voorgeschiedenis. De Periode tot 1901", in: Eddy Houwaart and Wout de Boer (eds) *Geschiktheid Gewogen: Claimbeoordeling en Arbeidsongeschiktheid in Nederland 1901-2005* (Hoofddorp: TNO 2006) 23-51.

78 De Swaan, *In Care of the State.*

as the catalyst forces for the introduction of social security legislation in general, and the Industrial Injuries Insurance Act in particular.
In his study on the Dutch political history of disability policy, the legal historian Anton Rommelse, for instance, writes about industrialisation and capitalism in the Netherlands, which started off as a form of agricultural mechanisation around the 1870s. Rommelse writes that when the waterways and railway system were extended, larger industries were established, such as the textile factories in the region of Twente. He describes the process in which these forms of industrialisation gave rise to economic changes which made labour subject to market forces. Population growth led to a surplus of manual labourers during the second half of the nineteenth century. Moreover, social inequality became more visible as company owners were able to make a profit from these economic and industrial changes, while labourers had to deal with bad working conditions and poverty.[79] According to Rommelse, it was in encounters with poverty and the associated problems that the reformist agenda of social liberalists was formed, and the first steps towards social security legislation were taken. Liberalism traditionally emphasised the importance of individual freedom and independence and therefore limited state intervention to what was absolutely necessary. However, Rommelse claims, company owners, who were often liberals, worried about moral decay among workers and felt the need to contribute to a form of edification. Whether the desire to find a solution for this so-called Social Question was motivated by empathy, paternalism or the wish to make workers more productive, it resulted in a more widely-supported idea that the state should make some interventions. The Children's Act *(Kinderwet*, 1874) was introduced to end child labour, and after a parliamentary committee investigated working conditions in various industries in 1887, safety measures were implemented and working hours and wages were regulated in the Labour Act (*Arbeidswet*, 1889) and the Safety Act (*Veiligheidswet*, 1895). This paved the way for collective social security insurance, Rommelse writes, of which the Industrial Injuries Insurance Act was the first example.[80]

These socio-economic circumstances in nineteenth-century Netherlands, which accordingly led to changes in the political stance on social arrangements, are described by many scholars working on the history of social security legislation. There is, moreover, a long tradition of research in which the socio-economic position of companies is analysed together with growing state intervention at the beginning of the twentieth century.[81] In this historiography, the final design of the Industrial Injuries Insurance Act

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79 Rommelse, *Een Geschiedenis van het Arbeidsongeschiktheidsbeleid in Nederland*, 10-13.

80 Ibidem.

81 See for instance: Willem de Vries, *De Invloed van Werkgevers*, Noordam, "Sociale Verzekeringen 1890-1950", 570-604, *Honderd Jaar Sociale Zekerheid in Nederland*, Kappelhof, "'Omdat Het Historisch Gegroeid Is'", 71-91.

is considered the outcome of many debates on state power and the self-determination of companies, in which employers had quite a say.[82] This resulted in the rather distinctive design of the Industrial Injuries Insurance Act in which the authority over the claim assessment and the payment of benefit was in the hands of the state bank, but in which employers could still decide to pay premiums to a private insurance company. These private insurance companies would then lobby on behalf of employers and critically assess the activities of the Rijksverzekeringsbank, to ensure social security legislation was an employer-employee affair.[83]

The work of Rommelse and others gives very detailed descriptions of political reasoning and provides an overview of the socio-economic and political context within which the Industrial Injuries Insurance Act took shape. But they lack two things: a bottom-up approach; and cultural-historical reflection on the meaning of the Industrial Injuries Insurance Act for social relations and the notion of what incapacity for work was. As Marian van der Klein has pointed out, many histories of the Act describe an 'almost intrinsic logic' of the development of social security legislation in the Netherlands. The focus has been on the struggle for power, but these histories leave out the perspectives of people who are often considered powerless, such as labourers and, as Van der Klein

82 One of the most debated issues is the difference between the original draft of the Industrial Injuries Insurance Act and the first version that was finally implemented. In the first draft by Cornelis Lely, the Rijksverzekeringsbank was to be solely responsible for implementing the law. However, this was rejected by the First Chamber. The 1901 version of the Industrial Injury Insurance Act, also drafted by Lely, therefore included the free choice of insurer and the possibility for companies to transfer risk and pay a premium to a private insurance company of their choice. Although the Rijksverzekeringsbank was still responsible for the assessment of claims and the payment of benefits, the revised Industrial Injuries Insurance Act is often seen as a victory for business owners, who retained political power over social security policy. This is one of the main conclusions of sociologist Marcel Hoogenboom's work. Hoogenboom, *Standenstrijd en Zekerheid*.

83 We should be careful not to exaggerate the real power of employers in the practice of implementing the Industrial Injuries Insurance Act. According to Peter Kerklaan, private insurance companies such as the *Werkgevers Risico-bank* had to work with labour unions which were suspicious of the motives of employers' organisations, making it difficult to represent employers' interests. In addition, Loes van der Valk has shown that historians tend to think that company owners exercised control over the Industrial Injuries Insurance Act because the insurance premiums for companies insured by the Werkgevers Risico-bank were much lower than those for companies insured by the Rijksverzekeringsbank. She used accident statistics to show that this was because the Rijksverzekeringsbank had expected fewer claims than it received and was therefore faced with higher costs, which it passed on to employers. The low premiums paid by Risico-Bank cannot therefore be seen as evidence of the employers' dominance, but rather as evidence of mismanagement on the part of the Rijksverzekeringsbank. Peter Kerklaan, "De Lange Houdbaarheid van de Ongevallenwet in Nederland 1901-1967", *Tijdschrift voor Sociale en Economische Geschiedenis* 3.4 (2006) 64-90, Loes van der Valk, "Taak, Bevoegdheid en Prestaties van 'Risico-overdracht' Onder de Nederlandse Ongevallenwet 1901", *Tijdschrift voor Sociale en Economische Geschiedenis* 7.4 (2010) 50-74.

has shown, women.[84] As a result of this top-down approach, political and economic processes have been described in quite some detail, but the reflection on the social consequences of the Industrial Injuries Insurance Act has only rarely been studied. For this we need to turn to sociologists, who have analysed the Act as an example of major changes in societal relations at the end of the nineteenth century.

Why societies started to take care of 'individual hazards'

One of the most prominent works on social security legislation in Europe comes from Abram de Swaan. In his book *In Care of the State. Health Care, Education and Welfare in Europe and America*, he poses the question of why societies came to accommodate collective arrangements to avert the individual consequences of hazards.[85] De Swaan describes a process of 'collectivisation of welfare'. He states that social security emerged out of a form of class struggle, with capitalism as the driving force.[86] This was not the type of class struggle in which the working class rebelled against capitalists. Instead, it was the result of a process in which new alliances were forged between reformist politicians, leading government officials, employers and trade unions. Once the consequences of poverty were felt by the rich, De Swaan claims, the interdependency between these 'elites' intensified. Concerns about the Social Question, for instance, but also the realisation that workers would become significant consumers once poverty was averted, made them aware of social interdependency and proceed to collective action.[87] According to

84 In order to diversify the history of the Industrial Injuries Insurance Act, van der Klein herself has written about the involvement of the women's movement in the design and implementation of the Act. She has shown how the women's movement was reluctant to play a prominent role in debates about industrial accidents, because it did not want to tarnish the image of women's work. However, 25% of the working population in the Netherlands around 1900 was female. Van der Klein corrects the image of women benefiting from disability benefit legislation only as widows, and uses statistical analysis to show that women were more likely to claim benefits as workers than as widows. Marian van der Klein, *Ziek, Zwak of Zwanger. Vrouwen en Arbeidsongeschiktheid in Nederlandse Sociale Verzekeringen 1890-1940* (Amsterdam: Aksant 2005) 31-51.

85 De Swaan, *In Care of the State.*

86 Ibidem, 173-183.

87 According to de Swaan, one of the main debates was on how to distribute the costs associated with collective goods. In these debates, it was mainly small businesses that resisted any form of collective insurance. De Swaan points to the threatening image of large companies, a powerful state and powerful trade unions, that put smaller companies in an insecure position, and he uses this as to explain their resistance. However, this resistance was broken by new alliances that were formed between reform-minded politicians in the expanded state bureaucracy, supported by business owners and labour unions. De Swaan sees this 'four-sided configuration' as the basis for the process of collectivisation of social security. De Swaan, *In Care of the State,* 19-20, 173-183.

De Swaan, collective insurance schemes '(...) ironed out both the tops of plenitude, which were scarce, and the numerous abysses of misery in individual lives'.[88]

Rob Schwitters brings the more general subject of social security legislation down to a focus on the Industrial Injuries Insurance Act but analyses it in the same Swaanian terms.[89] He states that the social relations in cases of accidents had become more and more defined in legal terms, and traces the origin of the decision to introduce the Industrial Injuries Insurance Act to the legal principle of professional risk (*risque professional*), which meant that the scope of the Act was limited to workplace accidents, and that Act was not applicable to accidents outside of the work environment. According to Schwitters, the rationale behind this was that, in accepting employment, workers relinquished some of the control over their own lives, and should therefore receive a form of protection in return. This was what the responsible minister who drew up the Industrial Injuries Insurance Act, Cornelis Lely, had claimed. [90] In the explanatory memorandum Lely emphasised the collective nature of the Act and wrote that the Industrial Injuries Insurance Act was created to protect the collective from common threats.[91] This is why, according to Schwitters, despite its limited scope, the Industrial Injuries Insurance Act represents a shift to thinking about hazards as a collective responsibility. Schwitters points to a process of *sociologicalisation* starting in the 1880s, whereby people started to realise that individuals were socially dependent on each other and started to reflect on this fact. Accidents were no longer considered a matter of providence, but the result of risk. In this process, the legal foundation of accidents changed from guilt to calculation, which Schwitters sees reflected in a rather radical *rationalisation* of injuries, liability and responsibility. Before the introduction of the Industrial Injuries Insurance Act, Schwitters claims, social relationships were based on solidarity and were highly informal. With the Act came a much more formal and instrumental way of looking at help, which he understands as shared self-interest. To Schwitters, the Industrial Injuries Insurance Act is a manifestation of these processes of sociologicalisation and rationalisation going hand in hand.[92]

The social historian Greg Eghigian focusses on the implementation of disability benefit in Germany, but comes to similar conclusions. He argues that the welfare state was not so much a redistribution of income as a redistribution of risk and insecurity,

88 Ibidem, 20.

89 Robert Jan Schwitters, *De Risico's van de Arbeid. Het Ontstaan van de Ongevallenwet 1901 in Sociologisch Perspectief* (Groningen: Wolters-Noordhoff 1991) 1-8.

90 Ibidem, 305-313.

91 *Staatsblad van het koninkrijk der Nederlanden* (No. 1), Royal Decree 2 January, 1901.

92 Schwitters, *De Risico's van de Arbeid.*

which made the welfare state an administrative solution to the Social Question. As a consequence, he claims that workers began to feel entitled to benefit, which translated in 'overwhelming litigiousness'.[93]

De Swaan, Schwitters and Eghigian identify industrialism and capitalism, as well as the Social Question, as the main processes that made different social groups more interdependent and therefore required social arrangements to take care of 'individual hazards'. What makes their work different from political-historical approaches to the introduction of social security legislation is that they also analyse this as a process in which individual generosity and compassion is transferred to the state. As we shall see later in this chapter, this had a big impact on how the Industrial Injuries Insurance Act functioned in the lives of the workers who claimed disability benefit, and, subsequently, on how the incapacity for work was enacted in the legal practice of higher appeal cases. Also, De Swaan, Schwitters and Eghigian have analysed sociological processes around security arrangements and adopted a broad perspective. To do so, De Swaan explicitly rejected the use of primary sources or fieldwork to prevent himself from getting lost in details, and to hold on to the bigger picture of the process of collectivisation over a long period of time and in multiple regions.[94] Schwitters and Eghigian have built their theses on extensive archival work, but have also focussed on the broader societal developments.

This bigger picture is informative and allows transnational and comparative analysis, but it lacks a more detailed, bottom-up analysis. In this dissertation I take the 'bringing into being' of the category of incapacity for work as my main concern, and for this purpose details and specificities are crucial. As we shall see, the collectivisation sociologists described that took shape over the course of the nineteenth and twentieth centuries can be found in historical source material and case histories, because the process of becoming more interdependent had individual consequences and was evident in the higher appeal cases in which the incapacity for work was investigated. The implications become evident when observed in individual practices, as that is where incapacity for work was effectively implemented: it was enacted in the details. I take the work of De Swaan and others as a starting point, and from there I drill down into the practices through which incapacity for work took shape.

The incapacity for work as loss of income with poverty as consequence

This brief historiography of the introduction of the disability benefit legislation shows that incapacity for work has mainly been studied as a given in the socio-political history of the beginning of social security arrangements in the Netherlands and Europe. In this

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93 Eghigian, *Making Security Social*.

94 De Swaan, *In Care of the State,* 11-22.

narrative incapacity for work is the loss of the ability to generate income. It is interesting to note that in their consideration of the welfare state, the historians and sociologists discussed above stay rather close to their historical actors in their enactment of incapacity for work. While they focus on a much broader socio-economic analysis, they analyse incapacity for work as an individual problem with an injured body, a 'hazard' for which a collective solution was needed. As we shall see, this is one of many enactments of incapacity for work and was thus by no means universal. My aim is to shift the attention away from the bigger socio-economic contexts and instead focus on what these scholars have taken as a given: incapacity for work in the practice of the execution of the Industrial Injuries Insurance Act. While taking their insights on the introduction of disability benefit legislation as the starting point for my analysis, I shift the focus to the day-to-day operationalisation of the Act to see how incapacity for work was made.

As we shall see, in the practice of the higher appeal cases, this focus on individual hazards and the chances of earning a living was not that vital to the discussion about incapacity for work in the actual application of the Industrial Injuries Insurance Act. That does not mean that the underlying rationale of collective arrangements to prevent individuals from falling into poverty did not play a role at all in the establishment of the incapacity for work. In the following section I will focus on how this rationale translated into the formulation of the law of the Industrial Injuries Insurance Act itself. Then I will show how the focus on collective arrangements to prevent individual loss of income interacted with the organisational structure of the Rijksverzekeringsbank, as well as with techniques with which workers tried to reinforce their claim to benefit.

2 LIMITED SCOPE, CONSIDERABLE IMPACT

The Industrial Injuries Insurance Act that came into force in 1901 may seem rather limited in its scope. According to Article 19 of the Act, workers were solely insured for accidents that took place during working hours and at the actual workplace; this did not include accidents on the way to work or during breaks.[95] Jurisprudence shows that the Act was not applicable in situations in which people burned their hand on the stove while making coffee,[96] or when they slipped on a banana peel and broke their leg while taking care of

95 National Archives The Hague (hereafter NA), 2.09.39, Centrale Raad van Beroep (hereafter CRvB), Inv. No. 129 Uitspraaknummers 487-980, 1905, januari 3-1905, december 22. Please note that I have deliberately not translated the Dutch names of the archives and inventories. The documents are archived by their Dutch names, an English translation would make it more difficult to find them in the National Archives.

96 Ibidem.

the company dog on their way to work.[97] Two separate disability benefit acts, for the agricultural and maritime sectors, were still in the making.[98] Moreover, the first version of the Act only applied to designated dangerous industries and occupations in which people had to work with very hazardous equipment, such as heavy steam or gas engines.[99] The case histories that I discuss in this chapter, therefore, only concern the incapacity for work of labourers in these specific risky occupations.

Before the Industrial Injuries Insurance Act was introduced, only a few people were insured against disabilities. Some factories had their own insurance policies, and some companies were affiliated with so-called Industry Funds (*bedrijfstakfondsen*) that had arranged forms of industry-wide collective insurance. However, many of the workers who ran the most risk, namely the unschooled manual labourers in factories, did not have enough money to pay for insurance at all. Around 1890, only 14% of the total working population in the Netherlands was insured against disability caused by a workplace accident. With the introduction of the Act, this number increased to 25%.[100]

However limited in its application, the political and social impact of the Industrial Injuries Insurance Act was considerable. This had mainly to do with the protection of the socio-economic position of labourers, which had gained importance in the political debates in preparation of social security legislation. As stated before, scholars have pointed out that poverty was increasingly considered to be a threat to society as a whole, and that was one of the main incentives to introduce disability benefit, even if it meant the government playing a central role in a sphere that used to be dominated by charity.[101] The focus on the financial consequences of incapacity for work due to a workplace accident, therefore, became central to the design of the Act itself which was manifested in the articles concerning the incapacity for work.

The loss of physical abilities is the loss of income

The first article of the Industrial Injuries Insurance Act stated that workers working in the designated fields, which this article summed up, were insured against the monetary effects of an accident that happened to them while participating in activities corresponding to their profession.[102] In the second article the legal concept of worker (In Dutch the

97 NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

98 Article 11 of the Industrial Injuries Insurance Act 1901

99 Article 10 of the Industrial Injuries Insurance Act 1901.

100 Van Genabeek, “Voorgeschiedenis. De Periode tot 1901”, 41-42.

101 Van Genabeek, “Voorgeschiedenis. De Periode tot 1901”, 23-51, Schwitters, *De Risico’s van de Arbeid,* 1-8.

102 Article 1 of the Industrial Injuries Insurance Act 1901.

gendered term *werkman* was used) was specified as a person who received a salary[103] for the work they performed.[104] A person who was not on the payroll, for instance a pupil who performed activities as part of an apprenticeship, was therefore not considered a workman, and the Act did not apply to their situation.[105] These two articles already reveal the focus on the incapacity to generate an income. By excluding pupils and other young people who performed unpaid labour, this suggests that it was the (male) breadwinnership of these workers that the state wanted to protect.[106]

The Rijksverzekeringsbank had six weeks to investigate the incapacity for work, the workplace accident and the causal relationship between the two. If the labourer was able to resume their work within three days, the legislator decided there was no need for monetary compensation. If a doctor in the service of the Rijksverzekeringsbank had indicated that the person under consideration was not able to go back to work, then compensation amounting to 70% of the salary was granted for as long as the incapacity for work lasted, with a maximum of 43 days.[107] During that time the Rijksverzekeringsbank covered the costs for medical examination and treatment.[108] Article 21 of the Industrial Injuries Insurance Act stipulated that once the causal relationship between the incapacity for work and the workplace accident had been established, and the incapacity for work had been determined to exist in full or in part, the Rijksverzekeringsbank would grant disability benefit. This benefit consisted of financial compensation of 70% of the daily wage that the worker had earned before the accident happened. Section b of Article 21 stated that in the case of partial incapacity for work, a proportionate percentage of that 70% was granted in line with the loss of the incapacity for work. The Act did not get any more specific than that, which, as we shall see, resulted in a search for a set of fixed percentages that had to correspond with the incapacity for work.

Article 22 of Act described what the legal concept of incapacity for work entailed, namely the loss in physical powers and capability that was once there, but had been lost

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103 Article 5 of the Industrial Injuries Insurance Act 1901 stated that this included the monetary value of the income that was paid in kind, such as food or housing.

104 Article 2 of the Industrial Injuries Insurance Act 1901.

105 The focus on breadwinnership was even more pronounced in cases where a worker had died in a workplace accident, and the family claimed widow's benefits.

106 For a deeper analysis of this notion of breadwinnership and its gendered implications in different welfare regimes, see: Jane Lewis, "Gender and the Development of Welfare Regimes", *Journal of European Social Policy* 2.2 (1992) 159-173, Van der Klein, *Ziek, Zwak of Zwanger,* Gareth Millward, *Sick Note: A History of the British Welfare State* (Oxford: Oxford University Press 2022) 72-101.

107 Article 20 of the Industrial Injuries Insurance Act 1901.

108 Article 19 of the Industrial Injuries Insurance Act 1901. The practical implementation was regulated by a separate government decree.

after the accident. It states: 'For the application of the Act, a workman is considered fully or partially disabled when he is fully or partially unable to perform labour, according to his powers and capabilities from before the accident.'[109] This rather broad definition was purposely left open for interpretation so that the policymakers of the Rijksverzekeringsbank would have the scope to organise the application of the Act as they saw fit. Jurisprudence would then ensure that the Act was applied in reasonableness and fairness (*redelijkheid en billijkheid*). It might not come as a surprise that this led to debate between government officials and newly appointed doctors in the service of the Rijksverzekeringsbank on how to determine incapacity for work and on how to make sure the application was fair.[110] These debates resulted in bureaucratic regulations that sought the answer in standardisations. In the higher court cases, these standardisations then became subject to debate, bringing back the topic of good faith and fair dealing.

Industrial Injuries Insurance Act as experiment

The Industrial Injuries Insurance Act provided a legal foundation for the distribution of disability benefit. However, it did not give a very clear lead on what could be considered to constitute this incapacity for work. The board of the Rijksverzekeringsbank was given considerable authority to organise the administration as they saw fit, and the practice of the examination of claims would then be corrected where necessary in appeal cases. In a way, the Act was designed as an experiment and the legislator already anticipated future revisions of the Act. The interpretation of incapacity for work that was presented in Article 22 of the Industrial Injuries Insurance Act, namely the inability to earn an income, was already broad in its definition and left much room to be changed and adapted over the course of time in the implementation of the act.

Now let us shift attention to the execution of the Act by the Rijksverzekeringsbank and focus on how incapacity for work was enacted in their statements. As we shall see, the emphasis on the ability to earn an income and the need to prevent poverty, which was the rationale of social security legislation in the first place, faded into the background.

109 'For the purposes of this Act, a workman shall be deemed wholly or partly unfit for work if he has become wholly or partly unfit for work corresponding to his strength before the accident and to his abilities.' Article 22 of the Industrial Injuries Insurance Act 1901.

110 Van Genabeek, "Opbouw: de Periode 1901-1920", 78-94.

3 CALCULATING INCAPACITY FOR WORK

As said, disability benefit was introduced to compensate for the loss of income due to the loss of the physical powers required to perform work. However, from the outset of the Industrial Injuries Insurance Act, and in the process of execution of the Act, this focus on the incapacity to earn a living faded from view. Instead, the incapacity for work became an *estimation*, largely based on physical injuries, and expressed as *percentages*. It was referred to as something which could only be established by estimation, yet at the same time it was subject to quite specific calculations. This resulted in incapacity for work being enacted as something that could be measured through forms of standardised tests and compared with a reference group of people with similar injuries.

Setting up the logistics of the Industrial Injuries Insurance Act

When the Act was introduced in 1901, Robert Macalester Loup was appointed as the director of the new Rijksverzekeringsbank. The Act had been very generous with the authority that was granted to this national state bank.[111] Companies were, for instance, obliged to provide the Rijksverzekeringsbank with information about the accident.[112] Witnesses could be interrogated,[113] and labourers were obliged to report to the Rijksverzekeringsbank and undergo a medical examination whenever and wherever the bank requested.[114] However broad the authority of the Rijksverzekeringsbank, the description in the Act of the practical aspects of the claim assessment and the distribution of benefit was rather limited. A claim had to be submitted, investigated and then granted or denied. The Act did not specify how these steps should be taken, or who exactly should perform the claim examination. Considering the medical aspect of the claim evaluation, the Act was rather unique since it demanded that the centralised Rijksverzekeringsbank not only administer the insurance scheme but also carry out the medical examination.[115] Macalester Loup and his two fellow board members,[116] therefore, decided to appoint a doctor and hospital director, P.H. Kooperberg, to become the head of the department of claim examination. Kooperberg, who was granted the title of medical advisor, had just

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111 Article 13 of the Industrial Injuries Insurance Act.

112 Article 62 of the Industrial Injuries Insurance Act.

113 Article 64 of the Industrial Injuries Insurance Act.

114 Article 29 of the Industrial Injuries Insurance Act.

115 J.P.C. van der Burgh, H. Bijleveld and G.P. van Dam (eds) *Rijksverzekeringsbank 1901-19141: Gedenkboek Opgedragen aan Dr. H.L. van Duyl* (Haarlem: Tjeenk Willink 1941) 25-79, Van Genabeek, "Opbouw: de Periode 1901-1920", 78-94.

116 H.P. Berdenis van Berlekom and H.W.E. Struve.

over three months to arrange all the logistics of this examination before the Industrial Injuries Insurance Act came into effect in February 1903.[117]

The breadth of its authority and responsibilities, together with the time constraint, led the Rijksverzekeringsbank to focus on the infrastructure of the Act first and to consider medical doctors to be the professionals of choice to perform the claim examination. By the time the Act came into effect, the logistics to perform the required steps in the claim examination were there, but when it came to the consideration of what exactly should be considered incapacity for work, this was supposed to become clear in the execution of the Act. When an accident occurred, a doctor of choice,[118] often the family doctor, had to make a preliminary assessment of the injuries and estimate how long they were likely to be off work.[119] Kooperberg and his colleagues, the medical officers *(controleerend geneeskundigen)*, would then check these estimations and carry out further examination of the incapacity for work.[120] These medical officers were trained as medical doctors and were involved in social medicine. They were insurance doctors, employed as government officials. Their profession and social insurance medicine had to be 'more or less, invented', as Joost van Genabeek describes it.[121] Medical officers had taken the medical oath, and their medical training was rooted in a clinical context, but their function in the new context of social insurance medicine came with its own tasks, practices and insights. The profession of medical officer was made up together with the claim assessment under the Industrial Injuries Insurance Act. There was no real guidance on how the expected incapacity for work should be established, and the Rijksverzekeringsbank had deliberately left this open to take shape in everyday practice. Through case studies, reported in medical journals, and through correction by the Central Council of Appeal,

117 Van Genabeek, "Opbouw: de Periode 1901-1920", 78-94.

118 This was the result of negotiations between the Rijksverzekeringsbank and the Dutch Society for the Advancement of Medicine (*Nederlandsche Maatschappij ter Bevordering van de Geneeskunst*), which considered free choice of doctor to be a fundamental part of the doctor-patient relationship and medical professionalism. Danièle Rigter, "Het Effect van de Invoering van de Ongevallenwet 1901 op de Gezondheidszorg" in: Karel Peter Companje (eds.) *Tussen Volksverzekering en Vrije Markt. Verzekering van Zorg op het Snijvlak van Sociale Verzekering en Gezondheidszorg 1880-2006* (Amsterdam: Aksant 2008) 97-173.

119 J.F. Brust, "De Taak van de Geneeskundigen in Verband met de Uitvoering van Artikel 61 der Ongevallenwet", *Tijdschrift der Ongevallen-Geneeskunde* 1.1 (1916) 8-13.

120 At first, Kooperberg thought he could handle all the medical examinations himself, but this proved impossible. Within a year, six medical examiners had been appointed, and in 1905 an administrator was put in charge of processing incoming claims. But the number of claims continued to rise in the following years, and in 1908 11 more administrators were employed to handle all the bureaucratic tasks involved in implementing the Industrial Injuries Insurance Act. More medical officers were employed in the following years. Van Genabeek, "Opbouw: de Periode 1901-1920", 73.

121 Ibidem, 105-112.

doctors would gain experience and improve their judgement.[122] What was considered to be incapacity for work was made up and changed in the course of the execution of the Act.[123] And in this process of making up incapacity for work, standardisation became a prominent factor.

Percentage of incapacity for work

The Industrial Injuries Insurance Act text itself did provide one *way* in which incapacity for work could be approached, namely as a percentage of the former ability to generate an income. I argue that this was a first step in a process of standardisation of incapacity for work.

Article 22 of the Act stipulated that any person who was considered to be fully unable to work would receive 70% of their former wage. By "deducting" 30% from the former wage in the event of full incapacity for work, the legislator wanted to reduce the incentive to abuse the Act by purposefully inflicting injuries or inducing workplace accidents.[124] As a consequence, the incapacity for work had to be converted into a percentage to calculate the amount of benefit. A person whose incapacity for work was estimated at 50%, for instance, would receive 70% of 50% of their former daily wage, a benefit of 35%. This calculation might seem rather straightforward in cases in which it was obvious for all parties that a person was no longer able to perform their work. In practice, such cases hardly existed. More often, the calculation was highly complicated. How was one to decide whether someone was unable to work for 85% or 86%? In 1905 the Council of Appeal decided that the estimation should be expressed as a percentage divisible by 5, making it impossible to consider a person as having incapacity for work of 1% or 2%. However, the difference between 85% and 80% incapacity for work was still rather difficult to pinpoint, and was often at the centre of disputes between the Rijksverzekeringsbank and injured workers. When we look at the records of the Central Council of Appeal, the severity of incapacity for work was disputed in more than half of the cases in the sample

122 Ibidem, 78-94.

123 P.H. van Eden, Kooperberg's successor, reflected on this in the first issue of the Journal for Insurance Medicine (*Tijdschrift voor Ongevallen-Geneeskunde* (1916-1920)), which was later renamed the Medical Journal of the Rijksverzekeringsbank (*Geneeskundig Tijdschrift der Rijksverzekeringsbank* (1920-1940)). He noted that because insurance medicine was not part of the core medical curriculum, medical officers lacked proper training and were left to figure out for themselves how to effectively integrate medical knowledge into the legal framework of the Workers' Compensation Act. The journal helped them to do this. P.H. van Eden, "De Beoefening der Ongevallen-Geneeskunde", *Tijdschrift voor Ongevallen-Geneeskunde* 1.1 (1916) 3-13.

124 P.H. van Eden, "Het Vraagstuk der Kleine Renten", *Tijdschrift voor Ongevallen-geneeskunde* 1.2 (1916) 58-69, J.E. Millard, *Gids voor Werklieden tot de Ongevallenwet en Beroepswet. In Vraag en Antwoord* (Haarlem: Tjeenk Willink 1903) 22.

years 1905 and 1915 — respectively, 276 out of a total of 459 cases, and 467 cases out of a total of 863 (see appendix I).[125]

It was not just the Rijksverzekeringsbank that defined people's incapacity for work in terms of percentages. Led by the legal context, workers who lodged an appeal also considered themselves incapable of working by a certain percentage. In the higher appeal cases, workers often claimed that their incapacity for work was much higher than the estimated percentage. Often their own assessment was 100%, or simply 'more unable to work' than the percentage that the Rijksverzekeringsbank had estimated. But workers would also come up with their own estimation, which resulted in disputes about the calculation rather than capacities.

The focus was not on whether a person was able to earn a living after a workplace accident, as might be expected considering the reasoning behind the introduction of the Act in the first place, but on whether or not the estimated percentage fitted the incapacity for work. Moreover, the calculation, which the legislator had encouraged through Article 22 of the Industrial Injuries Insurance Act, caused both the Rijksverzekeringsbank and the workers who claimed benefit to talk about the (or their) incapacity for work in percentages. This approach, or way of speaking, suggested that the incapacity for work was a product of a calculation. But this calculation demanded a clear substantiation of where the boundaries between those percentages could be set. What was calculated exactly? What should be taken into account when estimating a person's working capacity? For the Rijksverzekeringsbank, the incapacity for work centred around attempts to satisfy two potentially conflicting values, two underlying aims that should form the basis of a fair application of the Act: the aim to have objective measurements to substantiate the estimation, and the desire to tailor the application to the specificities of the individual case. In this interplay, a form of standardisation began to take shape in the estimation process. I will explain this by first focussing on how the Rijksverzekeringsbank approached the calculation of the incapacity for work, and then illustrate how this was done in the practice of the higher appeal cases.

The difficulties with estimation and experience-based standards

The Rijksverzekeringsbank searched for a way to add a human dimension to "fair" and straightforward examination procedures and tried to achieve this by placing the procedure in the hands of experienced doctors.

125 The remaining cases dealt with whether the accident was a workplace accident within the meaning of the Industrial Injuries Insurance Act, or was a dispute between the Rijksverzekeringsbank and companies that considered themselves less dangerous than declared and demanded lower premiums.

The medical advisor to the Rijksverzekeringsbank, Kooperberg and his successor Pieter Hendrik van Eden, considered the substantiation of boundaries between percentages a difficult exercise and a highly subjective process. In documents of the Rijksverzekeringsbank, and in court, putting someone's incapacity for work into a percentage was always referred to as a process of *estimation*. The percentage of someone's incapacity for work could only be measured approximately.[126] However, it needed to be measured. Van Eden tried to prevent too much arbitrariness, not by formally standardising the examination procedures, but by placing a great deal of trust in the expertise resulting from experience of the doctors who performed the medical examinations. However, these doctors built their knowledge through their own forms of standardisation.

Van Eden reflected on the process of estimating the incapacity for work, and described how and why he thought this was a subjective undertaking that needed to be approached with care and caution. He underlined how every claim was different and should be analysed separately. In a 1916 article in the *Tijdschrift voor Ongevallen-geneeskunde* (Journal for Accident Medicine), published by the Rijksverzekeringsbank, he wrote as follows:

> *'Whatever rules or formulas are drafted, in the process of examination of the incapacity for work, which is required to be put into percentages, the factor of the personality of the estimator can never be neglected. Apart from that, there are many difficulties that arise in the process. So many circumstances should be taken into account, and so much knowledge is required about the functioning of human bodies, as well as about specific working abilities vital to different industries. The determination of this estimation, related to the formula provided by the act, can therefore be considered one of the most difficult and important parts of the legislation.'*[127]

Van Eden considered the estimation of the incapacity for work to be a difficult task, and further explained how the many different circumstances ensured it was impossible to

126 Van Eden, "Het Vraagstuk der Kleine Renten", 58-69.

127 'Welke regels of formules daartoe ook worden opgesteld, toch zal bij de beoordeeling der arbeidsongeschiktheid, een beoordeling welke zich in percenten behoort uit te drukken, de persoonlijkheid van den schatter een nimmer te verwaarlozen factor blijken. Maar hiervan afgezien, wat tal van moeielijkheden doen zich hierbij voor. Hoevele omstandigheden moeten niet in aanmerking genomen worden en hoeveel kennis, zoowel van de verrichtingen van het menschelijk lichaam als van de door een speciale tak van arbeid gestelde eischen, is hierbij nodig. Het vaststellen van de op deze schatting betrekking hebbende formule in de wet is dan ook zeker als een der moeielijkste en belangrijkste onderdeeling der wetgeving te beschouwen.' Van Eden, "Het Vraagstuk der Kleine Renten", 58-69. All translations in this dissertation are my own.

follow a clear set of rules when estimating someone's incapacity for work. According to Van Eden, the Act offered two options in calculating a person's incapacity for work. Either the difference between the former working capacity and the current working capacity could be measured, or the calculation could be based on the functioning of the worker in relation to the work they used to perform. This required all sorts of deliberations on what should be taken into account. How could a worker's former working capacity be measured retroactively? Should every worker be medically examined when starting employment? Or, as Van Eden pictured: what if an injured painter, while being hospitalised, discovered he had an excellent singing voice — should his potential capacity to become an opera singer be taken into account?[128] Van Eden also saw a danger in oversimplification through standardisation. He stated that models and tables existed according to which the calculation of the incapacity for work could be measured, but they should only function as guidelines and be used with great caution 'to not add someone else's mistakes to one's own errors in the estimation'. With this, he referred to private insurance companies that made the process of estimation rather simple by plainly stating that the loss of two legs was equal to 100% incapacity for work and the loss of one leg equalled 50%. This, according to Van Eden, failed to take into account the fact that different body parts had different values. Instead, he made clear that whether or not the loss of a leg resulted in incapacity for work depended not only on the injury but also on the type of work a person performed. The context-specificity of each case, the fact that there were so many circumstances that had to be taken into account, made it impossible to approach the estimation as a form of mathematics, in his opinion.[129]

While acknowledging the fact that the estimation of the incapacity for work, as demanded by the Industrial Injuries Insurance Act, was not easy, Van Eden worried about too much subjectivity in the practice of claim examinations. Van Eden was particularly concerned about the number of claims for small percentages of incapacity for work, which seemed to keep rising.[130] Especially at the outer margins, when people lost only a bit or almost all of their ability to work, it was difficult to make a case for a specific estimation.[131] The Act was not supposed to be applied randomly, since that would lead to legal inequality, and, moreover, this would increase the likelihood of fraudulent claims or the use of disability benefit as 'beer benefit' – a little bonus added to a salary that was already sufficient.[132] The execution of the Act demanded at least an attempt to provide

128 Ibidem.

129 Ibidem.

130 Ibidem.

131 Ibidem.

132 Unless there had been a significant change in the worker's physical condition, the Industrial Injuries

standards and to avoid the somewhat absurd disputes over whether a person's incapacity for work should be 15% instead of 10%.[133]

For Van Eden, the solution lay not only in the abolition of small disability benefits, but also in increasing the objectivity of the people in charge of estimating the incapacity for work. Van Eden claimed that: '(…) [e]very case should be analysed by itself, as objectively as possible, based on data that are as complete as possible.'[134] In the opinion of the Rijksverzekeringsbank, as represented by Van Eden, this objectivity could be gained through experience and specialisation. Over the years, medical officers gained experience with workplace accidents, injured workers and the process of examination. They combined their medical training with their acquired knowledge of the process of rehabilitation. They compared the injuries of different people, published about their experiences in medico-legal journals, and by sharing case studies they tried to gain information on how the incapacity for work would change over time.

As Lorraine Daston and Peter Galison have shown, objectivity is not just a neutral or unbiased standpoint on an object of investigation; instead it has a history of its own. They trace historical variations in the notion of objectivity, and Van Eden's focus on personified objectivity can be considered what Daston and Galison call 'trained judgement', which became a prominent interpretation of objectivity in the twentieth century. This trained judgement was rooted in the idea that an accurate observation could be made by being guided by experience and through educated analysis of data.[135] Van Eden acknowledged that medical examiners brought their own interpretations to the claim assessment. However, through experience and by applying their knowledge, they were able to come up with the right techniques to provide "objective" standards and measurements, which then could be applied in such a way that they were tailored to the specificities of every case.

What we see here are the requirements by which incapacity for work was to be established. The Industrial Injuries Insurance Act gave an incentive to talk about the incapacity for work as a matter of calculation. The Rijksverzekeringsbank, as represented by Van Eden, considered this calculation a difficult process, since the claim assessment was a constant search for acceptable norms by which individual working capacity should be examined. Moreover, the aim was to serve individual needs and to take the worker's

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Insurance Act provided lifelong benefits once the percentage of incapacity had been established. Article 21 and 70 of the Industrial Injuries Insurance Act 1921

133 Van Eden, "Het Vraagstuk der Kleine Renten", 58-69.

134 '(…)[E]lk geval moet op zich zelf, zoo objectief mogelijk aan de hand der, zoover het kan, volledige gegevens beoordeeld worden.' Ibidem, 61.

135 Lorraine Daston and Peter Galison, *Objectivity* (New York: Zone Books 2010) 309-361.

circumstances into account, while also upholding the legal certainty and equality which the law required.

To combine these aims, the Rijksverzekeringsbank placed a great deal of authority in the hands of people who embodied “objective” knowledge. The doctors who were hired as medical officers were the people who gained experience with the application of the Act.

Interactions between aims and practices

Now let us take a closer look at what theses medical officers did in carrying out the claim assessments. Higher appeal cases in which a person lost a hand or a finger due to a workplace accident form an interesting study since it was a type of injury for which the Act was intended and which was considered rather common.[136] In the sample years 1905 and 1915, there were 16 and 14 cases respectively in which hand and/or finger amputation led to a dispute about the percentage of incapacity for work. It is noticeable that in all these cases, the focus lay on the specific hand that the person in question had injured, and the description of these injuries formed the basis of the estimation and corresponding benefit granted by the Rijksverzekeringsbank. In the 1915 case of K.B. de Ruiter, who lost the tip of his right middle finger while performing his job as a folder in a steam bleachery, the functioning of his hand was described in meticulous detail. The Rijksverzekeringsbank had initially considered De Ruiter to have an incapacity for work of 25%, but had ended his benefit because the medical officer saw no reason to consider him unable to work anymore. This officer, whose name is not mentioned in the verdict, had measured both forearms (the left was 21.5cm and the right 21.2 cm) and examined the stump of the right middle finger. He saw no deviations and considered De Ruiter fully able to work because he was left-handed. De Ruiter’s situation was considered equal to cases in which right-handed people lost phalanxes of fingers on their left hand.[137]

In cases like De Ruiters’, the goal was to find the percentage of incapacity for work that would fit the injuries a person was suffering from. Interestingly enough, the earlier rationale that the incapacity for work was the inability to earn an income was not a topic of concern. Moreover, it seems as though the aim to take as many of the particularities of the individual situation into account as possible had also been lost in the accumulation of cases. The analysis of De Ruiters’ left-handedness was the only specificity of this individual case that was taken into account. There was no mention of his occupation, no reflection on how and where the worker’s hand had to function in performing his job.

136 P.H. van Eden, “Behandeling van Vingerverwondingen”, *Tijdschrift voor Ongevallen-Geneeskunde* 1.6 (1916) 205-221.

137 NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30-1915.

The general norms against which the incapacity for work was measured were instead formed through medical case studies. A comparison of multiple individual cases, grouped by injury, formed the basis for the calculation.[138]

The steps taken to arrive at this outcome were standardised. In every higher appeal case that concerned hand injuries, the same assessment techniques were applied. First the injured worker had to make a fist so that the doctors could check if, and how, every individual finger could bend. The flexion of every joint was described, and every part of every individual finger was measured. The underarms were measured to see if the hand injuries impacted the strength of the arm muscles. Weather effects on the scar tissue were taken into account, and a general, clinical, impression of the hand concluded the investigation.

The findings were described in rather technical terms. In the case of K. Vogelzang, who had lost the tip of her right index finger, this is, for instance, how the estimated incapacity for work is substantiated by the Rijksverzekeringsbank:

> *'The right index finger cannot actively be brought into contact with the hand palm. If the fist is closed and the thumb is placed on the index finger, then the finger reaches the hand palm. The base and top joint can be bent in the normal manner. The metatarsal joint reaches a flexion of 67 degrees. Plaintiff has a good working hand, with well-developed callus, also the right index finger has callus and is covered with "working" skin.'*[139]

Statements by medical officers, like this one, contain a great deal of medical information, making the estimation of the incapacity for work largely a matter of medical technical investigations. What is important to note here is that the similarities in the way each individual hand injury was examined show how standardisation played a prominent role in the process of claim examination. This was not the type of standardisation that Van Eden dreaded; the Rijksverzekeringsbank did not put its trust in oversimplified tables in

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138 This is what the Health Council of the Netherlands later coined as mediprudence: a practice in which medical officers reach a kind of consensus on examination standards, based on an interaction between medico-legal knowledge and experience. See the 2007 report of the Health Council of the Netherlands, www.gezondheidsraad.nl/documenten/adviezen/2007/06/04/verzekeringsgeneeskundige-mediprudentie (accessed 25 July, 2023)

139 'De rechter wijsvinger kan niet actief in contact worden gebracht met de handpalm. Als de vuist gesloten is en de duim op de wijsvinger wordt geplaatst, dan bereikt de vinger de handpalm. Het grond- en topgewricht kunnen op een normale manier worden gebogen. Het middenvoetsbeentje bereikt een flexie van 67 graden. De eiser heeft een goed werkende hand, en bevat eelt. Ook de rechter wijsvinger bevat eelt en is bedekt met werkhuid.' NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30 1915.

which the type of injury was associated with a given percentage of incapacity for work. What the Rijksverzekeringsbank did rely on was the trained judgement of doctors. And in the process of finding ways to properly analyse a person's incapacity for work, they grouped together different types of injuries, applied the same forms of investigation, and compared the outcomes with a group of similarly injured workers. In time, by doing so, they gained more experience with this group, which reinforced this process of norm setting through comparison.

The aim was to find general norms and then apply them to the specifics of every individual situation. However, the general norm did not precede the individual application. These were not separate stages of the examination; they constituted each other in a sort of "Hackian" looping process. The norms were formed through experiences with the claim assessment. The experiences consisted of a multiplicity of individual situations that were then grouped together to form the norm by which individual cases were considered.[140] And because medical officers were doctors by training, it was bodily injuries that formed the centre of this grouping. Although things like occupation, education, intelligence or willpower were also considered important factors, these were much harder to calculate and so the focus was on what medical officers could measure and compare.[141]

Comparison to back up the legal claim

This practice of standardised tests and comparison based on the injury was adopted not only by the medical officers in service of the Rijksverzekeringsbank. People who lodged an appeal often referred to themselves as being part of a group of people with similar injuries. This can be considered a form of legal precedent that enforced the enactment of incapacity for work as calculation based on comparison.

In the case of S. Veenstra, for instance, this comparison was intertwined with other arguments to substantiate his claim for benefit corresponding to 80% incapacity for work instead of the estimated 30%. Veenstra lost his lower left leg after a workplace accident that happened to him on 20 January 1913. He stated that although he could walk with a walking cane, he was not able to perform any tasks at work. Even when he went for a walk, he needed the cane for support, which made it impossible for him to do any loading work. Veenstra addressed the topic of financial self-sufficiency, and emphasised his lack of self-sufficiency by stating that the fact that he collected the remaining potatoes

140 Deborah Stone, "Physicians as Gatekeepers: Illness Certification as a Rationing Device", *Public Policy* 27.2 (1979): 227-254.

141 According to the ophthalmologist G.F. Rochat, these were fundamental to a person's true (in)ability to work. But these were characteristics that could not be calculated, and without calculation, he argued, legal certainty and equality would be jeopardised. G.F. Rochat, "Het Schatten der Minderwaardigheid der Eenogigen", *Nederlandsch Tijdschrift voor Geneeskunde* 71 (1927) 1231-1235.

from his neighbour's garden was not a sign of his ability to work, but of poverty instead. He added that he had to leave Amsterdam, and move to the island of Ameland, because life in the city was too expensive. He had, moreover, heard that other people who lost the use of their leg had also been declared 80% unable to work. And often in such cases, he claimed, the leg had not even been amputated. 'An injured leg can hardly be considered worse than losing a leg', he stated.[142] Veenstra also compared himself to others who had lost a leg when he added to his plea that no employer would even consider recruiting a person with one leg. It is notable that Veenstra accepted the perspective of the medical officers of the Rijksverzekeringsbank that he should be compared to other workers with leg injuries. Looking at the Act itself, one might expect that Veenstra's claim that he had fallen into poverty because of his inability to perform labour would be central to the analysis of his incapacity for work. After all, the Act was put in place to avert poverty. However, Veenstra, who pulled out all the stops to prove his point, mainly focussed on his comparison to others. This does not show that Veenstra sees himself as a member of this group. What it demonstrates is that he tried to connect with the rationale developed for the estimation of his incapacity for work to enhance the value of his claim. Comparing oneself with others might be a human trait, but here it also functioned as a way to be considered just as unable to work as other people with leg injuries, making a case for more benefit in the legal practice in which incapacity for work was established.

Whereas Veenstra kept his comparison rather general, there are multiple cases in which workers demanded specific tests that had been performed in similar cases. Especially when the use of X-ray photos became more common in the course of the 1920s, injured workers often specifically demanded to have X-rays taken, arguing that the medical officer had not examined them in an 'objective' manner. In interaction with the Industrial Injuries Insurance Act and the practice of claim examination, workers added to, or adopted, the practice of standardisation and comparison, and placed themselves in that narrative to validate their claim.

Calculation based on the group of people with similar injuries

However open the formulation of the incapacity for work was in the Industrial Injuries Insurance Act, it did leave the Rijksverzekeringsbank with a calculation model and with the authority to execute the law in a manner that was in 'the spirit of the Act'. Therefore, in the practice of the execution of the Act, and in the interaction between the Act, the medical officers in the service of the Rijksverzekeringsbank and the workers who claimed benefit, incapacity for work became a search for norms and standards by which it could be measured and aligned. The incapacity for work enacted as the ability to earn

142 NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

an income, which was important for the introduction of the Act, was relegated to the background, and in the search for standards a comparison on the basis of the injured body parts took central stage, which made up incapacity for work as a calculation.

4 THE INCAPACITY FOR WORK AS A TEST OF INDIVIDUAL MORALITY

In the first part of this chapter we have seen how the process of collectivisation, of people in society becoming more interdependent, has been identified as the reason for the introduction of social security legislation. The Industrial Injuries Insurance Act, in particular, is often considered to be a form of institutionalised solidarity. This solidarity came with responsibility. Getting injured in a workplace accident and the process of rehabilitation were not solely personal or private issues. By claiming benefit, the disabled worker called on the collective to compensate for the financial consequences of this accident. In return this person had to submit to the investigation of their body and personal life, and was held accountable for the actions and choices that concerned their working ability. The interdependency and institutionalised solidarity that were considered to lie at the heart of social security legislation, however, did not come with inherent mutual trust. In fact, on the contrary, the Act was rooted in a history of worries about fraud and distrust towards labourers. This individual responsibility and a culture of distrust manifested themselves through a strong focus on the individual morality of the labourer, enacting incapacity for work as a form of moral accountability.

Transferring responsibility for working capacity

At the end of the nineteenth century, before the Industrial Injuries Insurance Act was introduced, workers who were unable to earn a living after an accident were often supported by local or religious communities. The will to help others could be motivated by compassion or moral beliefs, or any other reason people had to support a fellow human being. In the history of social work Berteke Waaldijk has argued that emancipatory values, such as the belief that poor people should become self-reliant, could come with disciplining practices and invasive forms of observation, thus showing that emancipation and discipline were not mutually exclusive.[143] In the implementation of the Act, we can see how these two "forces" went hand in hand.

143 Berteke Waaldijk, "Personeel van Sociale Instituties. Over het Verband Tussen Vrouwenbeweging en Maatschappelijk werk", *BMGN – Low Countries Historical Review* 130.2 (2015) 44-69.

De Swaan describes how social security legislation in general replaced a personal motivation to help others with a more abstract or distant notion of collective responsibility. This transfer of responsibility from the individual to the state often materialised through bureaucratisation and the expansion of the state apparatus. This led to a support system in which people were subject to monitoring and checks and were held accountable, not by an individual neighbour or church community, but by the abstract 'collective'.[144] Following the work of Norbert Elias, De Swaan connects the aforementioned collectivisation thesis to a process of civilisation. He writes that with collective social security, the lives of people became more intertwined, which led to social pressure to perform self-control in everyday life and to be more careful with, among other things, one's own body.[145] As we have seen before, the Industrial Injuries Insurance Act can be considered a product of this process of growing interdependency. With the execution of the Act, the functioning of the body, in particular its working capacity, became of collective interest. Factory owners were already held accountable for the protection of their workers' bodies. At the end of the nineteenth century, following the 1887 investigation into labour conditions in factories in the Netherlands (the *Arbeidsenquête*), the Labour Act and the Safety Act required employers to implement safety measurements, obligating labourers to, for instance, use splash goggles, auditory protection or safety shoes and helmets. With the agreement to make use of the labouring capacity of the worker came the responsibility to protect this capacity. Following De Swaan's thesis, social security legislation such as the Industrial Injuries Insurance Act extended this responsibility. Now it was not only the employer who was held accountable for safekeeping the labourers' working capacity; the labourers themselves also bore responsibility. In this respect it is interesting to note that when it came to the execution of the Act, company owners hardly played any role in legal matters relating to incapacity for work. In the higher appeal cases, only workers ever demanded that employers be heard in court to testify about their employee's incapacities or their work ethic, and these requests were never granted. Employers only appeared in higher appeal cases that concerned disputes about the amount of premium to be paid, or about whether or not an injured person was considered an employee within the meaning of the law. Company managers were consulted by the Rijksverzekeringsbank when gathering information about the accident and the worker's salary, but they did not appear as parties in disputes about incapacity for work.[146] So while political and economic historians have

144 De Swaan, *In Care of the State,* 246-252.

145 Ibidem, 246-252.

146 Although article 67 of the Industrial Injuries Insurance Act provided for the right to appeal against the decision of the Rijksverzekeringsbank, I have not come across any case in which the employer initiated the appeal.

focussed on the role and power of employers on a managerial level, in the application of the Act 'incapacity for work' effectively changed from an employer-employee affair into a societal matter.[147]

In De Swaan's analysis, and following the connection he makes between collectivisation and Elias' civilisation theory, social security legislation led to more interdependency. And because of this interdependency, poverty or disability became a social problem, in the sense that it became a threat to collective welfare.[148] By collecting premiums, which were deducted from the salary, the Rijksverzekeringsbank forced people to save money and avert risk. The Industrial Injuries Insurance Act can be considered both the product and a catalyst of increased interdependency. As a consequence, the risk of falling into poverty after a workplace accident was averted,[149] but it also demanded accountability with respect to the collective. This accountability was manifested not only in implicit norms to behave sensibly or to avoid risk, or later on, to make maximum effort to achieve rehabilitation. At the beginning of the Act this individual responsibility for workers to justify themselves when claiming benefit was reflected in public allegations of politicians and journals that labourers were simulating their injuries and abusing collective arrangements for self-enrichment. This is particularly visible in the appeals of workers in the cases of the Central Council of Appeal.

I will first elaborate on the mistrust towards labourers, which, I believe, was built into the Industrial Injuries Insurance Act itself and was perpetuated in the policies and documents of the Rijksverzekeringsbank. Then I will focus on how this mistrust was anticipated by workers who claimed benefit in appeal cases, and how the responsibility towards the collective was translated in the analysis of a worker's individual morality, in the enactment of the incapacity for work.

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147 There is a rich literature on what is often perceived as a peculiarly Dutch approach to the organisation of social security arrangements, characterised by a tendency to let employers and trade unions manage the insurance process themselves ('het zelf doen', as it has been called). See: Noordam, "Sociale Verzekeringen 1890-1950", 598, Joop Roebroek and Mirjam Hertogh, *De Beschavende invloed des tijds, Twee Eeuwen Sociale Politiek, Verzorgingsstaat en Sociale Zekerheid in Nederland* (The Hague: Vuga 1998) 153-167; J. van Gerwen, 'De Ontluikende Verzorgingsstaat; Overheid, Vakbonden, Ziekenfondsen en Verzekeringsmaatschappijen 1890-1945', in: J. van Gerwen en M.H.D. van Leeuwen (eds), *Zoeken Naar Zekerheid. Risico's, Preventie, Verzekeringen en Andere Zekerheidsregelingen in Nederland 500-2000* (Den Haag: Verbond van Verzekeraars/NEHA 2000); Kappelhof, "'Omdat het Historisch Gegroeid is'", 71-91.

148 At least in principle, de Swaan rightly adds. In practice, it was the worker's productivity that was at stake. As research into the history of disability has shown, disabled persons have often been treated as second-class citizens. See for instance the work of Sarah F. Rose, *No Right to be Idle. The Invention of Disability 1840's-1930's* (Chapel Hill: University of North Carolina Press 2017).

149 'The collectivising process of care arrangements has also levelled the rare peaks of affluence and the many troughs of misery in most individual lives'. De Swaan, *In Care of the State,* 10.

Institutionalised distrust

Before the Industrial Injuries Insurance Act was introduced, the financial consequences of workplace accidents were usually borne by the injured worker. People without insurance had the option of turning to the civil court and suing their employer for tortious liability, a judicial procedure that was both time-consuming and expensive. To win such a case, it had to be proven that the employer was guilty of violating the aforementioned Labour Act or Safety Act, or that it was a case of negligence.[150] This itself was rather hard to prove, because who could tell, for instance, if the boiler had exploded because of lack of maintenance? This required extensive research, which took resources that people often lacked. Especially in cases like these, the accused party went to great effort to suggest that the workers were simulating their injuries, drawing out the already lengthy procedure.[151] There was, moreover, no form of employment protection, which made it hard to find co-workers willing to be a witness in the case. As a result, workers were not only discouraged from starting such a judicial procedure, but were also framed as untrustworthy people.[152]

Contrary to the previous civil cases of tortious liability, the Industrial Injuries Insurance Act did not demand thorough investigations into who was responsible for the accident. And whereas private or companywide insurance arrangements applied all kinds of exclusion clauses, meant to correct the behaviour of labourers, the Act was applicable to all cases in which people were injured due to a workplace accident. We could, therefore, say that this social security arrangement was much less inherently distrustful than the previous civil law of private insurance policies. It did not, for instance, explicitly require workers to be careful or not drink too much.[153] But although these explicit restrictions on behaviour were not part of the Industrial Injuries Insurance Act, worries about fraud and about reckless behaviour still played a role in the execution of the Act such that workers were seen to have an implicit moral responsibility to avoid misusing the arrangement.

Prior to the implementation of the Act, worries about the possibility of people exploiting the arrangement were at the centre of the political debate, and caused the legislator to design the Act in such a way that a person who was considered fully unable to work would only receive 70% of their former salary, not 100%. By not paying the incapacitated person the same amount as they earned before the accident, it was thought the

150 Van Genabeek, "Voorgeschiedenis. De Periode tot 1901", 23-51.

151 De Swaan, *In Care of the State,* 183.

152 Roland Pierik, *Risico en Rechtvaardigheid*. *Arbeidsongeschiktheidswetgeving en de Politieke filosofie van Ronald Dworkin* (Lelystad: Koninklijke Vermande 1995) 6, Rommelse, *Een Geschiedenis van het Arbeidsongeschiktheidsbeleid in Nederland*, 15.

153 Article 28 of the Industrial Injuries Insurance Act excluded cases where a worker intentionally caused the accident, but otherwise liability did not affect entitlement to benefits.

worker would not be tempted to inflict an accident or simulate injuries, and, in general, would be careful with their own body.[154] Here we see how the worker was held accountable for claiming disability benefit and for taking good care of their body, and how worries about fraud translated into prevention techniques. A worker's guide to the Industrial Injuries Insurance Act, written by the attorney at law J.E. Millard and published in 1903, translated this as follows:

> *'The workman only receives 70% in case of full incapacity for work. Generally speaking, this is not unreasonable. There should not be an incentive to desire full disability over ability to work, which could be conceivable if he could receive a full wage for doing nothing! Besides, full incapacity for work often does not prevent a workman from doing small tasks or performing light work, with which he could earn some extra money. And what also needs to be addressed is that many accidents are, in fact, a workman's own fault and due to his own carelessness, for which the law does not charge him.'*[155]

These worries were expressed through heated political debates, which were reported in the newspapers. The Catholic newspaper, *Time* (*De Tijd)*, for instance wrote in 1908 that all political parties agreed that the practice of the Industrial Injuries Insurance Act was causing a lot of worry about the moral outcome of the law. While referring to liberal newspapers, *Time* wrote that even though all parties nowadays agreed on the necessity of disability benefit, the Act needed to be revised to discourage simulation. The newspaper quotes Doctor Bijleveld, one of the medical officers of the Rijksverzekeringsbank, who claimed that the Industrial Injuries Insurance Act had a bad influence on the *volksziel*, the soul of the people, because he saw many cases of simulation induced by the disability benefit act. As a consequence, Bijleveld claimed, much valuable working capacity was lost.[156] Here we see how worries about fraud went hand in hand with ideas about morality and the responsibility to safeguard your own working capacity.

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154 Van Genabeek, "Voorgeschiedenis. De Periode tot 1901", 23-51.

155 'De werkman ontvangt dus, in geval van geheele ongeschiktheid tot werken, niet vergoeding van het geheele dagloon, maar slechts 70 pct. In het algemeen is dit niet onbillijk. Er moet niet een prikkel bestaan om geheele ongeschiktheid te prefereeren boven geschiktheid, hetgeen denkbaar is, wanneer men vol loon krijgt voor niets doen! Bovendien sluit geheele ongeschiktheid tot werken meestal niet uit, dat de werkman wel door licht werk of losse kwarweitjes er iets bij kan verdienen. En ook moet in aanmerking gebracht worden, dat zéér vele ongevallen te wijten zijn aan eigen schuld en onvoorzichtigheid der werklieden zelf end at hun dit toch niet door de wet wordt aangerekend.' Millard, *Gids voor Werklieden tot de Ongevallenwet en Beroepswet,* 22.

156 "Het Getob met de Ongevallenwet", *De Tijd: Godsdienstig-staatkundig Dagblad*, August 14 1908, 2.

Socialist newspapers were critical of this widely shared idea that workers were abusing the Industrial Injuries Insurance Act. In the Nutcracker (*de Notenkraker*) a satirical weekly supplement to the socialist newspaper the People (*Het Volk*) the famous cartoonist Albert Hahn, for instance, mocks this strong focus on fraud (appendix II, figure 1). Socialist politician and general practitioner Ben Sajet also criticised this heavy focus on the possibility of workers simulating their injuries in an article in the Dutch Journal of Medicine (*Nederlandsch Tijdschrift voor Geneeskunde*). He argued that the increase in the Rijksverzekeringsbanks' cost was not due to 'quarrelsome and disgruntled claimants', as doctor J.A. Korteweg had claimed in the same journal,[157] but due to an increase in the number of accidents. He added that this should not be blamed on disabled workers, as the very purpose of the law was to meet their needs.[158] After ten years of the Application of the Act, Macalester Loup, the director of the Rijksverzekeringsbank, was happy to say the worries about simulation had been proved unfounded since there were hardly any cases in which people committed fraud by faking their injuries.[159] Although critics could say that the persons effectively simulating their injuries never made it into the statistics of the Rijksverzekeringsbank, it seems that worries about simulation began to ebb. In the cases of the Central Council of Appeal simulation was only discussed in the context of neurosis and, as we shall see in Chapter 3, far from being considered a fraudulent practice it was treated as a symptom of an illness instead.

157 J.A. Korteweg. "Misbruik en Ongewenscht Gebruik der Ongevallenwet", *Nederlandsch Tijdschrift voor Geneeskunde* 58 (1914) 705-717.

158 'The fact that the Industrial Injuries Insurance Act costs so much money is, of course, first and foremost the result of so many accidents. (...) Now one can regret that so many accidents occur and worry about how expensive the law is. But to draw the conclusion from the sheer size of the numbers that the people involved are personally to blame for this is highly offensive to them and does not prove the statement. From another point of view, it can be said that the large numbers prove that the law is doing a good job by providing for needs that need to be alleviated.' ('Dat de Ongevallenwet zooveel geld kost, is natuurlijk in de eerste plaats het gevolg daarvan, dat er zooveel ongevallen plaats hebben. (...) Nu kan men het betreuren, dat er zooveel ongevallen voorkomen en in verband daarmede zich ook over de duurte van de wet bezorgd maken. Maar uit de grootte der aantallen alléén de gevolgtrekking te maken, dat de betrokkenen persoonlijke schuld hieraan hebben, is voor deze in hooge mate beleedigend, maar bewijst daarom nog niet de uitgesproken stelling. Van een ander standpunt uitgaand, kan men juist zeggen, dat de groote cijfers bewijzen, dat de wet goed werk doet, door te voorzien in de nooden, die gelenigd moeten worden.' Ben Sajet, "Misbruik en Ongewenscht Gebruik der Ongevallenwet?" *Nederlandsch Tijdschrift voor Geneeskunde* 58 (1914) 1231-1235.

159 R. Macalester Loup, "Vrucht van Tien jaren Ongevallenverzekering", in: L. del Baere, H.P Berdenis van Berlekom and J.F. Brust et al (eds.), *Tien Jaren Praktijk der Ongevallenwet 1901* (Haarlem: Tjeenk Willink 1913) 1-26.

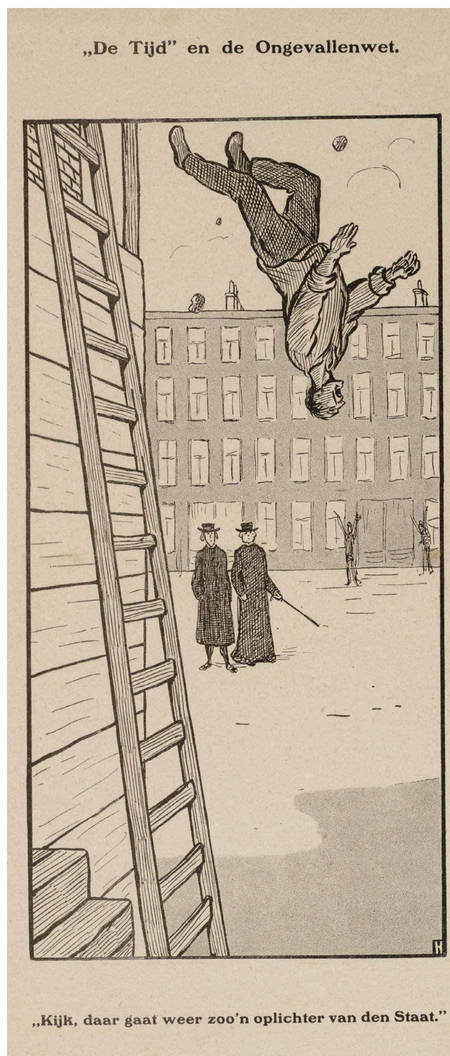

Figure 1. Political cartoon drawn by Albert Hahn, published on 2 February 1908 in the political-satirical socialist weekly magazine The Nutcracker (*De Notenkraker*). The image shows a worker falling from a ladder. In the background are two onlookers (neatly dressed, one possibly a priest) and the caption says: 'Look, there goes another crook of the state.' (International Institute of Social History BG C13/584)

This, however, did not mean that persons claiming benefit were given the benefit of the doubt. Rather soon, worries about simulation were replaced by worries about the exaggeration of the effects of a workplace accident, known as "aggravation". According to Macalaster Loup, aggravation was a problem in the application of the Act, and a great deal of surveillance was needed to prevent workers from focusing on pain and complaints.

'Before, their sorrowful state forced them to make an effort', he claimed. 'However, now they can rest, ensured of compensation for their injuries, which works against recovery.'[160] Especially in cases in which the incapacity for work was difficult to measure, such as in cases of medically unexplained impairments, the possibility of workers simulating or aggravating their injuries was discussed extensively.

Worries about workers aggravating their injuries were different from worries about straightforward fraud through simulation. Macalaster Loup and others recognised the complexity of the matter, taking the psychological and social effects of disability benefit into account, and often blamed the system instead of the person aggravating their symptoms.[161] The worries about aggravation, however, still show that an aura of distrust or doubt surrounded workers who claimed benefit.

This is, for instance, visible in the way the medical advisor Van Eden speaks about people who receive a small amount of benefit, referring to the benefit as an extra to buy more beer, or in the way officers in the service of the Rijksverzekeringsbank often divide workers into honest, hard-working labourers and lazy people who lean on their benefit and do not adapt to their new situation. This is especially significant in debates about recovery, which became an important topic in policy documents of the Rijksverzekeringsbank from the 1910s. In the journal of the state bank, Van Eden writes:

> *'In cases of minor injury, in which it is certain that with some effort and exercise any disability can be overcome, it seems contrary to the sense of fairness that the brave man who tries his best, and does not mess around, loses the right to benefit, whereas the indifferent person, lazy, and reluctant to perform any effort, sometimes even counteracting his recovery, still receives compensation.'*[162]

Officers in the service of the Rijksverzekeringsbank, especially doctors, did not hesitate to state that only the right kind of person, the hardworking person who genuinely suffered from the financial consequences of a workplace accident and was eager to recover, should receive benefit, thereby perpetuating the notion that there were a lot of bad apples in the system.[163]

160 Ibidem.

161 Ibidem.

162 'Uitgaande van een gering letsel, waarvan zeker is dat met eenige inspanning en oefening alle bezwaren kunnen worden overwonnen, komt het billijkheidsgevoel er tegen in opstand, dat de flinke man, die zijn best doet en aanpakt spoedig alle recht op uitkering verliest, terwijl de onverschillige, luie, onwillige, die niet de minste inspanning toont, ja soms eer tegenwerkt, een schadeloosstelling zou moeten ontvangen.' Van Eden, "Het Vraagstuk der Kleine Renten", 68.

163 This reasoning is rooted in a long Western tradition of distinguishing between 'deserving' and 'undeserving'

For medical officers, the idea was that with social security legislation came a responsibility for the workers. Workers had a responsibility to, first of all, protect their own body so they would not need to apply for disability benefit, and, second, not to abuse the arrangement by simulating injuries. And finally, if a worker in fact did suffer from a workplace accident, then they had the responsibility to not aggravate the injuries, which would lengthen the time during which they could profit from the social arrangement. In short, the individual workers had a responsibility to not profit unnecessarily from the social benefit, and as we shall see this translated into workers feeling the need to prove this. Moreover, this concern about aggravation was reflected in the way medical examinations were conducted. Rather than focusing on workers' histories or their function in the context of the workplace, medical officers focused heavily on the body, which was mocked in another cartoon in The Nutcracker in 1910 (appendix II, figure 2).

From the beginning of the Industrial Injuries Insurance Act, in the design and the practice of the execution of the Act, it was questioned by the legislator and the Rijksverzekeringsbank whether the individual workers would be able to bear this responsibility with respect to the collective, and these worries often took the form of suspicion towards the individual worker. Were they rightfully claiming benefit? Of course, in cases in which a person was severely injured, fraud was not in question. However, in time, the person would have to show that they were trying their best to do what they could, given their actual injuries and to make the most of their recovery process. And because workers were often considered reckless and untrustworthy, this responsibility on the part of the individual implied an investigation into their morality.

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recipients of charity. See: Deborah Stone, "The Deserving Sick: Income-Maintenance Policy Towards the Ill and Disabled", *Policy Sciences* 10.2 (1978) 133-155, Stone, *The Disabled State*, Nicholas Rogers, "Policing the Poor in Eighteenth-Century London: The Vagrancy Laws and Their Administration", *Histoire-Sociale - Social History* 24.47 (1991) 127-47, Paul Slack, *From Reformation to Improvement: Public Welfare in Early Modern England* (Oxford: Oxford University Press 1999), Linda Gordon, "Who Deserves Help? Who Must Provide?", *The Annales of The American Academy of Political Social Science* 577 (2001) 12-25, Michael Katz, *The Undeserving Poor: America's Enduring Confrontation with Poverty* (Oxford: Oxford University Press 2013), Sharon Farmer (ed.) *Approaches to Poverty in Medieval Europe: Complexities, Contradictions, Transformations, c. 1100-1500* (Turnhout: Brepolis Publishers 2016), Brent Ruswick, *Almost Worthy: The Poor, Paupers, and the Science of Charity in America 1877-1917* (Bloomington: Indiana University Press 2017).

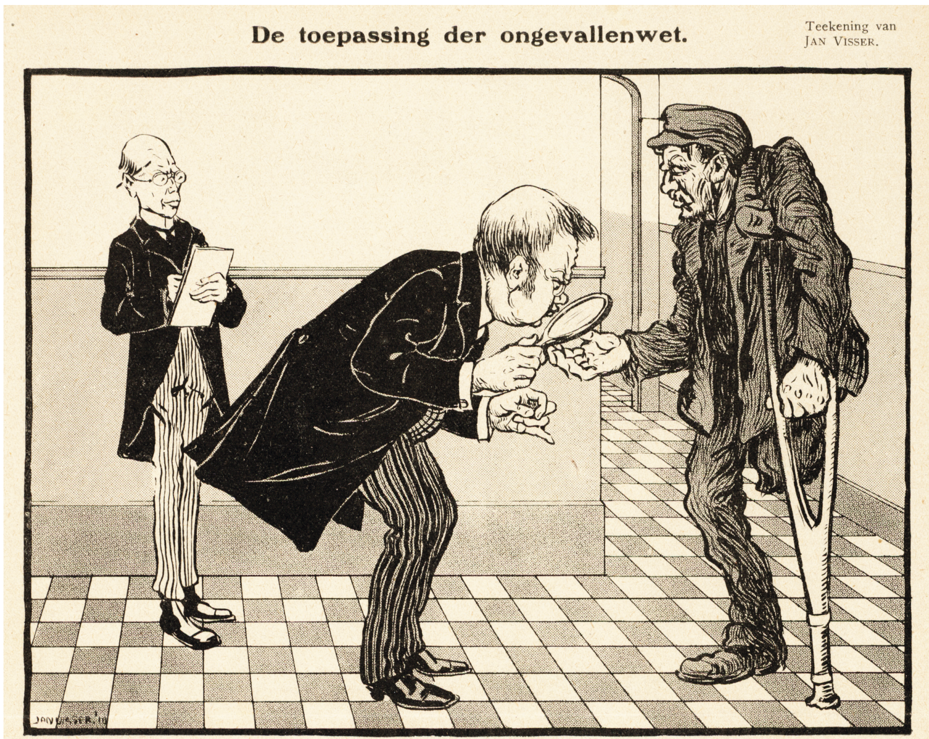

Figure 2. Cartoon by Jan Visser, published in The Nutcracker (*De Notenkraker*) on 10 March 1910. The image shows two neatly dressed medical officers and a worker who's leg has been amputated and is leaning on a crutch. One of the doctors is examining the worker's hand with a magnifying glass. The published version included a caption that read: 'What, calloused hands? So you can still work. Jansen, take him off the list!' (International Institute of Social History BG C13/99)

In the following I will show how this division between "hardworking people" and "lazy profiteers" played out in cases of the Central Council of Appeal and became part of the enactment of the incapacity for work. It was not that people could actually be divided between these two groups, since everyday practice was much more complicated than that. Rather, this division caused people claiming benefit to explicitly make an effort to show they were not one of these profiteers, emphasising and substantiating their moral accountability.

Moral accountability in court

In the appeal cases, workers dealt with their individual responsibility and their claim to benefit and a higher percentage of incapacity for work by providing proof of their former work ethic, good character and high moral standards.

In the 1915 case of K.G.M. van Veen, the doctor who estimated his incapacity for work, Bierens de Haan, claimed that Van Veen had 'put mildly, grossly exaggerated his complaints', because he could not find any objective signs of abnormality. In appeal, Van Veen not only claimed that his knee was very painful and that it was rather hard to travel to work and even harder to perform his work as a carpenter, he tried to boost his claim to benefit by stating that up until the day of the accident he had been a 'diligent and good workman' and that his employer was very pleased with his hard work.[164] A similar plea for good workmanship can be found in the case of K. Korporaal. On 23 October 1915 he was working in a butcher's and while rolling ham his fingers were 'pulled open'. Because he could not continue rolling ham, he started to cut out the meat to make sausages. In three days' time, however, his fingers started to fester, and he went to a doctor who then ordered him to stop working. The Rijksverzekeringsbank decided that Korporaal was not eligible for compensation, since he had still been able to work after the accident and since the injuries did not appear immediately, it was impossible to prove that the accident and the festering fingers were related. Korporaal said that he would not rest until justice was done. He hoped the judge would recognise that he deserved compensation for his loss of income. He was being punished for his perseverance, and not only his doctor but also his boss and two colleagues would be able to testify this was the case.[165]

The workers who lodged appeals against the decisions of the Rijksverzekeringsbank display an awareness of the fact that when it came to their work ethic and morality, the judges might not believe them. I encountered several cases where the worker clearly stated their eagerness to return to work and explicitly denied exaggerating their pain. In the appeal of T. Kersbergen, for instance, he writes how his doctor Schoemaker claimed that he thought Kersbergen was unwilling to use his arm, and that this caused an incapacity for work of 80% or 90%; however, based on anatomical deviations only, this would be 10% instead. In his appeal, Kersbergen mentioned this so that he could try to prove doctor Schoemaker wrong. According to Kersbergen, it was 'completely rational' to not only take anatomic harm into account, but also consider the innate properties of the individual person who has suffered an accident and to distinguish between energetic and unenergetic people. In Kersbergen's view there was no proof at all that he was unwilling to use his arm. In fact, he stated, he just did not have the energy to use it. 'I realise that the judge cannot just take my word for it', he stated, however, still stressing that a recalculation of his incapacity for work would be appropriate, so that the council could find that it was proven beyond doubt that he had an incapacity of at least 50%.[166]

164 NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

165 NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

166 Ibidem.

As proof of their good work ethic, workers like Van Veen and Korporaal claimed their boss or colleagues could confirm they had been hard-working employees before the accident. In particular, witness statements from doctors were provided to show the willingness of the workers to let themselves be examined and follow the orders of the doctor, and to prove that the worker in question tried their best to recover quickly and to not profit from the social benefit payments for too long. They were very aware of the fact that they would have to address their moral responsibility towards the collective and prevent any suspicions regarding their morality and work ethic. Workers used their story, confirmed by their employer and the authority of their doctor, to prove the moral validity of their claim to more benefit.

In the pleas of the Rijksverzekeringsbank, moral validity was seemingly of lesser importance, since the medical-scientific information was often presented as the main substantiation for a reduction or discontinuation of disability benefit. But simulation and aggravation were of concern to medical officers. Especially in cases in which the injuries were hard to measure and doctors found it difficult to pinpoint what exactly was affecting the working capacity of the person in question, the doctors often described the 'general impression', 'willingness to cooperate', and character of this person. Furthermore, this analysis of morality was connected to the process of standardisation described in the previous section. What was considered appropriate in terms of duration of the recovery process and the amount of pain experienced by the accident victim was established through comparison. The notion of aggravation was in itself a product of this comparison, since doctors could only tell if a person was exaggerating in relation to others.

Moreover, in cases of physically unexplained pains and disabilities, a lack of moral accountability was often pathologised. In Chapter 3 I will describe in more detail how this somatisation was done in practice; here, it is important to note that in the plea of the Rijksverzekeringsbank the moral validity of the claim was part of the consideration of what counted as incapacity for work, albeit always in relation to the medical analysis of bodily functioning.

The incapacity for work as matter of individual morality

The Industrial Injuries Insurance Act provided a group of workers with a form of social security that guaranteed that, in case of a workplace accident, they would be compensated for the loss of income due to incapacity for work. This scheme was not only put in place to help the individual cope with the hazards of physical labour and working with heavy machinery, but it was also supposed to avert poverty and improve social welfare. When claiming benefit, the individual had to prove their responsible attitude and show that they did so in an honest manner. The claim to benefit came with the cost of having to defend the right to the benefit and face suspicion. This suspicion manifested itself in

concerns about fraud in policy debates, reflected in the text of the Act itself, and articulated by medical officers. In appeals, in the dispute over what the incapacity for work was, this suspicion resulted in a strong focus by workers on their moral accountability. It was the worker who often addressed the suspicion by explicitly emphasising their good work ethic, their willingness to get better and efforts made to recover, and by underlining their wish to go back to work again. In doing this, they brought their morality to the process of granting disability benefit, enacting the incapacity for work as a matter of morals. By anticipating a debate about their morality, the worker was able to actively engage with it, twisting the narrative by pointing out they belonged to the group of hardworking people. In Chapter 4 we will see how this played out in their enactments of incapacity for work as lived experience and daily reality.

5 CONCLUSION: MAKING UP THE INCAPACITY FOR WORK IN THE EXPLORATORY PHASE OF THE INDUSTRIAL INJURIES INSURANCE ACT

The introduction of the Industrial Injuries Insurance Act and the first period of its implementation constituted an exploratory period in which the incapacity for work was not clearly defined, but made up in the course of the execution of the Act. In this chapter, we have seen how this produced multiple enactments of incapacity for work, two of which I have traced: quantification and moral accountability.

Scholars of the welfare state have argued that the introduction of disability benefit legislation in the Netherlands was motivated by the Social Question. The Act was introduced to prevent people from falling into poverty, enacting the incapacity for work as the lack of opportunity to earn a living. When zooming in on specific practices in the implementation of the Act, we see that this was not the notion of incapacity for work which the Rijksverzekeringsbank adhered to in practice. For while this may have been the motive or the rationale behind the implementation of disability benefit, the organisational structure of the Rijksverzekeringsbank, the choice to involve doctors in the claim assessment and the realities of the application of the Act produced other enactments of incapacity for work.

In the legal text of the Act itself, the political rationale was translated into a loss of the physical capacity to earn a living, while leaving a great deal of room for case-based interpretations to pave the way for fair application of the Act. Moreover, to prevent workers from profiting wrongfully from disability benefit, the Act provided the Rijksverzekeringsbank with considerable authority and the start of a calculation model. In the practice of the first version of the Industrial Injuries Insurance Act, the practical decision

by the board of the Rijksverzekeringsbank to let doctors perform claim examination led to incapacity for work becoming a matter of calculation based on a form of standardised comparisons of injuries.

In addition, I traced a rationale of distrust towards workers. This was rooted in civil cases of tortious liability, and perpetuated by the Act and officers in service of the Rijksverzekeringsbank. This may explain why workers substantiated their claim to disability benefits with proof of good workmanship, good character and cooperation, enacting incapacity for work as moral accountability.

The making up of incapacity for work, viewed from the perspective of the Act's implementation, shows that the 1901 version of the Industrial Injuries Insurance Act and the political deliberations that proceeded it, did not impose a single reality of incapacity for work on workers and medical officers. Instead, I have shown that the process of claim examination in the exploratory phase was, in fact, a messy and meandering process. Incapacity for work resulted from a tangle of interconnected practices, such as: the framing of the law of the Industrial Injuries Insurance Act and the time pressure under which an organisational structure had to be produced; ideas about fair application and about objectivity; the fact that doctors were the profession of choice to execute the claim assessment; the history of liability lawsuits; the availability of X-ray photography and language to describe the functioning of different joints of one finger; and the legal context of higher appeal cases that demanded a definite decision about a person's incapacity for work. Practices followed from each other, not in a linear process, like dominoes falling, but instead in constellations, like Mikado. I focussed on a few of these practices, to trace how and where they were connected and to see what incapacity for work they produced.

In the next chapter, which discusses the incapacity for work in the practice of the second version of the Act in the period 1921-1967 we will see that a few of the "sticks" were replaced, which disturbed the pile and caused new constellations and shifts in enactments of incapacity for work. With the new version of the Act, new clinical insights on rehabilitation, and newly available techniques to train and measure adaptability, the enactment of incapacity for work as moral accountability changed shape.

Chapter 2

Modes of adaptation

Overcoming incapacity for work
in the new version of the act (1921-1967)

In 1921 a new version of the Industrial Injuries Insurance Act came into effect. The Act underwent significant reforms, particularly in the sections relating to incapacity for work. Notions of what qualified as a workplace were extended, occupational diseases were now covered, and from now on working capacity had to be measured in relation to the specifics of the workplace and the labour market. In addition, the coverage for medical treatment was expanded to include prosthetics, rehabilitation and occupational training. With the reform of the Industrial Injuries Insurance Act, examination practices had to alter accordingly as well. This chapter therefore deals with the ways in which these changes affected earlier enactments of incapacity for work, and analyses which new enactments were brought into being by these policy changes. How was incapacity for work "made up" by the Rijksverzekeringsbank in the higher appeal cases during this period, from 1921 to 1967, when the Act was abolished?

First I will briefly discuss the ways in which the Industrial Injuries Insurance Act 1921 has been contextualised by political historians and sociologists working on social security legislation and the welfare state. So far, the new version of the Act has gained limited attention, primarily because historians commonly associate the birth of the Dutch welfare state with the period after World War II. Scholars of the welfare state mark a shift from pre-war social security arrangements, which were purportedly more focussed on employer-employee relations, to the 'new social security legislation' that tightened the relationship between citizens and the state. In this chapter I will argue that, based on the analysis of enactments of incapacity for work, this shift was already initiated by the new version of the Act, from the 1920s onward.

I will then delve into some of the main changes in the description of incapacity for work in the reformed Act, as well as the relevant changes in the organisation of its execution. The Act was revised to make more workers eligible for benefits and extend the legal definition of what counted as incapacity. More workers were now insured for workplace accidents, and the legal focus was no longer just on their ability to earn an income; the context in which they were able to work now had to be taken into consideration. Moreover, since rehabilitation training was now also covered, the reformed Industrial Injuries Insurance Act demanded new assessment techniques and new norms by which to calculate a worker's capacities and incapacities.

What follows is an analysis of the enactment of incapacity for work as a mode of adaptation and future capability. The higher appeal cases between 1921 and 1967, as well as reflections on the new claim procedure by officials in the service of the Rijksverzekeringsbank (renamed the *Sociale Verzekeringsbank* from 1956 on[167]), show how

167 References to the Rijksverzekeringsbank also include the Sociale Verzekeringsbank unless explicitly stated otherwise.

in interaction with the new Industrial Injuries Insurance Act, some of the enactments discussed in the previous chapter became more central to the benefit claim processes. In these processes the topic of morality in particular gained importance, combined with an increased emphasis on rehabilitation and on workers' willingness to overcome their disabilities. With the focus of the new Industrial Injuries Insurance Act on adaptation, and informed by the availability of rehabilitation knowledge and techniques, the Rijksverzekeringsbank underscored the responsibility of the worker to participate in the workforce, making up incapacity for work as something to overcome, and the willingness to adapt a matter of civic duty.

1 NEW ACT, NEW ENACTMENTS

In the previous chapter we have seen that the Industrial Injuries Insurance Act has mostly gained attention from political and socio-economic historians, as well as from sociologists, who have analysed disability benefit legislation from a top-down policymaking perspective. The same goes for the new version of the Act. Past studies on the Industrial Injuries Insurance Act 1921 either focus on its introduction or its abolition, and use it as an example in reflections on ruptures in politics or socio-economic developments in twentieth-century Dutch history. The Act is discussed in relation to the economic depression of the 1930s with correspondingly high unemployment rates,[168] it is analysed as part of the history of the Ministry of Social Affairs,[169] and some attention has been paid to the engagement of employers in matters of welfare arrangements in which the Industrial Injuries Insurance Act is used as an example of the steps taken towards decentralisation.[170] Apart from these studies, scholars have hardly paid any attention to the reform of the Industrial Injuries Insurance Act. This, I believe, has mainly to do with the fact that when it comes to the study of Dutch social security legislation, the main focus has been on the impact of the occupation of the Netherlands by Nazi Germany between 1940 and 1945 and the subsequent years of reconstruction, which have often been considered to have caused a shift in thinking about the use and application of welfare arrangements in the Netherlands. This is, moreover, very much in line with a historiography of the welfare

168 Kappelhof, ""Omdat het Historisch Gegroeid Is", 71-91.

169 Danièle Rigter, E.A.M. van den Bosch, Romke van der Veen and Anton Hemerijck (eds.) *Tussen Sociale Wil en Werkelijkheid: een Geschiedenis van het Beleid van het Ministerie van Sociale Zaken* (The Hague: VUGA Uitgeverij 1995).

170 Hoogenboom, *Standenstrijd en Zekerheid*, Kerklaan, "De Lange Houdbaarheid van de Ongevallenwet in Nederland 1901-1967", 64-90.

state that is concerned with a welfare-warfare nexus and explores the ways in which war has prompted the development of social policy and the advancement of welfare states.[171]

Political historians such as Joop Roebroek and Mirjam Hertogh have provided detailed descriptions of the deliberations among the politicians who lived in exile in London during World War II and were appointed by the Minister of Social Affairs to form a committee under the presidency of Aat van Rhijn in 1943. Inspired by the Beveridge report, this *Van Rhijn committee* reflected on the future of the Dutch welfare system. Van Rhijn and his colleagues considered social security '(…) the password of our time, with which one hopes to unlock the doors to a better future.'[172] Roebroek and Hertogh write how post-war social politics was shaped by a desire to make welfare arrangements not a form of insurance (*verzekering*) but security (*zekerheid*) instead, not just for labourers but for all members of society. While navigating debates about decentralisation, and tempered by politicians who worried about too much state involvement in societal matters, in the end, according to Roebroek and Hertogh, the proposals of the Van Rhijn committee were implemented in the policy pursued with the unification of the disability benefit acts.[173] Political historians disagree about the actual influence of the Van Rhijn committee and differ on whether or not World War II was the turning point in the development towards a more extensive social insurance system in the 1960s.[174] However, there is a shared notion of a historical shift in thinking about social security, of a so-called 'new social insurance', as Frits Noordam has put it, that led to a focus on security, with, as a result, the extension in the number and scope of state-arranged mandatory insurance schemes in the 1960s and 1970s.[175] According to Roebroek and Hertogh, moreover, this came with a shift from

171 See for instance: Arthur Marwick, *Total War and Social Change* (Basingstoke: Palgrave 1988), John Dryzek and Robert Goodin, "Risk-Sharing and Social Justice: The Motivational Foundations of the Post-War Welfare State", *British Journal of Political Science* 16.1 (1986) 1-34, Herbert Obinger, Klaus Petersen, Peter Starke (eds) *Warfare and Welfare: Military Conflict and Welfare State Development in Western Countries* (Oxford: Oxford University Press), Ke-Chin Hsia, *Victims' State: War and Welfare in Austria, 1868-1925* (Oxford: Oxford University Press 2022).

172 Arie Adriaan van Rhijn, *Sociale Zekerheid: Rapport van de Commissie, Ingesteld bij Beschikking van den Minister van Sociale Zaken van 26 Maart 1943, Met de Opdracht Algemeene Richtlijnen Vast te Stellen voor de Toekomstige Ontwikkeling der Sociale Verzekering in Nederland. Deel 1* (The Hague: Algemeene Landsdrukkerij 1945) 13-14.

173 Roebroek and Hertogh, *De Beschavende Invloed des Tijds*.

174 Ton Kappelhof, for example, identifies a more gradual change in policy and innovation in social security arrangements, which, moreover, began earlier, in 1937 with the social policy of the Minister of Social Affairs, Carl Romme.Kappelhof, ""Omdat het Historisch Gegroeid Is", 71-91.

175 Noordam, "Sociale Zekerheid 1950-2000", 807, 810-811.

private insurance to collective agreements, tightening the relationship between the citizen and the state, and making the arrangements less of an employer-employee affair.[176]

In short, although the Industrial Injuries Insurance Act 1921 was in effect for almost half a century, in the literature it is mainly analysed in its in-between status or as an early version of the social security legislation that was yet to come. In this context the Industrial Injuries Insurance Act 1921 is either of minor importance, or it is an example of tentative political steps towards a more decentralised and more generous social safety net.[177] It is easy to overlook the fact that with the reform of the Act far more workers were insured against workplace injuries, making the Act therefore of great importance to disabled workers at the time. While the focus on rupture makes sense when we study the Act within a larger frame of political history, histories of warfare and social security legislation in twentieth-century Netherlands, it feeds into a narrative of a socio-political logic that does not take into account practices such as chance or custom. As we will see, these were in fact prevalent in execution practices that came with the *Industrial Injuries Insurance Act*. In this dissertation, therefore, I switch that bird's eye view for a focus on day-to-day practices stemming from the Act, to see what happened with enactments of incapacity for work. Looking at the specificities of the new Industrial Injuries Insurance Act allows me to continue my analysis of interactions between the Act, execution procedures, examination practices and stories told by workers about their incapacity for work.

The focus on practices resulting from legislative changes, furthermore, elevates the Act from an in-between or prototypical form of true social security legislation to an actor in the making up of incapacity for work as a worker's individual responsibility to rehabilitate and get better for the common good. This not only evaluates the Industrial Injuries Insurance Act differently, but also puts into a different perspective the abovementioned claim of Roebroek and Hertogh that, from the 1960s on, social security legislation began to shift from a focus on the relationship between workers and employers to a focus on the relationship between citizens and the state. Looking at the socio-cultural consequences of actual practices in the execution of the Act, I propose a different chronology. In this chapter I aim to show that the Act was never just about employer-employee relations, but had always been about workers in society and about the relationship between citizens and the state, thereby nuancing the claim that this was a shift that came with the 'new social security' of the 1960s.

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176 Roebroek and Hertogh, *De Beschavende Invloed des Tijds,* 346-349.

177 As part of wat Romke van der Veen has called the construction phase. Romke van der Veen, "'L'histoire Se Répete? Honderd Jaar Uitvoeringsorganisatie Sociale Verzekeringen", in: A.Ph.C.M. Jaspers, F.M. Noordam, W.J.H. van Oorschot and F.J.L. Pennings (eds), *'De Gemeenschap is Aansprakelijk…' Honderd Jaar Sociale Verzekeringen 1901-2001* (Lelystad: Vermande 2001) 67-85.

In the following, we will see what the changes in the Industrial Injuries Insurance Act entailed and I will continue my analysis of practices of the Act as I did in the previous chapter. I will analyse how new enactments of incapacity for work appeared as execution practices changed. Some of these practices derived from experiences with the first Industrial Injuries Insurance Act, while others were directly related to the new act, or to socio-economic or political situations. In line with the practice focus of this study, I will take into account economic crises and high unemployment rates, as well as the invasion by Nazi Germany and politics around reconstruction and the unification of social security laws, insofar as they appear in the sources and become actors in enactments of incapacity for work.

2 REFORMING THE INDUSTRIAL INJURIES INSURANCE ACT

The reason for the reform of the 1901 Industrial Injuries Insurance Act can be attributed to the required changes to the organisational structure of the Rijksverzekeringsbank following the introduction of the Invalidity Act (*Invaliditeitswet*) in 1919 and the impending Sickness Benefits Act (*Ziektewet)*, which came into effect in 1930. When we take a look at the most substantial changes to the *Industrial Injuries Insurance Act*, we see that these were not just organisational in nature, applied to align the scheme with other social security arrangements, but were also prompted by experiences with the first version of the Act and evolving perceptions of the purpose of disability benefit insurance.

In 1919 the so-called *Radenwet* (Councils Act) was introduced. With this act, some of the tasks of the Rijksverzekeringsbank were transferred to 39 newly formed labour councils (*Raden van Arbeid*). These labour councils were led by medically trained officers who had been working for the Rijksverzekeringsbank before, but the staff included representatives of both workers and employers. The Industrial Injuries Insurance Act then had to be revised to give the councils the legal authority to perform their role in the claim assessments. For instance, they had to be granted the authority to determine premiums, collect accident reports and ensure that the payroll details of the employers were kept up to date so that the most recent wage could be used in calculating the amount of benefit. In addition to these administrative tasks, the councils were also responsible for legally monitoring the companies subject to compulsory insurance to ensure compliance with the rules of the Act. The labour councils were intended to handle the aspects of the claim procedure that required up-to-date local administration and practical knowledge of the workplace, so that the Rijksverzekeringsbank could focus on claim assessment and medical examinations. All in all, the Industrial Injuries Insurance Act 1921 primarily

entrusted the labour councils with preparatory and administrative tasks to ensure that the claim assessment went smoother and faster than before.[178]

This rather practical reason to revise the Industrial Injuries Insurance Act was further supported by the political aspiration to establish a more comprehensive system of social insurance legislation in the Netherlands. This system was aimed at not just protecting a group of workers in the few designated industries to which the Industrial Injuries Insurance Act 1901 applied, but rather insuring the entire working population against the financial consequences of incapacity for work. In 1919, the Invalidity Act came into effect. It introduced compulsory insurance for all workers against the loss of income due to disability or old age. The Invalidity Act was also executed by the Rijksverzekeringsbank, but differed from the Industrial Injuries Insurance Act since it was founded on the legal basis of social risk (*risque social*), which meant that workers were insured against disability in general and not just in the workplace.[179] Moreover, officially, the Invalidity Act did not measure working capacity, but the ability to earn an income instead. In 1919, the medical director of the Rijksverzekeringsbank, Pieter Hendrik Van Eden, wrote a manual for medical officers on how to examine disability. In this publication, Van Eden expressed his worries about the social and economic consequences of a broad interpretation of this new act, claiming that the Rijksverzekeringsbank should avoid granting too many workers benefit. He wrote that the Invalidity Act demanded the analysis of the full functioning of the body and not just the working capacity. For Van Eden it was therefore important that medical officers separated the subjective analysis from the objective analysis and from the eventual outcome of the examination. He also considered that the labour expert appointed by the Rijksverzekeringsbank in 1909, J.F. Staleman, should share his workload with three other so-called 'special agents', who would be tasked with analysing the salaries of various occupations on the basis of the information provided by the local labour councils and medical officers in order to substantiate their claim assessments.[180]

Since disabled workers could apply for benefit under both acts, the Industrial Injuries Insurance Act had to be revised in such a way that the arrangements did not overlap but supplemented each other. However, in practice, medical examinations for both acts were done by the same officials of the Rijksverzekeringsbank. According to Joost van Genabeek, the examination practices of the Industrial Injuries Insurance Act

178 Van Genabeek, "Voortgang en Verandering", 119-184.

179 A.W. Beekman, E. Boekman and W.J.J. Bronkhorst, *Practische Handleiding voor de Sociale Verzekeringswetgeving (Invaliditeitswet, Vrijwillige Ouderdomsverzekering, Ziektewet, Radenwet, Ongevallenwet)* (Amsterdam: Rijksverzekeringsbank 1919) 1-6, 214-221.

180 Pieter Hendrik van Eden, *Invaliditeitswet en Arts* (Haarlem: De Erven F. Bohn 1919) 42-46.

strongly influenced how cases were dealt with under the Invalidity Act.[181] Similarly, worries about the socio-economic consequences of a broad application of the Invalidity Act also had an impact on the claim examinations under the Industrial Injuries Insurance Act. The examination practices of the Invalidity Act interfered with or sometimes spilled over to claim estimations for the Industrial Injuries Insurance Act, making the boundaries between the two arrangements much more porous than intended, and thus becoming actors in the making up of incapacity for work.

Albeit to a lesser extent, this was also the case for the Act that arranged paid sick leave, the Sick Law (*Ziektewet*), which was introduced in 1913 but came into effect much later, in 1929. The Sick Law implemented a separate insurance scheme that granted workers their full wage for the days they were ill. Workers could not receive benefit from the Sick Law and the Industrial Injuries Insurance Act at the same time,[182] so there was less interference between the two acts. However, because compensation under the Sick Law was for the full wage, the temporary benefit during the so-called 'bridging period' (*overbruggingsperiode*), while the claim examination for disability benefit was still pending, was increased from 70% to 80% of the former daily salary. Because of this supposedly generous compensation, workers were under more suspicion of making fraudulent claims, which had an impact on their claim assessment. As we will see later, the deeply entrenched concerns about simulation and aggravation, which emerged in the context of the first Industrial Injuries Insurance Act, seemed to grow even stronger after the scope of the arrangements expanded. And although the legislator had implemented separate social insurance acts, the practices, ideas and officials involved were closely intertwined.

Another reason to revise the Industrial Injuries Insurance Act 1901 can be found in the fact that some of the arrangements in the Act were no longer considered just or fair. Some adjustments had already been made, and jurisprudence had for instance favoured more generous interpretations of the term 'workplace', making the commute to work part of the legal scope, and not just the factory or office building. The legal definitions of who was considered a 'workman', what locations fell under the definition of 'workplace', and what should be taken into account when measuring a worker's incapacity for work were debated intensively in appeal cases, and these definitions were changed substantially in the Industrial Injuries Insurance Act 1921.[183]

In many ways the new Act was more generous and encompassing than its predecessor. The group of employees who were legally considered 'workmen' was extended

181 Van Genabeek, "Voortgang en Verandering", 119-184.

182 The Sick Law applied to situations where a worker was ill, and not related to a workplace accident.

183 D.N. van Gelderen, "Herziening der Ongevallenwet 1901", *Geneeskundige Tijdschrift der Rijksverzekeringsbank* 6.1 (1921) 323- 332.

from workers in a few designated occupations to all workers on the payroll of all companies as well as individuals who were not technically in the service of a company but performed paid labour that was similar to paid employment.[184] The concept of a 'workplace accident' was no longer bound to a location, but connected to activities corresponding to the employment. And whereas before the injuries had to be sustained immediately after an accident, a 1928 amendment of the Industrial Injuries Insurance Act incorporated injuries that were sustained within a short period of time right after an accident (such as anthrax or heat stroke), paving the way for the incorporation of established occupational diseases in 1938.

For the present study, the changing description of what, by law, should be considered incapacity for work is the most striking. According to Article 18 of the Industrial Injuries Insurance Act 1921, a person was incapable of working if they were unable to perform labour corresponding to their former powers and abilities, in line with their former occupation and in the place where they performed their former job.[185] From now on, their career opportunities in the contemporary labour market should, moreover, also be taken into account. It was for this reason that the legislator had decided that not only should the costs of medical treatment be covered, but compensation should also include the expenses incurred for retraining. This extension of the legal definition of incapacity for work was there to make sure more workers would qualify for the financial protection of the Industrial Injuries Insurance Act. This meant that there would be more claims to examine, while at the same time the examination became more complex since more variables would have to be taken into account.

Medical officers now had to examine workers' abilities in relation to their work and also had to analyse the labour market in the area in which the worker lived. While these medical officers were already ill-equipped to measure working capacity in relation to work, they lacked substantial knowledge of the labour market. This meant that, with the implementation of the Industrial Injuries Insurance Act 1921, not only the organisation of the claim assessment had to be restructured, but the content of the assessment itself had to change quite drastically as well. The 14 labour experts working from the headquarters of the Rijksverzekeringsbank in Amsterdam were charged with the analysis of the fit between the workers' abilities and the workplace. To do so, they used information provided by medical officers and the local labour councils. According to Joost van Genabeek, these labour experts were considered the representatives of the Rijksverzekeringsbank and did not engage as much with the latest medical-scientific

184 In 1928 this was extended to contractors, in 1929 to relief workers, and in 1941 self-employed workers working on a commission basis became compulsorily insured.

185 Article 18 of the Industrial Injuries Insurance Act 1921.

insights as the medical officers did. However, the labour expert and the medical officer would have to come up with a shared decision about an individual's working capacity, and so the claim examination had to be a combination of medical analysis and investigation of the specificities of the workplace.[186] In the section below, I will describe in detail how the Rijksverzekeringsbank and the labour councils dealt with this new legal spectrum of what was to be considered incapacity for work, and how this caused new enactments of incapacity for work.

This short, general description of the most substantial changes of the Industrial Injuries Insurance Act already shows how the new Act resulted from the desire to make the claim assessment more in line with current ideas about the fair and just application of existing arrangements. The Act was still there to avert poverty, and experiences with the first version of the Act had taught the legislator what should be improved in terms of legal definitions as well as the organisation of the application of the Act. The new Industrial Injuries Insurance Act therefore was intertwined with the practices associated with the 1901 version of the Act, while it also produced new practices and legal definitions that brought about new grounds for claims to benefit, and therewith made up incapacity for work in new ways.

3 REHABILITATION AND ADAPTATION

We have seen how, with the introduction of disability benefit legislation in the Netherlands, medical officers struggled with their new task of having to estimate a worker's lost working capacity. However, according to one of these doctors, Gerardus Pieter van Trooyen, the claim estimation could, in hindsight, never have been easier than it was under the 1901 Industrial Injuries Insurance Act. At that time, medical officers were just to take into account the loss of an individual's physical working capacity, which was actually pretty straightforward in comparison with the multiple variables that had to be taken into account with the new Industrial Injuries Insurance Act, Van Trooyen claimed in 1928.[187] The quest for ways to properly measure incapacity for work continued. By 1921, doctors in the service of the Rijksverzekeringsbank had been used to certain modes of examination, with corresponding practices and discourses relating to incapacity for

186 Van Genabeek, "Voortgang en Verandering", 161.

187 G.P. van Trooyen, "Over Invaliditeitsschatting in Verband met Psychotechniek en Arbeidstherapie", in: J.R. Slotemaker de Bruine, H.W. Groeneveld, H.W. Nicolai, T.J. Verschuur, C.G.D. Borias, H.L. van Duyl, V. Gravenstein, J.C. Heyning and K. Lindner, *Vijf-en-twintig Jaren Sociale Verzekering* (Haarlem: Tjeenk Willink & Zoon 1928) 297-307.

work. Under the new Industrial Injuries Insurance Act, incapacity for work still had to be estimated and put into percentages, but now the individual physical or mental capacity to perform labour in general was supposed to be measured in relation to the former occupation and abilities. Legally speaking, incapacity for work was not just bodily functioning, but bodily functioning in a specific work context. The new Act was supposed to do more justice to the context specificity of an individual's working capacity: it was not just about the body, the work had to be taken into account as well.

Looking at the appeal cases of the Central Council of Appeal in the years 1925, 1935, 1945, 1955 and 1965, we see that in the practice of the claim examinations in this period, the Rijksverzekeringsbank (Sociale Verzekeringsbank from 1956) often did analyse the fit between the working body and an occupation, albeit in a standardised manner. It resulted in a strong focus on rehabilitation and adaptation on the worker's side of the equation. This made up incapacity for work as a temporary state, which workers should strive to overcome.

For the purpose of this analysis I have identified three ways in which medical officers in the service of the Rijksverzekeringsbank underpinned their statements about a worker's incapacity for work. The first one is the measurement of improved functioning of the injured body part, the second is the calculation of a suspected mode of adaptation, and the third the role of the worker's supposed willingness to undergo medical treatment and adapt to a new working capacity.

Improvement in physical capacities equals improvement in working capacity

Although the changes in the Industrial Injuries Insurance Act were considerable, and the legal description of incapacity for work changed substantially, that did not mean that the examination practices changed entirely, nor did it mean that previous enactments of incapacity for work disappeared overnight. In fact, comparing appeal cases from before and after 1921, the cases appear to be very much alike. We have seen how medical officers in the service of the Rijksverzekeringsbank were doctors and therefore focussed strongly on bodily functioning when measuring a worker's incapacity for work. In time they had gained experience with workers with similar injuries whom they used for comparisons, and they came up with forms of standardisation that simplified the calculation. Bodily functioning was still very much at the centre of attention for medical officers when estimating a person's working capacity.

When looking at the 1935 case of A.J. Beukers, you would hardly notice that the Industrial Injuries Insurance Act had changed. The Rijksverzekeringsbank argued for an end to the benefit in his case, giving the following reasons. In 1930 the flexion of Beukers' thumb was 155 degrees and in 1934 it was 145 degrees. Since Beukers' thumb could be brought towards every top of every finger he was able to work again, and therefore benefit

was no longer appropriate. Although this focus on the flexion of the thumb suggests that Beukers performed manual work in which he should be able to hold a tool, no reference to the workplace or profession in which his fingers would be used was made.[188]

Similarly, in the 1935 case of H. Bakker, incapacity for work was measured through the analysis of the individual bodily functioning. The Rijksverzekeringsbank had lodged an appeal against the decision of the council of appeal of Amsterdam, since the state bank had reduced Bakker's benefit after it decided his incapacity for work percentage was now 10% instead of 20%. The council had annulled this decision, and granted Bakker his original amount of benefit. In this higher appeal, the medical officer H. de Jong defended the Rijksverzekeringsbank's decision by basing this reduction in the benefit on the fact that Bakker had improved the functioning of his injured left arm, and was now able to bend his arm and elbow up to 140 degrees when raised in front and 70 degrees when raised at the side. Moreover, De Jong claimed that he had noticed some signs of neurosis: a sensibility disorder with non-organic limitations and light ataxia, a neurological disturbance in the coordination of movement, especially obvious in a top-nose test. He stated that it was only right to reduce the amount of benefit due to the fact that Bakker's functionality had improved. Although De Jong did not reflect on this in the appeal, in the next chapter we will see that the best medical treatment for neurosis was considered to be the resumption of work, which would add to De Jong's argument that Bakker's working capacity should improve once he had resumed his activities.[189] The officer De Jong did not address the fit between Bakker's capacity and his particular workplace situation, but he did analyse the workplace as a form of therapy, a means to improve Bakker's working capacity.

Another example of a case in which the measuring of bodily capacities was the main ground for reducing the percentage of incapacity for work was the 1935 case of B. Kleine in which the Rijksverzekeringsbank lodged an appeal against the annulment of their decision to grant Kleine benefit corresponding to 10% incapacity for work instead of the former 20% incapacity for work. The dispute about Kleine's working capacity was centred around a disagreement between the expert witness K.C. van Berckel and the medical officer of the Rijksverzekeringsbank. The surgeon Van Berckel had observed that the grip strength as well as the pronation and supination strength of Kleine's right arm were severely reduced. Van Berckel expressed difficulties in estimating Kleine's working capacity, since 'that is a matter of work performance, which cannot be deduced from this investigation'. He claimed that Kleine might be able to adapt to or overcome some of his fatigue and weakness, and in time improve his working capacity a bit, but he reckoned

188 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

189 Ibidem.

that the time in which the Rijksverzekeringsbank expected Kleine to regain his working capacity was too short. The medical officer, who is not mentioned by name this time, did not agree. He questioned the value of the tests that Van Berckel had performed on Kleine. He especially denounced the use of a dynamometer, since it only measured the willingness to squeeze and not the ability to do so. Instead, the medical officer claimed, the objective findings were there: the muscles in Kleine's upper arm and forearm were well-developed, there was only a slight form of atrophy in the hand (expressed in the muscle on the metacarpal bones, which measured 20 units on the right and 21 on the left). Moreover, the officer added, Kleine had suffered an injury before, and although he had lost his right finger he had been able to perform his work as a hewer, so Kleine had demonstrated he still had his working capacity and could earn his wage. A somewhat malicious remark was added by the medical officer of the Rijksverzekeringsbank, who stated that if Van Berckel considered himself unable to make statements about labour performance based on the injuries alone, '(...) he would have been better off not differing from the estimation made by himself [the medical officer] and the labour expert of the Rijksverzekeringsbank.'[190] So while the expert witness was hesitant to make statements about Kleine's working capacity based on improvements in bodily functioning alone, the officer in the service of the Rijksverzekeringsbank claimed authority over matters of incapacity for work. He based this on the fact that he and his colleagues had the experience or the knowledge to be able to take more into account than just bodily functioning. However, he still made the improvements in bodily functioning the centre of his analysis.

Although this focus on bodily functioning may seem like a continuation of former examination practices, with the Rijksverzekeringsbank grounding the right to benefit in the same rationales regarding incapacity for work, this is only partially the case. Medical officers continued their search for properties and measures of incapacity for work, and first and foremost tried to find them by measuring body parts and comparing and calculating the functionality of arms and backs and legs. However, that was only part of the examination. The labour expert charged with the estimation of the percentage of incapacity for work had to collect information about the work environment as well. Moreover, officers in the service of the Rijksverzekeringsbank were also very much aware of the fact that incapacity for work in practice was contextual, and that recovery from injuries was not enough to make a worker fully capable of working again. With the new Industrial Injuries Insurance Act, "functionality", the quality of movement of the injured part of the body to perform specific work tasks, became central to the analysis of incapacity for work.

190 Ibidem.

Especially the case of Kleine, as well as the abovementioned insights of the medical director Van Trooyen in the *Geneeskundig Tijdschrift der Rijksverzekeringsbank* (Medical Journal of the Rijksverzekeringsbank), show that officers in the service of the Rijksverzekeringsbank were familiar with the fact that working conditions had to be taken into account. Moreover, it was the Rijksverzekeringsbank itself that had concluded that medical officers lacked knowledge about workplace conditions, and had therefore already introduced the function of 'labour expert' in 1909.[191] The labour experts had to collect technical information and details about a variety of professions to make sure that medical officers were able to decide to what extent injured workers were able to meet the standards of these professions.[192] Apart from the job description of the labour experts, this group of Rijksverzekeringsbank employees are rarely mentioned in the primary sources on the Rijksverzekeringsbank.[193] Furthermore, in court files their perspectives were seldom reflected, since it was the medical officer who took the stand and represented the Rijksverzekeringsbank; disabled workers in the appeal cases did not refer to the labour experts either. It seems that these labour experts mainly operated internally within the organisation of the state bank, which makes it difficult to evaluate their practical role in the process of the claim assessment. However, when mentioned in the statements of medical officers, labour experts often embodied the notion that the Rijksverzekeringsbank was engaged with matters of the practical functionality of workers. In 1933 the medical officer C. Becker and medical director Pieter Hendrik Eden wrote an obituary of J.F. Staleman, the first person to hold the position of labour expert, which was published in the *Geneeskundig Tijdschrift der Rijksverzekeringsbank*. They wrote that they had learned from working with Staleman that 'the theoretical estimation of the amount of working capacity was often not in line with the practical value that the victim of the workplace accident possessed in reality.' In the context of the workplace, workers were simply capable of more than could be measured.[194] This shows that officials of the Rijksverzekeringsbank thought of themselves as examiners who, by emphasising the potential of every worker, brought the improvement of bodily functioning in relation to the actual workplace conditions. It is in this light that the somewhat sneering comment of the nameless official in the case of Kleine can be interpreted: after all, it was the Rijksverzekeringsbank that pre-eminently considered matters of incapacity for work and

191 Armand ten Voorde, "100 jaar AD. De Nodig Gebleken Aanvullende Factor", *AD visie* 6 (2009) 18-19.

192 Monique Klompé, René Ravenstein, Tessy van Rossum and Armand ten Voorde, *Een Typisch Nederlands Beroep. Kroniek van Honderd Jaar Arbeidsdeskundigheid* (Nijmegen: NVVA 2009) 7-30.

193 Ibidem.

194 Pieter Hendrik van Eeden and C. Becker, "In Memoriam J.T. Staleman", *Geneeskundig Tijdschrift der Rijksverzekeringsbank* (1928) 13, 129.

reflected at length on the nuances and difficulties of claim examinations in publications such as their medical journal.

The new Industrial Injuries Insurance Act had led to organisational changes as well as extended examination procedures. The Act had changed, the execution of the Act was reorganised and somewhat decentralised, but when it came to the claim examination it was still mainly based on the insights of medically trained medical officers. Technically it was the labour experts who were now in charge of the estimation of a worker's incapacity for work, combining medical insights from medical officers with their own knowledge of working conditions. The medical officers would write a report and then the labour expert would calculate the percentage of incapacity for work.[195] However, working from the headquarters of the Rijksverzekeringsbank in Amsterdam, and given the fact that there were only 14 of these labour experts who had to analyse all the cases, they relied heavily on the insights of the medical officers, who were now mostly working at the offices of the local labour councils. Moreover, since it was impossible for labour experts to examine the specificities of every individual workplace, here too forms of standardisation developed. The information about a variety of occupations, collected by the labour experts, served as a body of knowledge, of general insights, and was not always tailored to individual situations or based on individual inspection of every worker's workplace situation.[196] This explains the strong focus on things like grip strength or being able to make a fist: these were abilities that most manual labourers would have to possess. Therefore, there were still multiple higher court cases in which a worker's working capacity was reduced to the flexion of the joints, enacting incapacity for work as the inability to make a fist or to bend over forwards.

The awareness of a prevailing notion that incapacity for work was about bodies in the context of specific work was there, but it did not always materialise in a fundamental change in the analysis of a person's working capacity. Often it was a continuation of incapacity for work as a matter of bodily functioning, as we have seen in the context of the 1901 version of the Act. For in the appeal cases incapacity for work was often still very much a matter of measuring the flexion of joints or improved abilities to form a fist, making the improvement of the functioning of the injured body part equivalent to the improvement of working capacities. But whereas before the comparison was made mainly between workers with similar injuries, in the context of the new Industrial Injuries Insurance Act a comparison was also made between workers with similar jobs.

195 Van Genabeek, "Voortgang en Verandering", 143.

196 J.P.C. van der Burgh, *Rijksverzekeringsbank 1901-1941* (Haarlem: Tjeenk Willink & Zoon 1941) 239.

Adaptation and expected incapacity for work

By extension, or alongside this focus on injured body parts, a focus on rehabilitation can be traced in the higher appeal cases. Adaptation began to be the *buzzword* in the context of the claim examination from the 1920s on, and remained central to the analysis of workers' incapacity for work until far beyond the end of the Industrial Injuries Insurance Act. The legal text of the new Act considered a person partly or fully incapable of working in relation to their former capacities as well as their former occupation. It added that the labour market should also be taken into account, suggesting that the claim examination should consider working capacity a tailor-made as well as relational matter, considering the worker's functionality in specific workplace activities.

When we look at the appeal cases, it becomes clear that this focus on functionality in context resulted in an emphasis on the adaptation of the worker to their new mode of functionality. In 1935 there were multiple cases in which the medical officer claimed that a person's working capacity should improve in time and/or with exercise, adjusting the percentage of incapacity for work to this expected adaptation. In the case of I.H. Janssen the officer stated '(...) I still believe that the time period I described should be adequate for achieving practical and full working capacity.'[197] Similarly, the Rijksverzekeringsbank claimed in the case of J.A. Fransen that, as expected, the worker indeed adapted to his new working capacities. Experience taught the Rijksverzekeringsbank that self-employed workers were often pretending they could not work. Fransen was now able to carry some crates, and it would only be right to reduce the percentage of incapacity for work. In the cases of K.G. Slot and J.L. Mulder, the medical officers also emphasised a specific time frame for the return of grip strength, while incorporating certain types of exercise. In both cases the Rijksverzekeringsbank claimed that an increase in the working capacity and therefore reduction in the corresponding benefit should be calculated for the course of this time span. In the 1945 case of B.K. van der Molen jr., the medical officer pleaded for a reduction of benefit corresponding to a 25% incapacity for work by stating that a further decrease in the functionality of Van der Molen's right hand was not to be expected.[198] In all of these cases the worker's future working capacity was taken into account in the calculation of incapacity for work. Incapacity for work was not just a matter of functionality now, but also in the future. And this future working capacity was estimated based on experience with workers with similar injuries as well as on the expectation that workers would commit to training or therapy.

Sometimes the reduction in benefit was considered a way to encourage a worker to adapt to their new abilities and invest more in the improvement of their working ca-

197 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, Januari 3 – 1935, Juni 26.

198 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

pacity. In the 1925 case of J. van der Meer, the professor in psychiatry and expert witness Leendert Bouman suggested considering Van der Meer no longer incapable of working because his benefit prevented the worker from doing his utmost to rehabilitate and adapt to his new functionality. The Rijksverzekeringsbank used this testimony to substantiate their decision to consider Van der Meer fully capable of working.[199] The case of D. Bosma, which came before court in 1935, shows a similar rationale behind the reduction in the benefit. Bosma had injured four fingers on his left hand, and the Rijksverzekeringsbank had decided he was able to work for 60%, which according to the council of appeal should have been 40%. The medical officer stated that in cases of limited flexion (*flexiebeperking*) it was common to consider a person incapable of working for 20% to a maximum of 30%, at least for the period in which they were in the process of adaptation (the so-called *overgangsrente*, transition benefit). He substantiated the plea of the Rijksverzekeringsbank with a detailed medical description and the analysis of the functionality of Bosma's hand, which he had measured, and added that with a lot of perseverance on the side of Bosma there would soon be more improvements. Benefit corresponding to 60% would therefore not be to Bosma's advantage, he claimed.[200]

Incapacity for work was often not static. Frequently workers would be able to resume their work, and most of the recipients of benefit would not be permanently incapable of working. It was therefore common to apply a gradual reduction in the disability benefit. However, the introduction of the new Industrial Injuries Insurance Act and the new legal definition of incapacity for work had explicitly made the work environment part of the equation to make sure that benefit was granted corresponding to an actual, practical incapacity for work. In the practice of the claim examination this did not necessarily translate into a more generous or comprehensive interpretation of incapacity for work, but instead gave workers the assignment to make sure they adapted to be able to perform their occupation. Here working capacity became something to strive for that would manifest itself once a worker resumed their work. This enacted incapacity for work as something that should be overcome, in time and through adaptation. And while the legislator had wanted to make sure the claim assessment was more in line with the analysis of a worker's *actual* working capacity, in the practice of the examination it was often a calculation of a theoretical and enforced future working capacity that was central to the decision of the Rijksverzekeringsbank.

199 NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

200 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

Therapy as proof of the right attitude

Added to this focus on adaptation with its timeline plotted by the Rijksverzekeringsbank was the pressure put on workers to undergo surgery or medical treatment. The Industrial Injuries Insurance Act 1921 provided compensation not only for the treatment of injuries, but also for rehabilitation therapy. It is important to note that although workers were obliged to let themselves be examined upon request by the medical officer or the labour expert as a condition of being granted the benefit, the Act itself did not force workers to make use of the treatments or retraining offered.[201] When we look at the appeal cases, however, in the practice of the claim examination workers were expected to undergo surgery and medical treatment. Resistance was often considered proof of unwillingness to cooperate, obstructing the timeline plotted by the Rijksverzekeringsbank, and so, through the back door, medical treatment was taken into consideration in the calculation of a person's incapacity for work.

In the 1935 case of G. Müller, his refusal to undergo surgery was for instance considered a 'contradictory attitude' that prolonged his incapacity for work. The Rijksverzekeringsbank therefore considered him 30% unable to work, instead of the previous 100% incapacity for work, claiming that Müller should take the 70% difference 'upon himself'.[202] In 1955 the working capacity of both D.V. van der Arm and N. van Dijk was taken into consideration in court. In both cases the worker had been advised to undergo surgery to amputate what remained of an injured finger, and both Been and Van Dijk had refused to do so. In these cases the Rijksverzekeringsbank deemed that the worker did not do their utmost for rehabilitation. Whereas they could improve their pace of work and therewith increase their production value, they were lacking motivation, it was argued, and therefore, according to the medical officer, a reduction in their benefit would be appropriate.[203]

This analysis of the willingness to undergo medical treatment as a sign of adaptation and motivation of workers by the Rijksverzekeringsbank/Sociale Verzekeringsbank continued until the end of the Industrial Injuries Insurance Act. In his 1965 case, M. Visser's unwillingness to have his finger amputated was interpreted by the officer in the service of the Sociale Verzekeringsbank as a lack of effort on the part of Visser. The officer stated:

> *'(...) in this regard it is important that the victim of the accident delivers a performance that is in line with his true capacities. Every examiner that is convin-*

201 Article 25 and 75 of the Industrial Injuries Insurance Act 1921.

202 NA, 2.09.39 CRvB, Inv. No. 264 uitspraaknummers 33200-34062, 1935, juli 4 – 1935, december 31.

203 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

> *ced that the accident victim does whatever he possibly can will be satisfied with the delivered performance.'*[204]

This time the medical officer was actually not convinced that Visser had done everything in his power to improve his work performance; after all he could have had his finger amputated. Therefore, according to the officer, a reduction in the benefit to match the potential working capacity (after amputation) would be appropriate.[205] Here we see how the rationale of incapacity for work as something that could soon be overcome to allow the resumption of work could result in a pressure to undergo treatment or surgery.

In the higher court cases, the medical officers of the Rijksverzekeringsbank displayed their trust in medical treatment and rehabilitation therapy, even though this included new and experimental forms of treatment, especially where rehabilitation medicine was concerned. The outcomes were hard to predict, and sometimes medical treatment could have side effects that made injuries worse, or would be at odds with this focus on quick recovery and the resumption of work. In his 1925 case, J. Maas claimed that he suffered from abnormal fatness due to a lack of nutritious food and exercise while receiving treatment in a medical institution. This made it harder for him to use his right leg, which impeded the rehabilitation process and made him more incapable of working.[206] In the case of D.J.H. Broer, handled by the Central Council of Appeal in 1935, the expert witness Doctor Reehorst stated that Broer's mental and physical health had deteriorated while being hospitalised. Broer had lost a lot of weight due to massage treatment, but most of all he had lost his trust in his own working capacities, Reehorst claimed. It would have been better if Broer had been put to work straight away, as the treatment had done more harm than good.[207]

Sometimes not going into therapy could be considered a sign of cooperation as well as a positive attitude. In the course of the 1930s, the Rijksverzekeringsbank started to make a distinction between different types of injuries in their approach to the rehabilitation of the worker.

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204 'In dit verband is van belang dat de ongevalsgetroffene een prestatie levert die in overeenstemming is met zijn werkelijk kunnen. Elke opzichter die de overtuiging heeft dat een getroffene doet wat hij kan zal genoegen nemen met de dan geleverde prestatie.' Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

205 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

206 NA, 2.09.39, CRvB, Inv. No. 129 Uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

207 NA, 2.09.39 CRvB, Inv. No. 263 Uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

In cases of physical injuries, such as hand or leg injuries, the Rijksverzekeringsbank would often recommend physiotherapy or demand that the worker should be admitted to a rehabilitation centre.[208] In the next chapter we will see how in cases of traumatic neurosis, for instance, medical treatment was considered unbeneficial and quick resumption of work was the advice. In those cases, the request by a worker to undergo further treatment was considered a sign of a fixation on benefit and an unwillingness to rehabilitate.

In all cases, when it came to the calculation of incapacity for work, what was taken into account was the willingness to cooperate as well as the dedication of the worker to keep to the plotted timeline and achieve the estimated future working capacity. Here we see that 'adaptation', which became important in the execution procedures of the Industrial Injuries Insurance Act 1921, was a rather complex process that entailed all kinds of expectations and timelines. In the interaction between the Act, the consequent examination practices, the standardisations of the measurements of bodily functioning and analyses of workplaces as well as available medical treatments and techniques, incapacity for work was enacted as an individual effort to resume work in an expected or desired way. This enactment of incapacity for work as a mode of adaptation fitted very well with how officials in the service of the Rijksverzekeringsbank understood the socio-economic responsibility of workers in society.

4 THE SOCIAL QUESTION OF DISABILITY

In the previous chapter we have seen that it was mainly workers themselves who explicitly stressed their good morals in response to the distrust towards workers and worries about fraud. In the course of the application of the new Act it was the Rijksverzekeringsbank that started to take the required attitude towards adaptation and rehabilitation as a sign of good morals, connecting it to the so-called 'social question of disability', the economic and social costs of social security arrangements in relation to the individual's responsibility to contribute to the common good.

'Where there's a will, there's a way'

The *Geneeskundige Tijdschrift der Rijksverzekeringsbank* was published between 1920 and 1941 and was considered the main journal for officers involved in the claim assessments under the social security laws that the Rijksverzekeringsbank administered.[209]

208 Such as a Zander-Institute. See: Thomas J.A. Terlouw, "De Opkomst en Neergang van de Zander-Instituten rond 1900 in Nederland', *Gewina* 27 (2004) 135-158.

209 Van Genabeek, 'Voortgang en Verandering", 119-184.

During those years of publication the topic of adaptation was rather prominent. This ties in with a more general appreciation of rehabilitation after World War I. The war had left millions of soldiers wounded and disabled. As historians such as Julie Powell and Heather Perry have described, this led the countries involved to come up with rehabilitation programmes. The war had prompted the rise and development of orthopaedics,[210] which led to an increased supply of and demand for prosthetics, reconstruction programmes and vocational training, often funded by the individual states. Whether this was to compensate the men who had sacrificed themselves to serve their country, a way to build a nation state, a mode to reclaim the former soldiers for the workforce, a way to help them regain their male identity, or a combination of those things, often historians analyse the emergence of rehabilitation programmes as an example of the intersection between war, medicine and welfare.[211] According to Paul van Trigt these rehabilitation programmes reflect a "logic of normality" that has shaped the approach to disabled people in most Western European countries. This logic treats disability as a deficit that needs to be repaired in order for people to become part of society and of the general workforce again - something that Van Trigt argues has not been very prominent in the Netherlands. He distinguishes this normality logic from a "logic of care", which treats disabled people as dependent and in need of care, which he claims was prevalent in the Netherlands up until the 1980's.[212] While this may be true for the approach of disabled people in institutions or healthcare facilities, on which Van Trigt bases his thesis, here I argue that in the context of social security legislation, disabled workers were very much approached from a logic of normality.[213]

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210 For a discussion of the interaction between war and developments or ruptures in medicine, see: Roger Cooter, "War and Modern Medicine", in: William F. Bynum and Roy Porter (eds) *Companion Encyclopedia of the History of Medicine* (London: Routledge 1993) 1536–1573.

211 See for instance: Henri-Jacques Stiker, *A History of Disability* (Ann Arbor: University of Michigan Press 2000), Julie Powell, *Bodies of Work: The First World War and the Transnational Making of Rehabilitation* (New York: Cambridge University Press 2023), Heather Perry, *Recycling the Disabled - Army, Medicine, and Modernity in WWI Germany* (Manchester: Manchester University Press 2017), Jessica Adler, *Burdens of War. Creating the United States Veterans Health System* (Baltimore: John Hopkins University Press 2017), Julie Anderson, *War, Disability and Rehabilitation in Britain: 'Soul of a Nation'* (Manchester: Manchester University Press 2011), Lisa Herschbach, "Reconstructions. Making the Industry; Re-making the Body, Modelling the Nation", *History Workshop Journal* 44 (1997) 23-57, Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (Chicago: University of Chicago Press 1996).

212 These two logics can be linked to the approach of disabled people in terms of 'sameness' and 'difference'. Van Trigt, *Blind in een Gidsland,* 22-25, 62-87, 120-63.

213 As van Trigt has pointed out, for much of the twentieth century, healthcare and social security systems in the Netherlands were seen as separate spheres. It may well have been the case that persons who became disabled as a result of a workplace accident were treated rather differently from people who had been disabled all their lives. They were approached as workers rather than as disabled people. Ibidem.

Although the Netherlands did not fight in World War I, and the Industrial Injuries Insurance Act compensated workers, not veterans,[214] Dutch medical science engaged with the transnational development of orthopaedics. And the more readily available knowledge about prosthetics, 'the gospel of rehabilitation' as Julie Powell calls it, reached the office of the Rijksverzekeringsbank. Articles written by the medical director or medical officers display a lot of enthusiasm about rehabilitation and the possibilities opened up by retraining programmes and 'clinical workplaces'.[215] To celebrate its 50th anniversary, which was dedicated to the theme of rehabilitation, Rijksverzekeringsbank set up an arm training school and a facility to help disabled workers regain the ability to walk with the help of prostheses.[216] Often in publications by medical officers on rehabilitation, the rationale of a worker overcoming incapacity played a role in these publications.

Pieter Hendrik van Eden, the medical director of the Rijksverzekeringsbank between 1915 and 1928, played an interesting part in this. As the head of the claim organisation he was charged with the translation of changes in the Industrial Injuries Insurance Act into the practice of the claim examination.[217] His interest in rehabilitation was already

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214 Disabled veterans are often analysed as a separate, more privileged group. There is a common view among historians that veterans were usually treated with more respect and considered more deserving of compensation than disabled workers. See for example: David Gerber (ed.) *Disabled Veterans in History* (Ann Arbor: University of Michigan Press 2012), Deborah Cohen, *The War Come Home: Disabled Veterans in Britain and Germany, 1914-1939* (Berkeley: University of California Press 2001).

215 In 1929, a government commission was set up by the Ministry of Labour to explore the possibilities of work for disabled people, and the organisation Labour for Invalid Persons (*Arbeid voor Onvolwaardigen*, later renamed *Actio Vincit Omnia*, Work Conquers All, short A.V.O.) lobbied for the introduction of work facilities for disabled people. Not out of charity, as they claimed, but as a social matter, for it would benefit the whole nation if these people were to contribute their working capacity to the total workforce. Doctor J.S. Stratingh, affiliated with A.V.O. studied the economic advantages of the 'use' of disabled workers' capacities and claimed in several publications that the amount of unutilised labour could be estimated around 100 million guilders and stated that, therefore, 'a closer look at the problem of proper employment of invalid workers is certainly justified.' J.S. Stratingh, *Bijdragen tot het Onvolwaardigenprobleem. Een Onderzoek naar de Sociale en Economische Positie der Onvolwaardigen en Arbeidsonvolwaardigen in een Omschreven Gedeelte van ons Land* (Assen: van Gorcum 1946) 3. See also: W. Mol and E.P. Schuyt, *Over Lichamelijke Gebrekkigheid. Bijdrage tot het Vraagstuk der Onvolwaardige Arbeidskrachten* (Amsterdam: J.A. Paris 1930). For a discussion of A.V.O. see: H.J.E. Hermans and S.H. Schmidt, "Een Blinde Fietsenmaker in het Stedelijk. Tenstoonstelling en Congres 'Arbeid voor Onvolwaardigen' in 1928", *Gewina* 25.4 (2002) 226-240. Not much has been written about work and disability in the Netherlands, and I could not find much about actual facilities for disabled workers. Although this is a matter for further research, my impression is that the focus of such initiatives was mainly on people living in institutions, because, as we will see in Chapter 4, disabled workers emphasised their lack of job opportunities and workplace adaptations. See for a study of rehabilitation programmes for blind persons. Van Trigt, *Blind in een Gidsland*, 62-87, 120-151.

216 L.C. van Soeren, *50 Jaren Sociale Verzekering: 1901-1951* (Amsterdam: Rijksverzekeringsbank 1951).

217 We should not exaggerate the direct influence of the medical director on the policy of the Rijksverzekeringsbank. There was considerable debate about the extent of this influence on the way the

clear in 1919 when he wrote a dissertation on 'Adaptation In the Context of Accident Insurance'. In this dissertation he displayed an optimism about the physical and mental capacities of human beings to adapt.[218] He focussed on hand injuries, and based his insights on medical literature as well as case studies, plus an analysis of the accident statistics of the Rijksverzekeringsbank. Van Eden came to the conclusion that in the context of claim examinations under the Industrial Injuries Insurance Act, the focus of medical treatment should not be on healing alone, but should also be on the motivation of the workers to activate the remaining functionality and compensate for what was lost.[219]

These insights were repeated in the articles that Van Eden published in the medical journal of the Rijksverzekeringsbank. He particularly hinted that he wished to encourage workers to keep pushing themselves to make the most of their situation and their changed bodies. His Dutch translation of a German poem, which he came across in a catalogue for an exhibition of prosthetic limbs, is exemplary. The poem goes by the title *Merkspruch* and was aimed at encouraging a person who had lost a limb to practice the use of prosthetics, to not complain and to not lose their patience or blame another person for their loss. The poem made clear: '(...) force yourself to practise and learn, you will not succeed with only a few attempts. Keep pushing, show courage and consult, because where there's a will, there's a way.'[220] In a 1927 article, Van Eden explored in more detail the necessity of encouraging workers to adapt to the new, more limited functionality of their bodies, with or without prosthetics. He reviewed a British journal about rehabilitation and restoration, and emphasised that in the treatment of victims of

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medical officers carried out their work. According to the medical officer D. Brockx, the medical officers had acquired their own experience and knowledge and were unlikely to suddenly change the way they worked. Perhaps, he wrote, the presence of the medical director might bring about some changes over time. 'Maar dat een nieuwe ambtenaar de magische macht zou bezeten hebben om binnen één jaar veertien medici, die allen reeds jaren hunne functie bekleeden, zonder officiële drang of dwang, te brengen tot eene principeele wijziging in de opvatting hunner taak – lijkt mij toe tot het gebieden der onmogelijkheden te behoren.' D. Brocx, "Bestaat Er Een Nieuwe Koers Bij de Rijksverzekeringsbank?", *Sociale Voorzorg* 2.1 (1920) 110-139. Nevertheless, van Eden was the public face of the Rijksverzekeringsbank, and his views on rehabilitation were reflected in the statements of other medical officers in the higher appeal cases.

218 He explained that he believes that humans have a form of 'reserve power', powers that are not normally activated but are there to cover for lack of power in cases of heavy physical or mental strain. Pieter Hendrik van Eden, *Aanpassing in Verband met de Ongevallenverzekering* (Haarlem: Tjeenk Willink & Zoon 1919).

219 He stated that in many cases the adjustment was natural, and the fact that only a few workers appealed against the Rijksverzekeringsbank's decision to reduce their benefit showed that the workers also considered themselves to be adjusted. 'And our experience has shown that the Dutch workmen who feels wronged, would have easily found his way to court.' Ibidem, 148-149.

220 '(...) dwingt u zelf tot oefenen en leeren, het lukt niet met een enklen keer probeeren. Zet door, toon moed en overleg, want waar een wil is, is een weg.' Pieter Hendrik van Eden, "Merkspruch", *Geneeskundig Tijdschrift der Rijksverzekeringsbank* 6.6 (1921) 22.

workplace accidents the focus should not just be on healing alone. Instead, he claimed, resumption of work was of utmost importance.

He wrote:

> *'The Industrial Injuries Insurance Act only provides temporary financial compensation. Charity does not lead to recovery, but only increases the days spent in idleness. The social, human and economic duty is only fulfilled when the disabled person has found regular employment again, in as far as human abilities allow.'*[221]

Van Eden added that he learned from the British journal that rehabilitation was, in fact, the answer to the 'economic and social question of disability', and that it was therefore imperative to instil in workers a sense of faith and trust in their own capabilities. Here we see that the medical director of the Rijksverzekeringsbank analysed the improvement of one's capacity for work as a duty, a responsibility of the individual worker towards society.

This notion was already reflected in Van Eden's publication on the application of the Invalidity Act,[222] but was now also addressed in the context of the Industrial Injuries Insurance Act. Whereas in this 1919 dissertation Van Eden focussed on the opportunities of adaptation, here it was emphasised as a social obligation. Van Eden continued by also pointing out the duty of employers to make use of the workforce of disabled workers, since it was 'ridiculous' to think that an injured worker could not be productive. On the contrary, he claimed, '[o]ften, an accident is a costly lesson to teach a worker to be more accurate, mindful and "efficient".' Further on he wrote: 'The patient needs to immediately perform productive labour, and this labour serves as medicine by itself', connecting the 'social question of disability' to the rationale of incapacity for work as something to be overcome.[223] The medical officer D.N. van Gelderen delved deeper into the topic of the individual duty to rehabilitate in a 1926 article. He gave a short overview of the ways in which the Industrial Injuries Insurance Act had helped disabled workers to avoid poverty, which he considered rather necessary. However, Van Gelderen worried about the increasing numbers of recipients, and stated that the Act had weakened

221 'De Ongevallenwet geeft alleen tijdelijke geldelijke vergoeding. Weldadigheid leidt niet tot herstel, doch vermeerdert alleen de dagen, in ledigheid doorgebracht. De sociale, menschelijke en oeconomische plicht wordt slechts vervuld, wanneer de invalide, voor zoover dit naar menschelijke krachten mogelijk is, weer een geregelde werkkring heeft gevonden.' Pieter Hendrik van Eden, "Rehabilitation Review", *Geneeskundig Tijdschrift der Rijksverzekeringsbank* 12.4 (1927) 119-124.

222 Van Eden, *Invaliditeitswet en Arts*.

223 Van Eden, "Rehabilitation Review", 119-124.

workers' desire to protect themselves against accidents. And this was a costly matter for society, not only in terms of capital, but also in terms of a loss of good morals. He stated that incapacity for work had a negative effect on the psyche of disabled workers. 'Only through labour – adjusted to one's own personal ability and nature – can a person experience the joy of life, which is necessary for the maintenance of order in society', he wrote.[224] Van Gelderen went on to reflect on the unwillingness of employers, including the public authorities, to hire workers with disabilities, while in fact statistics had shown that when there are labour shortages many of these workers would be fit for employment. He stated that working capacity was not increased by rest; on the contrary, according to him the old adage applied: 'if you don't use it, you lose it'.[225] Van Gelderen therefore advocated better cooperation between employers and employees to preserve the individual worker's powers, to avoid accidents and to help injured workers resume work as quickly as possible.

The inhibitory effect of the Industrial Injuries Insurance Act and work as civic duty

The notion that workers who received benefit were less willing to recover was prevalent in the journal. Exemplary are the multiple articles in which medical officers expressed their surprise about cases in which workers were, in fact, capable of overcoming their pains and impairments. J.J. van der Sluis, for instance, wrote in a 1928 article with the significant title 'What an insured worker is also capable of' about a case in which a chauffeur had injured his left lower leg. This chauffeur had dressed the wound and continued his work, while later in the evening he suffered great pain. He continued to work, up until 14 days later when he was in so much agony that he had to halt his work. An X-ray picture showed a fracture of his lower leg. Van der Sluis stated: 'To me this case is worth mentioning since it is an example of what an insured worker could be capable of with energy and work ethic.'[226] This optimism was not shared by F.W. Hoefman, who stated his opinion that X-rays should be standard procedure in every claim examination because '(...) when it comes to the examination of accident victims, one cannot be "safe" enough, since insured workers seem to be in the possession of a rather odd mentality.'[227]

224 'Alleen door arbeid – aangepast aan ieders persoonlijke kracht en geaardheid – kan men die levensvreugde genieten, die mede noodzakelijk is tot het instand houden van een geordende maatschappij.' D.N. van Gelderen, "Arbeidsongeschiktheid", *Geneeskundig Tijdschrift der Rijksverzekeringsbank* 11.2 (1926) 47-57.

225 'Rust roest'. Ibidem.

226 J.J. van der Sluis, "Waartoe Ook een "Verzekerde Getroffene" in Staat Kan Zijn", *Geneeskundig Tijdschrift der Rijksverzekeringsbank* 13.7 (1928) 199-200.

227 F.W. Hoefman, "Ingezonden. Te veel of Te Weinig Röntgenopnamen voor de R.V.B.?", *Geneeskundig Tijdschrift der Rijksverzekeringsbank* 26.2 (1941) 24-26.

In this notion of the worker's 'odd mentality' or unwillingness to put an effort into recovery and regaining working capacity, the presumption can be traced that workers would inherently not want to rehabilitate. As Deborah Stone and others have shown, social security arrangements were often designed in such a way that wage labour would remain financially attractive; otherwise, it was thought, the arrangements would negatively affect the work ethic of the working classes.[228] This was also the case with the Industrial Injuries Insurance Act, which paid out 70% of the last earned daily wage in the case of full eligibility. The desire to motivate workers to make more of an effort to adapt to their new bodies can moreover be linked to a long Western European tradition of complaints about idleness, a cultural dichotomy between laziness and productivity and the invention of the modern work ethic, which is often connected to Protestantism, capitalism and/or the building of nation states.[229] Although Stephen Fineman and Melis Hayez have stressed that this productivity culture is less a Western analysis, for instance, suggests, they emphasise that productivity has often been considered a measurement of civilisation and a mark of national character, as well as being used in a discourse of social exclusion that tied the individual body to a greater collective or national project.[230]

When analysing the ways in which the new Act brought about new enactments of incapacity for work, these assumptions can be considered the result of a connection between already existing worries about fraud and distrust of workers in general and the extension of the reach and corresponding rise in the number of benefit recipients resulting from the new Industrial Injuries Insurance Act, as well as the Invalidity Act and the Sick Law. The revision of the Act was intended to make sure more workers were in-

228 See: Stone, *The Disabled State*, Rodney Lowe, *The Welfare State in Britain Since 1945* (Basingstoke: Palgrave Macmillan 2005), Jackie Gulland, *Gender, Work and Social Control: A Century of Disability Benefits* (London: Palgrave Macmillan, 2019), Gareth Millward, *Sick Note: A History of the British Welfare State* (Oxford: Oxford University Press 2022).

229 This productivity culture is often described on the basis of, and in conversation with, the ideas of prominent theorists such as Adam Smith, John Stuart Mill, Max Weber and Karl Marx. See for example: Rani van der Ploeg and Ruth Zinstok, *Wij Zijn Allen Werklieden. De Opkomst van de Moderne Arbeidsmoraal in Nederland in de Negentiende Eeuw* (Baarn: Ambo 1986), Patrick Joyce, *The Historical Meanings of Work* (Cambridge: Cambridge University Press 1987), Regenia Gagnier and John Dupré, "On Work and Idleness", *Feminist Economics* 1.3 (1995) 96-109, Stephan Fineman, *Work. A Very Short Introduction* (Oxford: Oxford University Press 2012). In the past few years historians have moved beyond a Eurocentric scope and have also written histories of work from a global perspective. See for instance: Melis Hafez, *Inventing Laziness: The Culture of Productivity in Late Ottoman Society* (Cambridge: Cambridge University Press 2022), Jan Lucassen, *The Story of Work. A New History of Human Kind* (London: Yale University Press 2022). So far, analyses of the history of the meaning of work have mainly taken a broad perspective, focusing on the history of ideas or the socio-economic circumstances of workers worldwide. A cultural-historical reflection on the meaning of work, or a history of work from below, remains to be explored.

230 Fineman, *Work. A Very Short Introduction*, Hafez, *Inventing Laziness.*

cluded and more circumstances were taken into account, but the initial idea that social security legislation protected society from the social consequences of poverty seemed to have moved even further to the background and was not addressed by officers in the service of the Rijksverzekeringsbank. With the rising numbers of benefit recipients and corresponding costs in times of economic recession (1930s) and war (1940s), the individual responsibility to contribute their labour capacity for the common good was a topic of concern.

This interaction between the Act, worries about workers' morality and socio-economic conditions is evident in a debate between the mine physician A.H. Vossenaar and the labour expert H.B. Marijt. In his article, a version of a talk he gave in 1935, Vossenaar stated that it seemed as though the risk of accidents had increased with the arrival of the Industrial Injuries Insurance Act. Whereas before, workers would just continue their work, against their better judgement, because they would otherwise be living in poverty, now there was a tendency, especially amongst medical officers, Vossenaar claimed, to meticulously analyse every little injury on its own and to not take into account the ways in which the rest of the body could take over the functions of a little finger or injured eye. Especially in cases of minor injuries, he wrote, it was better to not inform the worker of their incapacities, and to just let them resume their work without any benefit, because workers were capable of much more than they, and employers alike, thought. In short, he claimed that the Industrial Injuries Insurance Act and corresponding examination practices had negatively affected workers' trust in their own capacities to adapt to the new, more limited functionality of their bodies. He stated that the Rijksverzekeringsbank should stop considering an accident to be an earth-shattering experience for a worker, since that only added to what he called 'the army of invalids': 'Even though, in these sorry times, everything should be aimed at preserving national powers, at not weakening the industrial workforce, and at letting reality be the guiding light in everything that should be left alone or done.'[231]

The labour expert H.B. Marijt did not agree with Vossenaar, at least not when it concerned the willingness of workers to participate in rehabilitation programmes. He wrote that there were, in fact, many recipients of benefit who were perfectly able to rehabilitate and their right to benefit was phased out accordingly. According to Marijt, Vossenaar did not do justice to the fact that a claim assessment was always a matter of estimation, and in this estimation the officer had to decide whether he would focus on the interests of the individual worker or the interests of society. In this consideration the specificities of an individual's functioning were important, for it was something different

231 A.H. Vossenaar, "Invaliditeit en Aanpassing. Naar een te Utrecht dd 27 november 1934 Gehouden Voordracht", *Geneeskundig Tijdschrift der Rijksverzekeringsbank* 20.2 (1935) 33-46.

for a weaver to lose an index finger than it was for a miner, who might still be able to hold a shovel. He ended his contribution by saying:

> *'Those who are up to the task to examine the incapacity for work, whether it is medical or technical, in my opinion, had better not let their judgment be troubled by the exceptional cases of adaptation to which Dr V. refers, neither should they be affected by weak-hearted sympathy with the victims of an accident and they should take into consideration the cases in which minor injuries have led to undue forms of invalidity. They should strive to find the middle ground.'*[232]

In reaction, Vossenaar wrote that one should be careful not to underestimate the social consequences of a generous application of the Industrial Injuries Insurance Act. He stated:

> *'If a large group of useful community members is prevented from giving their full labour potential because of the inhibitory effect of social arrangements, then it is necessary to make it loud and clear once again that 'each' should make 'his own' contribution, because society is deprived of what belongs to it.'*[233]

This clash between Vossenaar en Marijt mainly dealt with a difference in views on whether or not a more strict and uniform application would be preferable. While Vossenaar worried about corruption of the system, Marijt pleaded for a more nuanced application in which a middle ground was sought between the interests of society and the interests of the individual. However, they both acknowledged a certain 'inhibitory effect' of the Act on the recovery of injured workers, and their interaction reveals that they both assumed the interests of society and of the individual are inherently at odds. These articles not only provide insight into historical reflections on the limits of this idea of mutual beneficence, which is still very topical, they also show how the Industrial Injuries Insurance Act had an impact on relations between citizens and the state, making medical treatment, bodily

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232 'Zij die, hetzij medisch, hetzij technisch, de invaliditeit hebben te beoordelen, zullen m.i. goed doen, zich bij hun oordeel noch door de door dr. V genoemde sterke staaltjes van aanpassingsmogelijkheden te laten leiden, noch te vervallen in een weekhartig medelijden met de getroffenen en die gevallen in het oog houden, waar betrekkelijk geringe letsels tot overdreven invaliditeit leidden, doch er naar streven, het juiste midden te bereiken.' H.B. Marijt, "Ingezonden", *Geneeskundig Tijdschrift der Rijksverzekeringsbank* 20.4 (1935) 111-120.

233 'Indien een groote groep van nuttige gemeenschapsleden wordt teruggehouden van het geven harer volledige arbeidskracht uithoofde van regelingen die remmend werken op haar productiviteit, dan is het alweer noodig luid te doen klinken "ieder het zijne" te geven, omdat hier aan de gemeenschap het haar toekomende wordt onthouden.' A.H. Vossenaar, "Ingezonden", *Geneeskundig Tijdschrift der Rijksverzekeringsbank* 20.5 (1937) 145-151.

functioning and adaptation an individual responsibility as well as a social affair. Here the Rijksverzekeringsbank enacted working capacity as a form of moral duty, not just towards employers but to society as a whole.[234] Looking at the Industrial Injuries Insurance Act from close up, we can see that, although legally based on the professional risk (*risque professional*), in practice it was hardly about the relation between workers and employees at all. Instead, from the introduction of the first Industrial Injuries Insurance Act, but especially in the context of the 1921 version of the Act, social security legislation involved the interference of the state in the bodily sphere of the disabled worker.[235] So while Roebroek and Hertogh and others have focussed on political deliberations concerning post-war social security arrangements and therefore claim that with the arrival of the new welfare state in the 1960s social security insurance became more about the relation between the citizen and the state,[236] after exploring the practices of the claim examination of the reformed Act, I argue that the citizen-state relationship was already at the heart of social security legislation in the 1920s.

What about employers?

Whereas officers in the service of the Rijksverzekeringsbank stressed the duty of the worker, it is interesting to note that the role granted to employers in cases of incapacity for work was rather limited. Van Eden considered that employers had the wrong impression that disabled workers would be less efficient, and similarly, Van Gelderen complained about employers not making use of the labour capabilities that injured workers still had. Chapter 4 discusses the ways in which workers enacted their own incapacity for work

234 This is addressed more generally by James Kennedy in his essay on notions of work in the post-war Netherlands. He writes that although work was also seen as a form of self-realisation, it was primarily in the service of the collective. ‘Your own fulfilment was important, but the duty to devote oneself fully was primarily to promote the “well-being” of the community. It was precisely in this collective endeavour that the individual would be given his own unique place’ (‘Je eigen voldoening was belangrijk, maar de plicht om je volledig in te zetten moest in eerste instantie het “welzijn” van de gemeenschap bevorderen. Juist in dit gezamenlijke streven zou het individu zijn eigen, unieke plek krijgen’.) James Kennedy, *Aan Het Werk* (Amsterdam: Prometheus 2022) 20-21. While Kennedy’s essay is primarily concerned with the second half of the twentieth century, I note that the rationale of combined personal and collective growth through work was already reflected in statements made by the Rijksverzekeringsbank in the 1920s and 1930s.

235 This can be understood as an example of a process that Michel Foucault called biopolitics. The control, discipline and optimisation of the capabilities of the worker’s body for its productive utility and to establish political obedience. Michel Foucault, *Society Must Be Defended: Lectures at the Collège de France, 1975-1976* (New York: St. Martin’s Press 1997) 243–244. See for an application of biopolitics to the study of social policy: Martin Hewitt, “Bio Politics and Social Policy: Foucault’s Account of Welfare”, in: Mike Featherstone, Mike Hepworth, and Bryan Turner (eds) *The Body: Social Process and Cultural Theory* (London: SAGE Publications 1991) 225-255.

236 Roebroek and Hertogh, *De Beschavende Invloed des Tijds,* 346-349.

and puts the assumptions about idle workers in a different perspective: finding work could be difficult and the labour market could be cruel to disabled labourers. However, the Industrial Injuries Insurance Act did not assign employers any duties other than to pay the premiums. Apart from the workplace safety regulations, designed to prevent accidents from happening, employers were not obliged to adjust the content of the work or the workplace to the needs of a disabled worker. In the course of the 1920s employers gained more rights in the context of the Industrial Injuries Insurance Act, but not more duties. With the *Radenwet*, employers were granted a say in the organisation of the claim procedure and the method used for calculating the premiums. In 1928 the *Fabrieksartsenwet* (Factory Doctors Act) stated that under specific circumstances and in cases of minor accidents, factory doctors in the service of the employer were granted the authority to treat the worker themselves and they did not need to file a report with the Rijksverzekeringsbank. These were measures aimed at making sure that workers would resume their work more quickly, which was considered in the best interests of both workers and employers.[237]

What is interesting to note here is that under the new Industrial Injuries Insurance Act the so-called 'labour market criterion' was supposed to be part of the analysis of a worker's incapacity for work. This meant that in the claim estimation what had to be taken into account was the possibility of a worker finding a job suited to their previous capabilities and their level of education, and near the town or city where they had performed their former work.[238] Possible problems finding work corresponding to the worker's former capabilities had to be directly related to the accident, not to economic circumstances or fluctuations in the supply and demand of certain categories of workers. Joost van Genabeek writes that in practice, this was very difficult to substantiate and was therefore hardly ever applied.[239]

In the appeal cases, only the workers themselves addressed this criterion. In multiple cases, workers were fired by their former employer for not being able to perform according to their former working capacities.[240] And although employers were often reluctant to hire disabled workers, as Van Eden and medical directors after him also acknowledged and addressed, the Rijksverzekeringsbank did not include the role of employers (or the labour market in general) as part of the equation when considering a person's

237 Van Genabeek, "Voortgang en Verandering", 137-139.

238 Article 18 sub 2 of the Industrial Injuries Insurance Act 1921.

239 Van Genabeek, "Voortgang en Verandering", 161-163.

240 This is also one of the results of the survey carried out by the Rijksverzekeringsbank in 1929 on the status of benefit recipients. Council of the Rijksverzekeringsbank, *Verslag Van Een Onderzoek Naar den Toestand der Rentetrekkers (Ongevallenwet)* (Amsterdam: Rijksverzekeringsbank 1929).

incapacity for work. Sometimes workers asked for their employers to be heard in court, providing substantiation for their claim to more benefit on the grounds of expertise in their specific work environment. In the 1935 case of K. van den Heuvel, for instance, his employer wrote a letter to the court providing his perspective on Van den Heuvel's working capacity, claiming that his functionality had deteriorated and that he did not expect him to ever become able to perform any work.[241] Sometimes employers were consulted by medical officers or labour experts, which meant that the Rijksverzekeringsbank considered their insights to be taken into account in the calculation of the worker's incapacity for work. However, in court, and much to the dismay of workers, employers were never consulted as witnesses or experts.

Although the Act adhered to the relational nature of incapacity for work, of the injured body and the conditions of the workplace, it was the individual and their body that had to adapt and become fit to work again, making up incapacity for work as an individual's duty towards society and a challenge that they needed to overcome.

5 CONCLUSION: CAPACITY FOR WORK AS CIVIC DUTY

In the previous chapter we have seen how the Industrial Injuries Insurance Act was introduced as a way of averting poverty and thus addressing the Social Question. In the initial phase of the new act, incapacity for work was not very clearly defined, but was described as the loss of the physical power to earn a living. The calculation model, initiated by the Act, led to comparisons between workers with similar injuries, and resulted in a form of standardisation in examination practices. While rooted in a context of distrust towards workers and worries about fraud, incapacity for work was also enacted as a matter of accountability of the individual worker to not abuse the social security arrangement. With the 1921 amendments to the Act, these enactments of incapacity for work shifted. This time the Rijksverzekeringsbank did not have to come up with an entirely new operational system; however, the organisation as well as the content of the examination did change substantially. The interaction between the reformed act and its operational structure, the experiences with the previous claim procedures, the socio-economic circumstances, war, the interest in rehabilitation medicine, and ideas about the beneficial effects of labour on the wellbeing of workers together made up the incapacity for work that the Rijksverzekeringsbank measured. And in this interaction the key term was adaptation, making up incapacity for work as a challenge to be overcome, not just for the sake of the worker in question, but for the benefit of society as a whole.

241 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

Continuing a quest for the true measurements of incapacity for work, the Industrial Injuries Insurance Act 1921 was designed so that the estimated incapacity for work was more in line with the worker's "actual" and future incapacity for work. In the practice of the claim examination under the reformed act, and infused with new notions and techniques of rehabilitation, the Rijksverzekeringsbank started to calculate a theoretical or future incapacity for work, which was supposed to bring the incapacity for work into being. Moreover, the required fit between the worker's bodily functioning and the specifics of the workplace translated into a strong focus on adaptation on the part of the worker.

This reflected previously described worries about fraud and the rationale that workers would want to abuse the benefit system. However, with the introduction of the Industrial Injuries Insurance Act 1921, this emphasis on moral responsibility was not just targeted at the elimination of fraud but addressed a more fundamental civic duty of every worker, including the workers actually considered entitled to benefit, to make sure they did not profit unduly from their situation and that they contributed to the national workforce. By taking into account the process of adaptation in the calculation of a worker's incapacity for work, the Rijksverzekeringsbank pushed workers into reducing the incapacity that was the source of their entitlement to benefit. Here we have seen how changes in the Act were supposed to bring the examination closer to a "true" or "more real" incapacity for work, yet instead it produced a new possibility to enact incapacity for work. Bodily functioning was analysed in a theoretical workplace setting, with an expected future working capacity as well as a moral duty to rehabilitate. This focus on rehabilitation as a civic duty shows how in the context of the Industrial Injuries Insurance Act, and already from the 1920's on, capacity for work was about being a good citizen. Rather than tying workers to employers, it made workers into citizens whose individual physical capacities and rehabilitation processes were taken into account by the state.[242]

I have now addressed some of the enactments of incapacity for work as done by the Rijksverzekeringsbank in the context of both versions of the Act. Medical officers operated at the crossroads of insurance medicine and legal procedures, while also considering themselves serving both the interests of individual workers and society as a whole. They were In the next chapter we will switch the perspective, and focus on medical doctors who worked in a clinical setting and were consulted as expert witnesses. These were doctors heard in court who embodied a form of neutral knowledge,

242 Heli Leppälä has identified a similar link between work and citizenship in post-war disability policy in Finland, but found that the meaning changed in the 1960s when policy became more focused on individual interests and work was increasingly seen as an entitlement rather than a duty. My research found no evidence that this process also occurred in the Netherlands, but a praxiographic analysis of work could provide new insights. Heli Leppälä, "Duty to Entitlement: Work and Citizenship in the Finnish Post-War Disability Policy, Early 1940s to 1970." *Social History of Medicine* 27.1 (2014) 144-164.

as they were not serving any of the parties involved. As we shall see, while constantly moving between their medico-clinical expertise and the legal framework to which their knowledge had to conform, these experts came up with their own versions of incapacity for work that interacted with the statements of the Rijksverzekeringsbank as well as the worker under investigation.

Chapter 3

Blurring borders

Medical experts navigating the realms of medicine and law

In the higher appeal cases concerning incapacity for work, three perspectives were heard: that of the Rijksverzekeringsbank, the injured worker and one or more expert witnesses. I have considered the ways in which the Rijksverzekeringsbank enacted, or "made up", incapacity for work, and in the last chapter of this dissertation workers will take the stand. In this chapter, the focus is on the medical doctors who were called in to provide an unbiased perspective, I refer to them as 'medical experts' because that was their role in court. In the appeals, both parties considered medical insights fundamental to their claims about the real properties of incapacity for work. The medical officers, who were specialists in insurance medicine, served and represented the Rijksverzekeringsbank and were therefore considered to be a party to the dispute. However knowledgeable they were, their medical opinions and references to other doctors were used to support the interests of the Rijksverzekeringsbank. Similarly, the workers also referred to the views of general practitioners, surgeons or psychiatrists that had been involved in their treatment to support their position. An expert witness was invited by the court to provide their *judgement (oordeel*), as it was called in the verdicts, their evaluation of the incapacity for work, with which the court would then either 'agree' or not. These doctors, expert witnesses as they were called, were not a party in the legal conflict; they were invited by the Central Council of Appeal to take up the seemingly straightforward task of providing an unbiased, impartial and technical medical view on the incapacity for work of the labourer under investigation.[243]

While the court case revolved around a legal question, namely whether a person was eligible for compensation in terms of the Industrial Injuries Insurance Act based on the severity of incapacity for work, the answer was to be found in the insights of an expert in a different field, namely medicine. Medical doctors were called in to advise the court on legal issues such as the question of whether a certain disease was caused by an accident or qualified as an occupational illness under the law. The process of medical assessment, however, came with its own problems and issues, such as the question of how to determine whether a person was ill, what symptoms should be taken into account, what information and techniques were available and how to value these outcomes in a medical-professional manner. Medical experts were asked to navigate both medical and legal fields and the corresponding problems to provide the Central Council of Appeal with the insights required to come to an informed decision. In this chapter I will show that this navigation resulted in the emergence of a space, a "border area", in which the two fields began to intertwine, a space that came with its own practices in which new realities of

243 As Deborah Stone has argued, the legitimation of medical authority, the gatekeeping position of doctors in the distribution of public programmes, derives from the "(…) belief that diagnosis of illness and disability is a relatively straightforward -and accurate- process." Stone, "Physicians as Gatekeepers", 227-254.

incapacity for work were enacted. Legal questions could not just be answered in medical terms: clinical knowledge and practices had to be translated into legal answers. And, as I will show in this chapter, while fulfilling their medico-legal role of experts, the legal terms were also translated into new clinical pictures and medical labels. I will illuminate where and how these areas became entangled, the ways in which medical experts were constantly crossing the borders between the two fields, and I will show that in the process the Industrial Injuries Act itself came to be seen as a pathogen, while the worker was increasingly reduced to a patient. Incapacity for work was no longer the result of an accident or injury, but was an illness in itself.

It might not be a surprising outcome in itself that medical experts analysed incapacity for work in terms of disease. There is a vast body of scholarly work that focusses on larger processes of medicalisation that occurred in Western countries over the course of the twentieth century, sometimes critically identifying a medical power play causing social and political problems to be answered in medical terms. Regardless of how medicalisation should be evaluated, doctors gained a prominent position in societal matters, and acquired a gatekeeping role in all sorts of social security arrangements. What remains to be unpacked is how exactly doctors gave substance to their role and responsibilities, and how they made medical knowledge fit to tackle social issues. Through my analysis of *how* and *where* medical experts made up incapacity for work as illness - my focus on the intricacies of medicalisation - I am able to make an innovative contribution to the medicalisation thesis. In this chapter I will show that the navigation of the medico-legal border area was a rather messy process, an attempt to deal with doubt. Medicalisation did not just involve a linear process of doctors assigning medical terminology and implementing medical criteria to assess work capacity; instead the formation of the doctor's expert perspective on incapacity for work was a circular process. With this I mean that while doctors did examine incapacity for work from a medical perspective, their understanding of diseases was, in turn, influenced by legal procedures and regulations. So, rather than looking at medicalisation as a matter of medical power play or gatekeeping, I look at how the legal context shaped both the medical labels and the incapacity for work that resulted from doctors exercising their expert role in court.

In the following I will first provide some historiographical background and elaborate on scholarly work on the gatekeeping position of doctors and on medicalisation, to show that while scholars have identified an increase in the influence of the field of medicine in societal matters, its material consequences for the making up of the realities of incapacity for work have remained invisible. I will further reflect on how expertise has been theorised and discuss how an emphasis on the navigation practices helps to analyse the statements of medical experts as the product of interaction between their own knowledge and experience, the requirements of the Industrial Injuries Insurance Act,

and the perspectives of the Rijksverzekeringsbank and of workers. Subsequently, I will focus on the application of medical expertise to two medical labels that offer a crucial window on the ways in which doctors used their insights to shape incapacity for work. Although doctors were consulted as experts on a worker's incapacity for work, they were trained to diagnose and treat patients. Therefore, medical labels played an important role in their analysis and were used to move incapacity for work between the medical and legal contexts. For this reason, I have chosen to focus on the examination practices corresponding to two medical labels: *traumatic neurosis* and *silicosis*.

This chapter reveals that these newly identified diseases were developed and shaped in the context of disability benefit legislation. Traumatic neurosis was employed to describe medically unexplained pains and impairments that could not be localised in the body. The diagnosis was determined through various methods and in interaction with the worker in question as well as the claim procedure. In contrast, silicosis was a disease that could be identified in the body. Although it was visible on X-rays, this did not mean, however, that diagnosing a person with the disease was straightforward, let alone determining the corresponding incapacity for work. By analysing the diagnostic techniques used for traumatic neurosis and silicosis, my objective is to provide a deeper understanding of the role of medical expertise in the navigation process in which incapacity for work was brought into being. Although the two labels were based on very different classifications and came with their own characteristics, as we shall see, there were more similarities than a simple distinction between mental and physical illness might suggest. In both cases the legal context shaped the diagnostic processes and clinical picture. I will show that the making up of these labels went hand in hand with the making up of incapacity for work. I thus conclude this chapter by showcasing that medical experts, through their constant navigation between medico-legal and clinical contexts and requirements, mixed up the enactment of diagnostic categories with the enactment of incapacity for work.

1 DOCTORS AS GATEKEEPERS IN SOCIAL ARRANGEMENTS

Much scholarly work has been dedicated to the ways in which doctors gained a position as experts in court as well as in society as a whole.[244] Historians have shown how the relationship between medicine and the state grew tighter in the nineteenth century,

244 Klasien Horstman, *Verzekerd Leven. Artsen en Levensverzekeringsmaatschappijen 1880-1920* (Amsterdam: Babylon-de Geus 1996). Willemijn Ruberg, "Expertise in Gerechtsdossiers. De Praktijk van de Forensische Psychiatrie in Nederland 1811-1930", *De Moderne Tijd* 3.1 (2019) 28-50.

when state intervention increased and doctors became more invested in topics like social medicine and hygiene.[245] The formation of the welfare state is often considered a new chapter in the long history of the cooperation between medicine and the state. In the Netherlands the introduction of the Industrial Injuries Insurance Act in 1901 marked this close relationship.[246] Doctors were now actively involved in the execution of social policy and insurance, and were granted the role of gatekeepers. The introduction of the profession of medical officer in the service of the Rijksverzekeringsbank, which I have described in the previous chapters, is just one aspect of this process. In a broader sense, all general practitioners now had to officially register and were obliged by law to play a role in a range of examination procedures.[247] In higher appeal cases, surgeons, psychiatrists and other medical specialists were requested to apply their medical knowledge in the service of the judgement of a person's legal incapacity for work. They were invited to provide a medical settlement of a legal and social question.

Scholars have identified this answering of social or legal questions in medical terms as a form of medicalisation that became a progressively more prominent mechanism in twentieth-century Western social and political arrangements. This process has been analysed rather critically by scholars, claiming that through medical categorisations of bodies and minds, sickness and health, norms were produced by which individuals were disciplined and governed.[248] They have seen doctors as holders of discursive power through their understandings.[249]

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245 For instance, so-called "hygienists" were linking medicine with social issues played a significant role in shaping public health policies. Eddy Houwaart, *De Hygiënisten, Staat en Volksgezondheid in Nederland 1840-1890* (Groningen: Historische Uitgeverij 1991), Annemarie Mol and Peter van Lieshout, *Ziek Is Het Woord Niet. Medicalisering, Normalisering en de Veranderende taal van Huisartsengeneeskunde en Geestelijke Gezondheidszorg, 1945-1985* (Amsterdam: Amsterdam University Press 2008) 82-137.

246 Klasien Horstman, "Om Het Beheer van de Arbeidsongeschiktheid. Het Politieke Debat over Ongevallenwet en Het Wel en Wee van een Medische Markt", *Tijdschrift voor Sociale Geschiedenis* 25.4 (1999) 383-406.

247 Joost van Genabeek, "Opbouw: de Periode 1901-1920", 68-78.

248 These scholars have often been informed by the work of sociologists and philosophers such as Irving Zola, Ivan Illich and Michel Foucault. See for discussion: Mol and van Lieshout, *Ziek Is Het Woord Niet.* 51-81, Joseph Davis, "Ivan Illich and Irving Kenneth Zola: Disabling Medicalisation", in: Fran Colleyer (ed.) *The Palgrave Handbook of Social Theory in Health, Illness and Medicine* (London: Palgrave Macmillan 2015) 306-323.

249 See for an overview: Bryan Turner, *Medical Power and Social Knowledge* (London: Sage Publications 1995), Robert Nye, "Kennis Over Macht. Medicalisering, de Staat en de Rechten van het Individu", in: Lysbeth Nys, Henk de Smaele, Jo Tollebeek and Kaat Wils (eds.) *De Zieke Natie* (Groningen: Historische Uitgeverij 2002) 22-40. Much research on medicalisation therefore aims to deconstruct the process itself, and in this context the role of doctors in the implementation of social security legislation is analysed rather critically. See for example: Peter Conrad and Joseph W. Schneider, *Deviance and Medicalization. From Badness to Sickness* (Philadelphia: Temple University Press1992), Karel Velle, *De Nieuwe Biechtvaders. De Sociale Geschiedenis van de arts in België* (Leuven 1991), David Armstrong, *Political Anatomy of the*

This critical perspective on medicalisation has been enriched with insights from the scholarship in science and technology studies, which has shown that expertise, especially in medicine, is a negotiation with a public or society that demands certain answers to new problems. As medical historians have shown, doctors were accorded expertise and were granted powerful positions in public matters in response to societal needs. This is why medicalisation and increased government involvement are often considered two sides of the same coin, and can be seen not just as a form of medical hegemony, but as a configuration of supply and demand.[250] Moreover, this can be further refined by the insights of scholars showing that doctors were not always willing to assist the state in matters of health assessment.[251] Often, the implementation of medical systems was met with reluctance from the medical side, indicating that medicalisation was not a comprehensive, top-down programme, nor a collaborative effort solely between the state and the medical profession, but a role that doctors hesitantly agreed to adopt.[252] In a similar vein, the political scientist Deborah Stone has made the argument that while the gatekeeping position of physicians is rooted in the belief that a medical eligibility assessment is an unambiguous process, doctors find themselves entangled in a complex set of tensions, leading to non-medical factors influencing their assessments. Doctors were tasked with providing impartial medical perspectives, yet significant work had to be done to make their input serve social inquiries.[253]

The history of medicalisation, in short, has been recognised as a complex constellation of new social questions that were increasingly answered in medical terms, through which the medical discipline gained prominence and power. There is much debate on the scope of medicalisation, and on the intentions, powers and rationales underlying

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Body: Medical Knowledge in Britain in the Twentieth Century (Cambridge: Cambridge University Press 1983) David Armstrong, "The Invention of Patient-centred Medicine", *Social Theory & Health* 9 (2011) 410-418, George Ikkos and Nick Bouras (ed.) *Mind, State and Society Social History of Psychiatry and Mental Health in Britain 1960–2010* (New York: Cambridge University Press 2021).

250 Paul Starr, *The Social Transformation of American Medicine*: *the Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books 2017), Frank Huisman, "Expertise and Trust in Dutch Individual Health Care", in: Joris vandendriessche, Evert Peeters and Kaat Wils (eds) *Scientists' Expertise as a Performance. Between State and Society 1860-1960* (London: Routledge 2015) 173-190, Ludmilla Jordanova, "The Social Construction of Medical Knowledge", in: Frank Huisman and John Harley Wamer (eds) *Locating Medical History: the Stories and Their Meanings* (Baltimore: Johns Hopkins University Press 2004) 338-363.

251 Robert Nye, *Crime, Madness and Politics in Modern France. The Medical Concept of National Decline* (Princeton: Princeton University Press 1984) 227-264.

252 Abram de Swaan, *The Management of Normality. Critical Essays in Health and Welfare* (London: Routledge 1990), Jens Lachmund, "Between Scrutiny and Treatment: Physical Diagnosis and the Restructuring of 19th Century Medical Practice", *Sociology of Health & Illness* 20.6 (1998) 779-801.

253 Stone, "Physicians as Gatekeepers", 227-254.

the process. What has thus far remained less apparent is how and where medicalisation processes took shape in the situated practices in which doctors were granted expertise. In this chapter I will zoom in on the way medical experts gave substance to their assignment to settle a legal issue with medical knowledge, and made up incapacity for work, which will bring the intricacies of medicalisation to the fore.

My practice-focussed analysis of incapacity will show that while the issue of incapacity for work was brought into the domain of medicine, as a result medical questions about this incapacity were equally brought into the realm of law. As we shall see, the medical knowledge that gave doctors their authority was not only applied, but also changed in the transition between clinical and legal contexts. This is very much in line with the findings of Klasien Horstman in her study of the gatekeeper position of doctors in the context of life insurance between 1880 and 1920. Horstman has shown that while medical experts provided the aura of reliability and trustworthiness that insurance companies needed, the professional practices in medicine that suited a therapeutic context had to adapt to the application of life insurance policies.[254] Horstman has described this process as a form of co-evolution, in which the knowledge and the policy for which it was needed interacted and constituted each other.[255] In this chapter, I take the analysis of the co-evolution of knowledge about medical labels in the context of the Industrial Injuries Insurance Act as a starting point to see how this subsequently brought about a new enactment of the incapacity for work.

To analyse diagnostic procedures, I will moreover creatively use concepts and notions developed by scholars who have theorised present-day labelling processes and apply them to my historical case. Trudy Dehue and Ian Hacking have focussed on the ways in which medical diagnoses are brought into being in a search for an ontological truth about these very labels. In her studies on labels such as ADHD and depression, Trudy Dehue finds that medical researchers provide a set of characteristics to define a disease and then work with these characteristics as if they are the true essence of a disease. By doing so, they induce a process that she identifies as ‘reification’, of making objects out of descriptions.[256] Similarly, Ian Hacking has argued that by clinically describing ‘human kinds’, a feedback process occurs in which people start to interpret themselves in the terms of the description while also altering the characteristics of the label, a process that Hacking calls the making up of human kinds.[257] Dehue and Hacking

254 Klasien Horstman, “Chemical Analysis of Urine for Life Insurance: the Construction of Reliability”, *Science, Technology and Human Values* 22.1 (1997) 57–78.

255 Horstman, *Verzekerd leven*.

256 Dehue, *De Depressie-epidemie*, Trudy Dehue, *Betere Mensen*.

257 Hacking, *Historical Ontology*, 99-114.

adhere to the notion that medical labels and classifications do not have essential properties, there is no ultimate signifier. Instead medical labels are produced and changed in the hands of those who identify and use them. While medical historians usually describe in detail the emergence of new diseases and their medical treatment in history, there are no medical-historical works that I know of that have used Dehue and Hacking's approach. By looking at medical statements and practices through the lenses of labelling and reification, I am able to identify the production of medical knowledge as a reciprocal process — an interaction influenced not only by medico-legal requirements but also by workers who came to be identified as 'patients'.

In the context of the higher appeals, medical experts were tasked by the court with assessing the properties of incapacity for work. They sought to find these properties not only in injured or sick bodies, but also in workers' behaviour. In doing so, they enacted incapacity for work via the "making up" of new diseases such as traumatic neurosis and silicosis.

2 INCAPACITY FOR WORK AS SYMPTOM: TRAUMATIC NEUROSIS

'When one does not know the what, the how or the why of a diagnosis, one can always say it's traumatic neurosis'.[258] With this joke, made at the 1904 international conference for industrial accidents, neurologist E.J. Buning reflected on a widely discussed diagnosis.[259] The doctor, who was also the medical director of the municipal hospital in The Hague, seemed to somewhat mock the disease, which was used as a term to describe pains and impairments that doctors could not locate in the physical body. However, as we shall see, traumatic neurosis was taken very seriously and doctors considered it to be a real disease, Buning included.[260] Instead, it is more likely that this joke was a hint of the pressure put on medical practitioners to come up with an answer to the what, how or why of incapacity for work, even when they were in the dark. It marked the conflict of doctors consulted in capacity cases. To deal with doubt, the making of the labels of traumatic neurosis and incapacity for work went hand in hand.

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258 'Indien men niet weet het wat, het hoe of waarom der diagnose, men noemt het heel eenvoudig dan maar "*traumatische* neurose".' 'Het Internationaal Congres voor Bedrijfsongevallen', *Algemeen Handelsblad* 4 June 1906, 5.

259 For research on the history of traumatic neurosis in other European countries, see e.g. Mike S. Micale & Paul Lerner (eds), *Traumatic Pasts, History, Psychiatry, and Trauma in the Modern Age, 1870-1930* (Cambridge: Cambridge University Press 2009).

260 [no author]"Verenigingsverslag van de Verenig tot beoefening der ongevallengeneeskunde", *Nederlandsch Tijdschrift voor Geneeskunde* 61 (1917) 1691-1702.

Before I go into the details of this co-creation, I will briefly discuss the sources I used. I selected all higher appeal cases in the sample years that dealt with the label 'traumatic neurosis', 22 in total. Looking at this number, it may seem like a niche topic. The label, however, received much attention in medical journals and conferences, and doctors worried about ever-rising numbers of workers presenting symptoms corresponding to traumatic neurosis.[261] D. Brocx, a medical officer in the service of the Rijksverzekeringsbank, had tried to temper these concerns by showing that only 0.1%, 307 cases out of the total of 313,155 accident reports between 1914 and 1917, involved workers who had been diagnosed with traumatic neurosis.[262] The numbers were not that high, but, it was said, traumatic neurosis had been a complete rarity in the Netherlands before the introduction of the Industrial Injuries Insurance Act in 1901.[263] There was much explicit concern about a possible correlation between disability benefit and the emergence of a new disease. This debate in medical journals is an early example of the navigation of the areas of medicine and the legal realm. Doctors employed the medical practice of publishing and providing medical cases in medical journals to discuss how the Industrial Injuries Insurance Act entered their consultation rooms.

Like the medical documents of the Rijksverzekeringsbank, the medical reports of the expert witnesses have also been destroyed. The verdicts of the higher appeal cases offer the only available insight into the acts and ideas of medical experts in the specific court cases. Yet they are still valuable, despite their limitations. In the verdicts, the deliberations of the expert witnesses are described quite elaborately. In most cases, moreover, the Central Council of Appeal accepted the estimation of incapacity for work proposed by the doctor who had been consulted as an expert witness.[264] I also used medical literature in the form of medical dissertations and articles in the *Nederlandsch Tijdschrift voor Geneeskunde* (Dutch Journal for Medicine).[265] My aim is to analyse how

261 The psychiatrist K.H. Bouman even warned of an imminent epidemic, while others saw the disease as a threat to the very basis of social security legislation, as it was highly contagious and would cost society a great deal of money. K.H. Bouman, *Problemen van Ontaarding en Begaafdheid* (Amsterdam: J.H. de Bussy 1916).

262 D. Brocx, "De Frequentie Der Traumatische Neurosen", *Sociale Voorzorg* 3 (1921) 829-852.

263 B.H. Stephan, "Over Nerveuze Stoornissen Na Trauma", *Nederlandsch Tijdschrift voor Geneeskunde* 35 (1891) 625-644, P.K. Pel, "Traumatische-Hysterische Neurose met Abasie-Astasie", *Nederlandsch Tijdschrift voor Geneeskunde* (1893) 496-509.

264 Much to the frustration of medical officers in service of the Rijksverzekeringsbank, G.P. van Trooyen, "Traumatische Neurosen", *Centraal Orgaan van de Werklieden-Verzekering* 5 (1908) 489-503.

265 The Dutch Journal for Medicine (*Nederlandsch Tijdschrift voor Geneeskunde*) was the most important medical journal in the Netherlands at the time. I selected 135 articles dealing with the implementation and enforcement of the Industrial Injuries Insurance Act. Some of the articles discuss casuistry in detail and also touch on the impact of the legislation on the incidence of certain diseases, on recovery and

incapacity for work was "made up" in the practice of the higher appeal cases, and this medical literature directly deals with the Industrial Injuries Insurance Act and reflects on the ways in which doctors acted upon their newly assigned and formalised authority. Since traumatic neurosis was considered to only exist in the context of the Industrial Injuries Insurance Act, the entanglement between the legal and medical context becomes very clear in this medical literature and, as we shall see, this in turn had an impact on the judgements by medical experts in court.

No organic origin

Although Buning's joke suggests that doctors would easily apply the diagnosis of traumatic neurosis every time they were not able to find out what was going on with the worker, the low numbers of patients suggest that this was probably not true. When looking at the higher appeal cases, however, it is interesting to analyse how doctors in fact arrived at the diagnosis of traumatic neurosis.

In case of traumatic neurosis it was often psychiatrists or neurologists who took the stand. Although some names, such as the famous psychiatrists Leendert Bouman and Frederik Salomon Meijers, kept showing up in the legal reports, and almost every expert was either a professor or the head of a psychiatric institution, a variety of doctors were consulted. It is important to keep in mind that these are higher appeal cases, which means the case was preceded by a legal trajectory. In the first appeal before the local labour council, other medical experts had been heard and their statements were part of the medical file. Often, workers had been examined by multiple doctors, and the medical experts who testified before the Central Council of Appeal often referred to medical insights from surgeons or family doctors who had analysed the workers' capacities before. These insights and investigation reports formed a personal medical history, on which the medical insights of the expert witness were largely built.

In every case in which the psychiatrist mentioned traumatic neurosis as a diagnosis, the journey to find out the true properties of the incapacity for work started with a physical examination. In cases in which a worker suffered from lower back pain, for instance, doctors extensively analysed the spinal cord. Often they took X-ray photos.

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rehabilitation. This medical literature also provides clues to the context and position from which doctors had to examine workers. Doctors debated the desirability of being involved in the implementation of the Industrial Injuries Insurance Act and how this affected their relationship with their patients. Journals such as the Dutch Journal for Medicine acted as a platform from which doctors could complain about the practicalities. In addition, the Rijksverzekeringsbank's medical advisers used the magazine to give instructions on how to fill in the declaration form correctly, how to prevent the proliferation of diagnostic categories, and to inform doctors of policy and administrative changes. This provides a valuable insight into the discrepancies and interactions between formal instructions, struggles with technical procedures and their impact on the medical examination.

Sometimes the physician would refer to this as 'clinical' or 'objective' research. In the 1925 case of A.C. Biets, the neurologist Schiphorst, for instance, claimed that he could not find any organic deviations and therefore considered Biets a patient suffering from traumatic neurosis.[266] Similarly, in the 1935 case of M.A. van Gent, the director of the psychiatric hospital in the town of Portugaal, Doctor Teenstra, stated that based on the physical examination he came to the conclusion that he could not find any signs of 'a bigger, specifically located form of injury of the brain or spinal cord.' However, he did assume that 'a general, more complicated form of damage was done to the central nervous system, caused by the accident'. Teenstra stated that the moments in which Van Gent portrayed 'pure psychogenic features' were clouding the pure perspective on the worker's incapacity for work, which is why he concluded that Van Gent was suffering from traumatic neurosis.[267]

In every case of traumatic neurosis, doctors ruled out a physical cause for the incapacity. This was in fact the only shared feature of every person diagnosed with the disease: the trauma was the lack of bodily explanation for the incapacity for work. The medical experts consulted in court could have left it there, simply stating that there was no physical cause for any incapacity for work. In fact, in the lower courts this could very well have been the case, perhaps ending the legal trajectory with no benefit or only a small amount. In one higher appeal case, the case of K. van der Born in 1915, the medical expert Doctor Mac Gillavry stated that it did not matter whether a worker was suffering from any illness whatsoever. Instead, he claimed that the focus should be on whether or not the person was disabled, and because he could not find any 'surgical deviancies', or physical problems, he considered Van der Born fully capable of working.[268] In all the other higher appeal cases, though, the question of the what and how of a person's incapacity for work was found to not yet have been answered satisfactorily. The medical experts continued their quest for the properties of incapacity for work, and searched for more answers.

Simulation

This lack of bodily signifiers of incapacity for work pulled the effective incapacity for work that labourers exhibited, or claimed to experience, into an area of doubt. To be clear, this

266 NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

267 'een grovere, gelocaliseerde aandoening van hersenen of ruggemerg by getroffene niet te vinden zyn, dat hy wel aanneemt, dat by het ongeval een meer algemeene, meer diffuse beschadiging van het centrale zenuwstelsel heeft plaats gevonden; dat by dezen getroffene zonder twijfel ook zuiver psychogene momenten in het spel zyn en het ziektebeeld vertroebelen.' NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

268 NA, 2.09.39 CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

was hardly ever a form of self-doubt on the side of doctors. I have come across just one case in which one medical expert explicitly stated that they did not have the expertise to make a statement on the truth about a worker's incapacity for work. In most cases, the medical experts questioned the statements, the behaviour or the experience of the workers.

As we have seen in the first chapter, a claim to benefit was in itself surrounded with worries about fraud. In cases of medically unexplained symptoms the problem of workers possibly simulating their complaints was even more eminent, since the "tool" of bodily examination had failed to be conclusive.[269] In medical journal articles about traumatic neurosis, doctors addressed this topic but stated that they did not worry so much about it. They pointed out that simulation was rather rare.[270] Doctors generally did not think very highly of the morals or work ethic of labourers. In fact some displayed disdain, and worried about fraudulent behaviour in general.[271] What they did trust, however, was their own discernment. At least in cases of traumatic neurosis, they wrote, fraud could very easily be exposed. The neurologist C.G. Bolten, for instance, wrote in the *Nederlandsch Tijdschrift voor Geneeskunde* that one could easily test the sincerity of the complaints by distracting a person.[272] If in doubt, a doctor could spy on them, and then it would be revealed whether or not they maintained their behaviour. Just as they did with the physical origin of the complaints, doctors ruled out the possibility of outright fraud in higher appeal cases involving traumatic neurosis. This meant that the experts had to find the origins of the incapacity for work somewhere else.

Aggravation and fixation

While doctors ruled out simulation, they had to provide an answer to why then a person was incapable of working while medically speaking there was nothing wrong with them. The Rijksverzekeringsbank often suspected these workers were exaggerating their complaints and therewith wrongfully pursuing more benefit. Psychiatrists in court and in medical literature, however, considered this exaggeration by workers a symptom in its own right and used the term 'aggravation'. In a 1913 article in the *Nederlandsch Tijdschrift voor Geneeskunde*, the psychiatrist P. Bierens de Haan reflected on his appearance in the Council of Appeal in Utrecht as a medical expert in a case in which he diagnosed a

269 Brocx, "De Frequentie Der Traumatische Neurosen", 829-852.

270 This could also be an indication that doctors may be easily misled.

271 L. del Baere, "Voordracht Gehouden voor een Vergadering van het Psychiatrisch-juridisch Gezelschap" *Centraal Orgaan van de Werklieden-verzekering* 5 (1908) 374-386.

272 G.C. Bolten, "Over Traumatische Neurose (Ook in Verband Met de Ongevallenwet)", *Nederlandsch Tijdschrift voor Geneeskunde* 5 (1907) 273-306.

worker with traumatic neurosis.[273] Bierens de Haan wrote how he learned that the worker had always been a nervous person, and noticed he was not very straightforward and did not work fully on his rehabilitation. 'He seems to be scheming,' the psychiatrist wrote.[274] While the Rijksverzekeringsbank had considered the worker a fraud, according to Bierens de Haan this perceived underhandedness was a sign of the disease. He wrote that it was a form of unintentional simulation, of pathological exaggeration. The worker in question was so involved with his own misery that this took up all his energy. The man was truly ill, Bierens de Haan argued: even if his body were perfectly able to perform any form of physical labour, he would lack the willpower and a sense of reality to be able to work.[275] This reasoning, published in the medical literature, resonated in higher appeal cases. Although he did not explicitly refer to medical literature in the higher appeal case of J. van der Meer in 1925, the professor in psychiatry Leendert Bouman stated something similar, namely that the worker was suffering from his own lack of willpower to rehabilitate.[276] Similarly, in the 1945 case of A.E.J. van Beveren, the unnamed medical expert claimed that the worker was complaining so much that he considered it a sign of psychiatric illness.[277]

In these cases, medical experts did not regard aggravation as an act of fraud or indicative of bad character. Nor did they see it as just a variation in the way that people dealt with their changed bodies, with medical examinations or the claim procedure. Instead, it was analysed by doctors as a manifestation of traumatic neurosis. This is where incapacity for work was brought from the legal context of possible fraud to the realm of medicine. Here the medical classification functioned as a vehicle that transferred incapacity for work from one context to another. The fact that these workers did not suffer from any physical injuries or impairments but were still unable to work was in itself considered a symptom of a disease, namely traumatic neurosis.

This negotiation of legal and medical contexts is especially visible in cases in which doctors determined that the worker dealt with either their injured body or the legal procedure in an obsessive and abnormal way. In Dutch medical literature the term 'fixation' (*fixatie*) was introduced in relation to traumatic neurosis in 1907. In the *Nederlandsch Tijdschrift voor Geneeskunde* the psychiatrist C.G. Bolten described fixation in a person with traumatic neurosis as follows:

273 P. Bierens de Haan, "Casuistische Mededeelingen: een Geval van Traumatische Neurose", *Nederlandsch Tijdschrift voor Geneeskunde* 57 (1913) 1013-1134.

274 'Hij heeft iets konkelends', Bierens de Haan, "Casuistische Mededeelingen", 1013-1134.

275 Bierens de Haan, "Casuistische Mededeelingen", 1014.

276 NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

277 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

> *'(...) his thoughts, his conversations, his entire being revolves around his disability and his illness and everything that comes with it, as well as with his chances of being granted benefit; neither the patient himself, nor any other person will be able to contrast these invalid ideas and bring them to the right proportion; on the contrary, every act in the mental or intellectual sphere is controlled by it.'*[278]

In the case of the aforementioned M.A. van Gent, fixation also took up an important place in the analysis of the medical expert. Van Gent, who claimed to be fully incapable of working, had been spied upon by an officer in the service of the Rijksverzekeringsbank and was spotted in the local swimming pool of the town Schiedam. Apparently Van Gent had been a regular there, and was seen actively swimming and even diving from a springboard while trying to perform summersaults. According to the medical officer, this showed that Van Gent was capable of much more than he claimed to be.[279] For the Rijksverzekeringsbank this behaviour seemed odd and pointed in the direction of fraud. According to the psychiatrists consulted as medical experts in this case, however, the worker was in fact suffering from a form of traumatic neurosis, namely benefits-neurosis (*renteneurose*). According to the psychiatrist Leendert Bouman, Van Gent was fully and pathologically fixated on receiving benefit. The psychiatrist Teenstra also testified and stated that the worker had a form of *commotion neurosis*, which caused a fixation on benefits. Similarly in the 1935 case of J. Smeets, the doctor Kuenen stated that he had a hard time assessing whether Smeets's desire for benefit played a role in his inability to recover from the injuries sustained during the accident. But, he added, in general this wish to receive compensation was by no means beneficial for the rehabilitation of workers with traumatic neurosis.[280]

In the professional literature, psychiatrists worried about this process of fixation, because it was thought that once a person came into this state of mind, it would be very difficult for them to recover from it. In fact, this whole process of legal examination was in itself considered detrimental to the recovery of the worker and could even cause more incapacity for work. The neurologist A.P. Timmer claimed that without benefit, traumatic neurosis would disappear because it would no longer be rewarding to cling to one's own incapacities.[281] Likewise, in his 1940 dissertation, physician L. Hardenberg wrote that

278 Bolten, "Over Traumatische Neurose", 273-306.

279 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

280 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

281 A.P. Timmer, "De Traumatische Neurose in Verband met de Voorwaardelijke Reflexleer van Pawlow', *Nederlandsch Tijdschrift voor Geneeskunde* 76.13 (1931) 1478-1489.

traumatic neurosis was, in fact, a form of social trauma due to the legal procedure of the Industrial Injuries Insurance Act. He stated that when a doctor wrongfully assumed a worker was incapable of working, this worker would become fixated on receiving benefit, and as a consequence, would become *truly* incapable of working since the fixation took away any motivation to invest in rehabilitation.[282] The attribution of a traumatic neurosis label to a worker could potentially contribute to the development of the disease, Hardenberg claimed. Consequently, through fixation, the worker would then lose his working capacity. Some doctors even went so far as to propose abolishing the opportunity to lodge an appeal entirely, to prevent workers with traumatic neurosis from further developing the disease.[283] This is an example of reification or a looping effect, since doctors emphasised that when treating a worker as a traumatic neurotic, the worker would subsequently behave in accordance with that diagnosis. According to Hardenberg, the worker would lose his work capacities while manifesting and cultivating his traumatic neurosis. As a consequence treatment would become necessary, and one form of treatment could be the abolition of the right to appeal. The label of traumatic neurosis was made up in relation to incapacity for work and in the context of the appeal procedure.

Here we see that the way in which workers dealt with their bodies or with their right to claim benefit was under scrutiny and was pathologised by medical experts. Subsequently, with the pathologisation of a worker's behaviour, the legal and medical context became entangled. In cases of traumatic neurosis, the Industrial Injuries Insurance Act, or at least the medical examination as well as the possibility of receiving benefit that came with it, did not just ensure compensation for incapacity for work, but also brought incapacity for work into being. Medical experts used traumatic neurosis to settle the question of incapacity for work. They turned the legal situation into something they could advise on. Traumatic neurosis served as an explanation for the inability of a labourer to work, as the legal context demanded a medical justification for this.

Reification and shape-shifting

To be clear, traumatic neurosis was never a well-defined or agreed-upon diagnostic label. In medical literature there was much debate on the cause, the nature and the effects of

282 L. Hardenberg, *Sociale Verzekeringsneurose Na Ongeval* (Amsterdam: H.J. Paris 1940).

283 Th. Van Schelven, "De Tegenwoordige Stand van het Vraagstuk der Traumatische Neurosen. Naar Aanleiding van Ruim 4000 Neurologische Rapporten over Oostenrijk-Hongaarse Soldaten", *Nederlandsch Tijdschrift voor Geneeskunde* 63 (1919) 1703-1718.

the disease.[284] It was brought in connection with a nervous character,[285] or a predisposition for neurosis.[286] Some doctors related traumatic neurosis to injuries of the spinal cord,[287] while others claimed it should be interpreted as an injury of the reflexes.[288] And yet others stated that it should not be distinguished from other forms of neurosis,[289] or they considered traumatic neurosis a form of social trauma.[290] In many articles (mainly those written by psychiatrists and neurologists) a clear set of characteristics was sought. Often these doctors analysed the cases in which they diagnosed a person with traumatic neurosis and compared them to find similarities that pointed towards a definite nature of the label. A 1907 article by the psychiatrist C.G. Bolten is interesting in this respect, because he used 25 cases of traumatic neurosis to establish a method to come to a diagnosis. He compared the workers he diagnosed with traumatic neurosis and then used the similarities to define some definite properties of the label. This is a rather clear case of reification: we see how the grouping of people in itself created the label they were being described with.[291] Traumatic neurosis was diagnosed in so many different ways that the label could be adjusted or changed according to the impression of the doctor or the requirements of the legal context.

Publishing and engaging in medical debates was part of the clinical profession of medical experts. It is therefore not surprising that the issues and doubt raised in medical

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284 To the great frustration of legal officers, such as L. del Baere, "Voordracht Voor een Vergadering van het Psychiatrisch-Juridisch Gezelschap", *Centraal Orgaan van de werklieden-verzekering* 5 (1908) 374-386. Later, a medical officer at the Rijksverzekeringsbank, L. Smit, wrote that there were completely conflicting opinions in the medical literature about the nature of traumatic neurosis. As a result, he noted that some assessments led to full benefits for those deemed to be 100% incapable for work, while others received no benefits at all. L. Smit, "De Geneeskundige Als Getuige-Deskundige in Ongevallenzaken", *Geneeskundig Tijdschrift der Rijksverzekeringsbank* 15 (1930) 328-335.

285 Bierens de Haan, "Casuistische Mededeelingen", 1013-1134, J.M. Kijzer, "Verzekeringsgeneeskunde. Het Voorkomen en Behandelen van de Traumatische Neurose", *Nederlandsch Tijdschrift voor Geneeskunde* 83.12 (1939) 197-203.

286 Bolten, "Over Traumatische Neurose", 273-306, H.K.G. Bartstra, "Klinische Lessen. 'Traumatische Neurose' of Organisch-Cerebrale 'Psychopathisering'", *Nederlandsch Tijdschrift voor Geneeskunde* 105 (1961) 913-916.

287 Based on the work of German psychiatrists Herman Oppenheim and Bern Holdorff, "The Fight for Traumatic Neurosis, 1889-1916: Hermann Oppenheim and His Opponents in Berlin", *History of Psychiatry* 88.4 (2011) 465-476.

288 Timmer, "De Traumatische Neurose in Verband met de Voorwaardelijke Reflexleer van Pawlow", 1478-1489.

289 E. W. de Flines, "Een Geval van Traumatische Neurose", *Nederlandsch Tijdschrift voor Geneeskunde* 57 (1913) 1133-1134.

290 Schelven, "De Tegenwoordige Stand van het Vraagstuk der Traumatische Neurosen", 1703-1718, L. Hardenberg, *Sociale Verzekeringsneurose na ongeval*.

291 Bolten, "Over Traumatische Neurose", 273-306.

literature found their way into court. In higher appeal cases, traumatic neurosis could be something different depending on the case or expert. This is already clear in the way that traumatic neurosis was referred to. It was brought into connection with other types of neurosis, such as *hysteria*[292], *neurasthenia*[293] and *psychostaenia*.[294] One doctor called it a form of *nomopathia*,[295] another said it was *commotioneurosis*,[296] and yet another described traumatic neurosis as a form of *neuralgic pain*.[297] Moreover, a variety of approaches were employed to diagnose or rule out the possibility of traumatic neurosis. Due to the requirements of the Industrial Injuries Insurance Act, which mandated a causal link between an accident and work incapacity for a worker to qualify for benefits, it was particularly crucial to determine whether a person had a pre-existing disposition to neurosis or if it resulted from an incident in the workplace.

In the 1915 case of J. Verbeek, for instance, the psychiatrist Frederik Salomon Meijers claimed that the worker was 'a patient by nature', by which he meant that Verbeek had already been suffering from neuroses in the past. The fact that Verbeek had become incapable of working after an accident therefore pointed to traumatic neurosis, according to Meijers.[298] By contrast, in the 1935 case of B.J. Bos, the psychiatrist Leendert Bouman focussed strongly on bodily signs of neurosis and after analysing different reflexes concluded that this was a case not of traumatic neurosis but of a spinal injury.[299] In the 1955 case of N.N. van Vliet, the psychiatrist Michael claimed that the worker was not suffering from traumatic neurosis but from neurosis in general. He argued that she was not able to combine a working life with running a household while also being the main caregiver for her husband, a heart patient. This caused her to become incapable of working, but this was not related to an accident and could therefore not be classified as traumatic neurosis.[300] Here we see how the diagnosis was an interaction between the worker, the medical expert and the medical dossier, but also incorporated expectations related to gender, previous abilities and age. These cases moreover show that the interaction with

292 NA, 2.09.39, CRvB, Inv. No. 129 Uitspraaknummers 487-980, 1905, januari 3-1905, december 22, NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

293 NA, 2.09.39 CRvB, Inv. No. 129 Uitspraaknummers 487-980, 1905, januari 3-1905, december 22, NA, 2.09.39 CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

294 NA, 2.09.39 CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

295 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

296 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

297 NA, 2.09.39 CRvB, Inv. No. 129 Uitspraaknummers 487-980, 1905, januari 3-1905, december 22.

298 'van huis uit patient', NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

299 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

300 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

the Industrial Injuries Insurance Act itself also played a prominent role in diagnostics. The variety in deliberations to arrive at a diagnosis impacted the outcome of the higher appeal cases. Regarding the causality requirement of the Act for recognising traumatic neurosis as a valid reason for receiving benefits, the different perspectives on the nature as well as the cause and effects of traumatic neurosis resulted in different analyses of incapacity for work. In the 1905 case of R.B. Willems, the medical experts Salomonson, Coopmans and Bouman, for instance, claimed that the worker had always been suffering from neurosis and they therefore did not consider there was any causality between the accident and the incapacity for work. And yet in the same year, in the case of Cornelis Leijden, the psychiatrist Gerbrandus Jelgersma considered the worker's traumatic neurosis the result of a spinal cord injury and therefore did see a causal connection between the accident and the incapacity for work.[301] These types of differences can be seen throughout the entire period the Industrial Injuries Insurance Act was in force. In 1965 in the case of C.G. Jacobs, an unnamed medical expert considered him 100% incapable of working because the worker's mental state was damaged by the accident, while in the same year in the case of W. van Veldhoven, the consulted expert related the traumatic neurosis to the worker's inability to adjust to his work, not to the accident, and as a consequence the worker was left without benefits.[302]

As Willemijn Ruberg has shown in her research on psychiatrists' use of the label 'hysteria' in criminal cases, with the shift from a medical to a legal context, classifications are changed and shaped throughout different stages of the procedure.[303] What we see here is that traumatic neurosis was used to make medical sense of the physically unexplained incapacity for work. The need for an explanation started in court, but then, by considering incapacity for work a symptom of a mental illness, it was drawn into the realm of medicine. In this realm, contesting insights and processes of reification led to traumatic neurosis as a suitable explanation for incapacity for work, since it could encompass all kinds of perceived abnormal or undesired behaviour. However, in the transfer back to the courtroom, traumatic neurosis as a diagnostic label with its diversity of interpretations also led to variation in the expert statements about incapacity for work. For while one worker could be considered fully incapable of working due to traumatic neurosis sustained during the accident, another was considered fully able to work since the traumatic neurosis was related to their character and not the accident. For medical experts in these higher appeal cases, the incapacity for work in practice

301 NA, 2.09.39 CRvB, Inv. No. 129 Uitspraaknummers 487-980, 1905, januari 3-1905, december 22.

302 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

303 Willemijn Ruberg, "Hysteria as Shape-Shifting Forensic Psychiatric Diagnosis in the Netherlands ca. 1885-1960", *Gender & History* 35.2 (2023) 565-581.

was both a symptom and the result of traumatic neurosis. Depending on the medical perspective of the consulted doctor, this then led or did not lead to legal recognition of the incapacity for work.

Reduction in benefit as therapy

In cases of traumatic neurosis, incapacity for work shifted between legal and medical contexts, and the production of a new medical label functioned as a vehicle. This transition is especially evident in cases in which medical experts proposed to reduce or discontinue the payment of benefit as a form of treatment. We have already seen that fixation was considered a problem, and some doctors in the medical literature considered the examination procedures under the Industrial Injuries Insurance Act and the availability of disability benefit a cause of traumatic neurosis. In order to counter a process of fixation and enhance the likelihood of recovery and restoration of the worker's full work capacity, doctors in higher appeal cases suggested reducing the percentage of incapacity and the corresponding benefit amount. For although these workers were genuinely ill and currently unable to work, psychiatrists argued that a cut in the amount paid would be beneficial for the worker as it would encourage their path to recovery. In court the medical expert and the worker were not supposed to have a therapeutic relationship. The medical expert was supposed to provide an unbiased perspective on the functionality of the worker under scrutiny, while the worker was a 'claimant'. However, by medically analysing a worker's behaviour and reaction to the procedure, and then advising on the worker's desirable future, the medical expert turned the worker into a patient — a person in need not just of benefits, but also of treatment.

The argument for reducing benefits as a form of treatment can be observed in the 1905 case of Antoon van Buuren. The psychiatrist Frederik Salomon Meijers considered that although the subjective complaints of the worker caused incapacity for work, a reduction in benefit would encourage Van Buuren to start working again.[304] The neurologist Coenen stated in the 1915 case of R. van Nieuwkerk:

> *'(...) [T]here are no physical deviancies noticeable, but it is a case of traumatic neurosis. Through work he will be able to manage himself more easily. He is ill and still needs some benefit (...) but an incapacity for work of 25%is rather high'.*[305]

304 NA, 2.09.39 CRvB, Inv. No. 129 Uitspraaknummers 487-980, 1905, januari 3-1905, december 22.

305 NA, 2.09.39 CRvB, Inv. No. 129 Uitspraaknummers 487-980, 1905, januari 3-1905, december 22.

In that same year, the neurologist Schipshorst stated in the case of A.C. Speetjens that '(...) withholding benefit is a good means to bring back a patient's working capacity'.[306] Similarly in 1925, the psychiatrist Leendert Bouman claimed in the case of J. van der Meer that a lowering of benefit could function 'as an incentive for the worker to put more effort [into rehabilitation]'.[307] And in the 1945 case of A.E.J. van Beveren, the medical experts considered that by granting the worker benefit, the psychological effect could be that Van Beveren would become permanently disabled.[308] These are cases in which the consulted medical experts considered the worker truly incapable of work; however, they adhered to the idea, widespread in the medical literature, that the benefit payments did not help the rehabilitation of workers who suffered from traumatic neurosis.

These doctors noticed that the worker under investigation was not able to work, and they considered the pains and impairments sincere and symptoms of a disease. The worker's incapacity for work was established as both a medical and legal given. However, what we see here is that doctors then brought the legal context back to the medical realm and proposed to use the reduction of benefit as a form of therapy. After all, as Bolten claimed, the state never intended to impede the recovery of 'weaklings'.[309]

It is important to note that this focus on productivity in higher appeal cases linked up neatly with the idea of incapacity for work as something to be overcome in time, which, in the previous chapter, I have shown to be an enactment by medical officers. While psychiatrists aimed at curing a disease and the Rijksverzekeringsbank stressed the need to regain productivity, in these cases different enactments of incapacity for work could coexist, resulting in a strong case for the reduction or abolition of benefits for workers diagnosed with traumatic neurosis. The loss of benefits without the option to lodge another appeal would compel the worker to cease pursuing their benefit claim and force them to resume their work, and in turn would restore their capacity for work. Here we see how the rationales of the Rijksverzekeringsbank and medical experts could coincide, but could still lead to different enactments of incapacity for work. For while the Rijksverzekeringsbank analysed the worker as a citizen, calling upon their moral responsibilities to overcome incapacity for work, in the eyes of the medical expert the worker was a patient in need of treatment, enacting incapacity for work as illness.

306 '(...) onthouden der rente een goed middel is om de patiënten weerom tot arbeidsgeschiktheid te brengen.' NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

307 NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

308 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

309 Bolten, "Over Traumatische Neurose", 273-306.

Incapacity for work as a sign of illness and benefit as a pathogen

In the cases of traumatic neurosis, incapacity for work was enacted by medical experts as a sign of mental illness. Whereas these workers were considered physically fine and would technically be able to perform their work, in practice they could not. And since doctors took their pains and impairments very seriously, the worker's behaviour had to be explained in court. Traumatic neurosis was a flexible diagnosis that functioned as a medical answer to a legal question, and thus became a vehicle that helped to shift incapacity for work between contexts.

It is notable that in the higher appeal cases workers did not consider themselves to be suffering from traumatic neurosis. This could, of course, be related to this aura of fraud around psychosomatic diseases. Moreover, as a vast body of research has shown, mental illness, especially hysteria, was long considered a 'female malady', something mainly women, children and weak men would suffer from.[310] Since we are dealing with a population of workers that was predominantly male, it could be possible that these workers found it difficult to think of themselves in terms of psychiatric labels. The fact that psychiatrists often referred to people with neuroses as weaklings (*zwakke broeders*), would probably not add to the desirability of the label for men who were, by contrast, supposed to be strong and rational.[311] Furthermore, as we shall see in the next chapter, this medicalised version of incapacity for work was only one of the different rationales that workers used to explain their own incapacity for work. Very often, though, they emphasised the day-to-day reality in which they were required to function and thus enacted their incapacity for work in other ways. This was not just in cases of traumatic neurosis;

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310 See for medical history of nervous diseases, among others: Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (London: Time Warner Books 1987), Marijke Gijswijt-Hofstra and Roy Porter (ed.) *Cultures of Neurasthenia (*Leiden, Brill 2001*), Sander Gilman, Helen King, Roy Porter, G.S. Rousseau and Elaine Showalter, Hysteria Beyond Freud* (Berkeley: University of California Press 1993), Akhito Suzuki**,** "Lunacy and Labouring Men: Narratives of Male Vulnerability in Mid-Victorian London", in: Roberta Bivins and John V. Pickstone (eds.), *Medicine, Madness and Social History: Essays in Honour of Roy Porter* (Basingstoke: Palgrave MacMillan 2007) 118-128, Andrew Scull, *Hysteria. The Disturbing History* (Oxford: Oxford University Press 2009).

311 Particularly after the First World War, traumatic neurosis was associated with soldiers who were too weak to cope with the horrors of war. Paul Lerner, "From Traumatic Neurosis to Male Hysteria: the Decline and Fall of Hermann Oppenheim 1889-1919", in: Mark Micale and Paul Lerner (eds.) *Traumatic Pasts. History, Psychiatry and Trauma in the Modern Age 1870-1930* (Cambridge: Cambridge University Press 2001) 140-171, Marc Roudebush, "A Battle of the Nerves: Hysteria and its Treatments in France During World War I', in: Mark Micale and Paul Lerner (ed.) *Traumatic Pasts. History, Psychiatry and Trauma in the Modern Age 1870-1930* (Cambridge: Cambridge University Press 2001) 253-279, Pieter Verstraete and Christine van Everbroeck, *Verminkte Stilte. De Belgische Invalide Soldaten van de Groote Oorlog* (Namen, Presses Universitaires de Namur 2014) 67-102, 133-153.

workers often stayed out of the realm of medicine altogether and employed other sources of knowledge about incapacity for work, such as their own experiences with their bodies.

By contrast, in the higher appeal cases, medical experts made therapeutics their main point of focus. Whereas we have seen in the first chapter that disability benefit legislation was introduced to prevent workers from falling into poverty, in the expert statements that were part of appeal case practice, it was said to be this legislation that caused workers to hang on to what happened to them, and thus destroyed their working lives. Since '(...) one wrong word can turn a happy productive human being into an unfortunate wretch', as the doctor Brocx had put it.[312]

3 INCAPACITY FOR WORK AS AN ILLNESS: THE CASE OF SILICOSIS

In cases of traumatic neurosis, medical experts were in doubt about the what and how of the diagnosis. According to them, this had mainly to do with the fact that there were no physical symptoms which they could locate in the body. Now let me shift attention to a diagnosis that may seem quite the opposite: cases of silicosis, a lung disease that mainly affected labourers working in dusty environments such as mines and quarries. This medical label was also new and became highly important in the context of the application of the Industrial Injuries Insurance Act. Silicosis was added to the list of occupational diseases covered by the Industrial Injuries Insurance Act in 1938. From 1 July 1939 on workers, especially miners, who suffered from what were termed 'dusty lungs' (*stoflongen*) could now claim compensation for incapacity for work, not due to an injury sustained during a workplace accident, but resulting from working in an environment designated as unhealthy or dangerous under the Industrial Injuries Insurance Act.[313] Although this illness could be localised within the body, managing doubt remained an essential aspect of the diagnostic process.

Cases of silicosis provide crucial insight into the enactment of incapacity for work because by bringing occupational illnesses within the realm of the Act, the legal definition of incapacity for work changed. Legally speaking, because the disease was added

312 'één verkeerd woord van een gelukkig arbeidzaam mensch voor altijd een betreurenswaardig stumper kan maken.' Brocx, "De Frequentie Der Traumatische Neurosen", 851.

313 Article 87b sub e of the Industrial Injuries Insurance Act stipulated that silicosis had to be contracted while working in mines, porcelain and glass factories, among others. In 1949, the legislator decided that this list of designated companies was meaningless, as silicosis was an occupational disease and could not be contracted at home. From 1949, workers exposed to silica dust were covered by the Industrial Injuries Insurance Act.

to the list of occupational diseases in 1938, the causality between the work and silicosis was considered a given. The question medical experts needed to answer was whether the diagnosed silicosis resulted in a given percentage of incapacity for work.[314] Unlike traumatic neurosis, silicosis was specifically mentioned in the Act as a disease that caused incapacity for work in labourers working in designated industries. The diagnostic label itself provided legal cover and the Industrial Injuries Insurance Act intertwined the medical and legal contexts. The medical experts consulted in these cases had to establish the existence and severity of silicosis and then come up with an estimation of the extent to which working capacity was affected by it. These doctors did not have to connect the silicosis to incapacity for work in a causal relationship, as the consulted psychiatrists in cases of traumatic neurosis had to do, but instead focussed on the severity of both the silicosis and the incapacity for work.

Additionally, cases of silicosis make an interesting case study because silicosis's true nature seemed to be found in the body. As medical research at the end of the nineteenth century had shown, inhalation of small pieces of siliceous rock resulted in the inflammation and scarring of the lungs, which then resulted in shortness of breath, coughing and fever.[315] The very physical aspect of silicosis made the classification and diagnostic procedure different from cases of traumatic neurosis, at least on the surface, as I will show. Due to the similarity in X-ray images between silicosis and tuberculosis, with the latter not recognised as an occupational disease under the Industrial Injuries Insurance Act, certainty could only be obtained through post-mortem examination. Therefore, although silicosis was considered a very physical disease, medical experts had to come up with other indicators to manage doubt and make their judgement suitable for the context of the higher appeal. Analysing cases of silicosis alongside cases of traumatic neurosis therefore gives us a diverse yet nuanced look at the ways in which medical experts enacted incapacity for work in different cases.

Contrary to cases of traumatic neurosis, the number of higher appeal cases that concerned incapacity for work related to silicosis was high. For the sample year 1955,

314 Industrial Injuries Insurance Act article 87b sub e.

315 Eric van Royen, "De Nederlandse Mijnondernemingen en het Silicosevraagstuk in de Jaren Dertig", in: E.S.A. Bloemen (ed.) *Jaarboek voor de Geschiedenis van Bedrijf en Techniek* (1987) 210-227. For international literature on silicosis as an occupational disease, see i.a Paul-Andre Rosental (ed.) *Silicosis: A world History* (Baltimore: Johns Hopkins University Press 2017), Joseph Meling, "Beyond the Shadow of a Doubt? Experts, Lay Knowledge, and the Role of Radiography in the Diagnosis of Silicosis in Britain, c. 1919-1945", *Bulletin for the History of Medicine* 84.3(2010) 424-466, Mark Bufton and Joseph Melling, "Coming Up for Air: Experts, Employers, and Workers in Campaigns to Compensate Silicosis Sufferers in Britain 1918-1939", *Social History of Medicine* 18.1 (2005) 63-86, Arthur McIvor, "Miners, Silica and Disability: the Bi-National Interplay Between South Africa and the United Kingdom, c1900-1930s", *American Journal of Industrial Medicine* 58.1 (2015) 23-30.

that is. In that sample year, out of a total of 243 cases, 111 cases (45.68%) involved miners who claimed eligibility for disability benefits due to suffering from silicosis. In the sample years 1905, 1915, 1925 and 1935 silicosis was not yet considered an occupational disease, and therefore did not fall within the scope of the Industrial Injuries Insurance Act. In 1945 and 1965 there were 12 and 10 cases respectively that dealt with silicosis.
This difference could be due to the fact that silicosis was a disease that took some time to develop and to be recognised as such. In fact, as the higher appeal cases show, often the miners in question had worked for several years underground and were exposed to a dusty environment. Then, when they started coughing or becoming short of breath they would work above ground. Only when a miner was no longer capable of working did silicosis become a matter of concern and was it investigated as such. This could be an explanation why it took some time for workers to find their way to the Industrial Injuries Insurance Act and corresponding appeal procedures, which then, combined with the effects of the German occupation, resulted in a low number of higher appeal cases in the year 1945.

The fact that there were not that many cases concerning silicosis in 1965 might be related to the fact that the population of miners fell from the 1960s on. The future of the mining industry in the Netherlands became uncertain due to competition from cheaper energy options, such as gas from the Groningen gas fields discovered in 1959. Moreover, as the mine historian Serge Langeweg has shown, there was a general shortage in the labour market and Dutch miners preferred working in industries that required less exhausting and dangerous work, especially since politicians started deliberating possibly closing the mines altogether. The mining workforce in the 1960s mainly consisted of workers from Spain and Morocco, working on short-term contracts. In cases of occupational illness, however, the Industrial Injuries Insurance Act required that a worker had been in the service of the company for over three months, and the claim to benefit had to be made within one year after resignation. As explained above, it could take years before the silicosis was established as such. At this point, it becomes apparent what thus far has remained invisible in the claim assessments, namely that the majority of workers in these higher appeal cases held Dutch nationality and were employed under longer-term contracts in the Netherlands. It could very well be the case that the miners who developed silicosis in the mines between 1955 and 1965 were just not eligible for compensation under Dutch law.[316] The following analysis of incapacity for work in cases of silicosis will therefore mainly be based on cases that came before the courts in 1955. In addition, I will discuss medical articles in which doctors reflected on the application

316 Serge Langeweg, *Mijnbouw en Arbeidsmarkt in Nederlands-Limburg: Herkomst, Werving, Mobiliteit en Binding van Mijnwerkers tussen 1900 en 1965* (Hilversum: Verloren 2011) 231-254.

of the Industrial Injuries Insurance Act in cases of silicosis as they can be considered medical practices as well and, as with the cases of traumatic neurosis, found their way into the courtroom.

Like the other chapters of this dissertation, the focus is on the multiplicity of ways in which incapacity for work was made up in practice. These cases of silicosis do not function as a sample representative of the other higher appeal cases. Instead, in what follows I will analyse the differences as well as the similarities between cases that deal with the two different medical labels and show that these very labels affected the outcome of what incapacity for work could be.

'One should not consider a lung, but a patient instead'

Above, I described the legal status of silicosis under the amended Industrial Injuries Insurance Act 1921. In higher appeal cases, doctors provided their judgement about the severity of silicosis and made a calculation of the corresponding percentage of incapacity for work. Although silicosis was a physical condition which was located in the body, that did not mean that it was easy to arrive at a diagnosis, let alone to decide on the severity of the resulting incapacity for work.

The physician Jan Frederik Hampe wrote in his 1942 dissertation on dusty lungs (*stoflongen*) that the clinical understanding of silicosis was, to say the least, ambiguous. Silicosis was typically described in what he called a *histological* manner: the focus was on the scarred tissue in the lungs, the nodules on the lymph. The X-ray picture was important in this form of diagnostics, since it showed the 'typical shadows' on the lungs that signalled the presence of silicotic nodules. It would therefore seem rather easy to decide whether a person was suffering from silicosis. Hampe, however, stated that this was actually just an anatomic interpretation of an X-ray, and not a diagnosis in itself. The shadows on the X-rays were just an impression of the existence of nodules. Only post-mortem autopsy would provide complete certainty.

More importantly, according to Hampe, the extent to which wellbeing was affected did not go hand in hand with the number of nodules found on the lungs. X-rays conducted during routine examinations revealed nodules on lungs of workers who, until then, had shown no signs of any ailments. The physician stated that a clinical classification demanded a rather different approach. 'One should not consider a lung, but a patient instead, whose general wellbeing is affected by the physical change in the lung induced through the inhalation of dust', he wrote.[317] Some workers were hardly affected

317 'Men denkt dan toch niet in de eerste plaats aan een long, maar aan een patiënt, waar de longenveranderingen ten gevolge van het ingeademende stof het algemeen welzijn hebben beïnvloed (...)' Jan Frederik Hampe, *Stof en Stoflongen. In het Bijzonder over Silicose en Silicatose* (Assen: Van Gorcum 1942) 157.

by numerous silicotic spots, while others could barely function with only a few nodules.[318] According to Hampe, this complicated the claim examination. 'How can one, to a probable degree, relate the (clinical, mental) symptoms to the specific changes in the lungs?'.[319] For the Industrial Injuries Insurance Act, the severity of the silicosis did not matter, said Hampe: 'By law, silicosis only exists when incapacity for work has occurred.'[320]

Hampe's observation is especially interesting because it refers to the complex relationship between medical labels and incapacity for work. The (amended) Industrial Injuries Insurance Act was there to compensate for incapacity for work in cases of occupational diseases, but to know whether a case was eligible, first silicosis had to be established. But then silicosis could only be diagnosed on the basis of the severity of the incapacity for work. Here we see how the Act itself required physicians to analyse incapacity for work as a symptom yet also as the result of silicosis. The process of establishing incapacity for work in these cases was not a process of measuring and analysing a set of symptoms, a linear process of ticking a list of boxes and then calculating the effect it had on a worker's ability to work. Instead it was a circular investigation in which symptoms of the diseases and signs of incapacity for work referred back to each other.

The Industrial Injuries Insurance Act simply demanded too much of doctors, claimed A.C. Appelman in a 1956 article in the *Nederlandsch Tijdschrift voor Geneeskunde*. The doctor in the service of the district of Limburg (in which the Dutch mines were located) wrote that, in cases of silicosis, the Act desired a clear demarcation of the medical label. This demanded more certainty about the disease than doctors could provide.

First of all, he wrote, the Industrial Injuries Insurance Act demanded that doctors distinguished silicosis from tuberculosis, which was very difficult. Whereas silicosis was considered an occupational disease by law, tuberculosis was instead a public health disease to which the Act was not applicable. The problem was that on X-rays both diseases showed the same image. Moreover, medical research had shown that silicosis could make a worker more susceptible to contracting tuberculosis, and vice versa, tuberculosis could make a worker more vulnerable to developing silicosis. Thus, in practice, these diseases were often found in combination. It was very difficult to know what came first, and whether it was silicosis or tuberculosis that caused difficulties in performing the work.

A second problem that Appelman identified was that the variety in diagnostic techniques made it impossible to know for sure what impact silicosis could have on

318 Ibidem.

319 'Wanneer zal men de gevonden verschijnselen (clinisch, psychisch) met voldoende mate van waarschijnlijkheid kunnen toeschrijven aan de specifieke longveranderingen?' Ibidem.

320 'Silicose bestaat voor de wet pas wanneer arbeidsongeschiktheid tot werken is opgetreden.' Ibidem, 173.

working capacity. There was no consensus about the physical symptoms of silicosis, or about the interpretation of X-rays. For lack of better options, he claimed, the pulmonary function test was used. The lung capacity was measured with a spirometer, which measured the volume of air that a worker could exhale. However, Appelman complained, every doctor evaluated the outcome differently. In his discussion of other techniques, a scepticism regarding workers' willingness to cooperate can be observed, similar to the sentiments expressed by medical officers. Techniques to analyse the functioning of the lungs were simply too inaccurate, for they demanded collaboration with the worker under investigation and, he wrote, '(...) it goes without saying that this was often insufficient'. And the investigation of elderly or overweight workers, or workers who suffered from cardiovascular diseases was even more difficult.[321] Here Appelman not only touched upon the difficulty of finding reliable technical measurements, but also revealed his distrust of workers' willingness to cooperate.

Added to the confusion, Appelman claimed, was the fact that working capacity had to be related to the capacities prior to the disease. A doctor therefore had to be very well informed about the working conditions, and even then, there was still the question of what should count as normal working capacity in a given workplace. For Appelman there was simply too much uncertainty to make expert claims about incapacity for work. As a consequence of this uncertainty, Appelman complained, the number of benefit claims based on silicosis would rise. The addition of silicosis to the list of occupational diseases covered by the Act backfired, he stated, because it only served to worry workers. 'Work-aversive persons report premature respiratory complaints', he added. The opportunity to receive benefit did not help the mental wellbeing of the worker, and, according to Appelman, it was far too profitable to appeal the decision of the Rijksverzekeringsbank: 'One expert after another tries to be even more generous than their predecessor.' Moreover, it would bring about distrust in medicine. According to Appelman the benefit made workers want to have silicosis. Here Appelman echoed the perspective of the chief mine doctor, Augustinus Vossenaar, who had been campaigning against the addition of silicosis to the list of occupational diseases. Vossenaar mainly reasoned in the interest of the mine companies: after all, the personnel costs increased once silicosis was covered by the Industrial Injuries Insurance Act.[322] Like in cases of traumatic neurosis, the mental wellbeing of workers was under scrutiny. In contrast, though, Appelman did not consider it the result of illness. Instead, for Appelman it was workers taking unfair advantage and

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321 '(...) het spreekt vanzelf, dat deze in vele gevallen onvoldoende zal zijn.' A.C. Appelman, "Capita Selecta. De Betekenis van Silicose als Beroepsziekte in Nederland.", *Nederlandsch Tijdschrift voor Geneeskunde* 100.III.34 (1956) 2446-2450.

322 Royen, "De Nederlandse Mijnondernemingen", 210-227.

therefore unduly profiting from the uncertainty around silicosis. He suggested that it would be better to compensate for silicosis in the form of higher pension once miners retired. Silicosis would then not be an occupational disease, but collateral damage of the hard work that mining was, for which workers should be rewarded. It is interesting to note that the medical interpretation of workers' behaviour largely depended on the specialisation of the doctor involved. I have shown that psychiatrists pathologised a desire for benefits and considered it a form of neurosis, but Appelman, like the medical officers of the Rijksverzekeringsbank, analysed it in terms of an aversion to work.

For Appelman, uncertainty needed to be eliminated. Like the psychiatrists in cases of traumatic neurosis, he reflected on his experiences with the ways in which the Industrial Injuries Insurance Act entered his consultation room, in a medical journal that functioned to inform physicians on medical insights and cases. He used his medical-clinical experience and knowledge to come up with a solution to unite the legal and medical realms. Either doctors would have to come up with standard measurements and norms, he claimed, or silicosis should be removed from the list of occupational diseases in the Industrial Injuries Insurance Act altogether. In cases of silicosis, incapacity for work was something that could only be measured with strict and standardised, agreed-upon frames of interpretation, preferably based on knowledge of the workplace. Since this was not the case, incapacity for work could not be measured and should therefore not be established, at least not for eligibility to benefits.

Both Hampe and Appelman emphasised the context dependency of both silicosis and incapacity for work. In fact, their analysis seems very much in line with what Coreen McGuire has shown to be the general indecisiveness of medical techniques. In her work she has traced how the value of 'normal breath' changed over time and in relation to different populations in Britain in the interwar period. McGuire has, for instance, shown how, due to a process of normalisation of disability in mining communities, the 'vital capacity' of miners' lungs was considerably lower than that of other workers. 'Normal breath', she stresses, therefore always depends on the population.[323] McGuire and others have sought to reveal the construction of what she calls 'socially useful numbers' and she has suggested that this process was highly political. McGuire has moreover shown that technical devices like the spirometer and corresponding measurement systems encompass norms about the boundaries between sickness and health. For while technical instruments are assumed to provide mere descriptions of the condition of a patient

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323 Coreen McGuire, 'X-rays Don't Tell Lies: the Medical Research Council and the Measurement of Respiratory Disability 1936-1945", *British Journal for the History of Science* 52.3 (2019) 447-465, Coreen McGuire, *Measuring Difference, Numbering Normal: Setting the Standards for Disability in the Interwar Period* (Manchester: Manchester University Press 2020) 174-201.

or a worker, instead they perpetuate the norms which they are assumed to objectively measure.[324]

The written work of Hampe and Appelman is, in fact, an example of this, for they engaged in a search for truly objective measurements and the quest for the true properties of both silicosis and incapacity for work. The physicians found it problematic that silicosis did not yet have a clear set of properties and that the diagnostic tools and corresponding outcomes did not provide much certainty on the disease or on the incapacity for work. They pointed out that much was left to the interpretation of the doctor. Hampe stressed that the experience of workers was essential to analyse their incapacity for work, while Appelman was concerned that workers would become focussed on benefits while doctors were too generous in their interpretations.

These different perspectives on the diagnostic procedures of silicosis are also evident in the findings of the 1954 Medical Committee on Mineworkers' Lung Diseases, a committee appointed by the Council of the Mines and commissioned to advise the Ministry of Social Affairs on the application of the Industrial Injuries Insurance Act in cases of silicosis. In fact, Appelman served as a member of this committee. The head was Willem Bronkhorst, the first professor in the Netherlands to specialise in lung diseases, who, as we shall see, had an important role as an expert witness in higher appeal cases. Based on their own experience as mine doctors, as lung physicians or as medical advisors of the Rijksverzekeringsbank, and with due consideration of the international medical literature on silicosis, the committee presented advice on how to properly assess the working capacity of workers with silicosis. They concluded that there was simply a lack of knowledge to determine with certaintythe relationship between silicosis and incapacity for work. X-rays were important in the establishment of silicosis. Trained experts would be able to notice nodulation 'at first sight'. 'Obviously, though, this X-ray image does not suffice on its own, because other diseases [such as tuberculosis] come with similar images', they claimed.[325] A thorough anamnesis and a general physical examination were therefore indispensable, the committee reported. Furthermore, they expressed much uncertainty about the ways in which silicosis could disable a worker. Changes in the functioning of the lung were noticeable, but were often not fully demonstrable. They analysed the international medical literature and concluded that there was much speculation about the ways in which incapacity for work could be measured and related to silicosis, but generally scientific proof was lacking. In the end, much came down to the subjective interpretation of the doctor. The committee proposed grading the severity

324 McGuire, *Measuring Difference,* 174-201.

325 Willem Bronkhorst, *Rapport van de Medische Commissie Longaandoeningen Mijnwerkers* (Heerlen: Mijnindustrieraad 1954) 1-27.

of the incapacity for work based on a scale of 1 to 5 (with 1 being able to perform heavy work, and 5 being incapable of performing any work at all), to at least ensure a very rough form of equal application.[326]

The reflections in the medical literature and in this policy advice demonstrate the significant degree of uncertainty that needed to be addressed and resolved to make medical knowledge fit the requirements of the Industrial Injuries Insurance Act. Although silicosis was a physical illness which could be found in the body, there was much uncertainty about how to interpret the examination and evaluate the outcomes of the application of medical techniques, especially in relation to a worker's incapacity for work. In the literature these physicians showed how both silicosis and incapacity for work were highly dependent on the context in which they were analysed. They concluded that doctors were simply not equipped to come to a conclusion, and needed forms of standardisation to make expert claims. The committee's report provided a sort of template, an advice for doctors on how to navigate the border area between the medical and legal realms.

I will now turn to the higher appeal cases to see how medical experts in court dealt with this uncertainty and complexity. How did they manage doubt and come to the substantiation of certain percentages of incapacity for work? And what incapacity for work did they enact? Although this structure might suggest that medical literature was a form of theory and we now turn to practice, I do not consider them to be separate spheres. As I have stated above, medical publications were a form of medical knowledge production, which I consider a practice. It was a practice in which insights and experiences were shared and on which experts in court built their medical realities and made them fit for answering juridical questions. The committee's report was a reflection and an advice on how to merge legal and medical questions concerning silicosis. This committee was, moreover, present in court, namely in the person of Bronkhorst himself. The reflections in the report I consider an example of how medical experts, Bronkhorst specifically, navigated medical and juridical issues and how these became entangled.

Embodied standardisation

In 1955, every worker who was suspected of having silicosis and appeared in court for a higher appeal under the Industrial Injuries Insurance Act, had personally encountered Professor Bronkhorst and/or his protégé, Hero Deenstra, who succeeded him as professor of lung disease at Utrecht University in 1956.[327] The verdicts stated that 'the appeal was filed in expectation of the report by Professor Bronkhorst'. With the consistent

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326 Ibidem.

327 Hendrik Maria Beumer, *Leven en Werken van Willem Bronkhorst (1888-1960)* (Lochem: N.V. Uitgeversmaatschappij de Tijdstroom 1972).

consultation of these pulmonologists the problem of inconsistent modes of examination, raised in Appelman's article and by the Bronkhorst Committee, was already solved. Since every worker was examined by the same doctors, they were analysed in a similar manner and with a relatively similar interpretation of the data. Although the outcome of the examination depended very much on the analysis by the doctor, at least it was the same doctor every time. This could be the reason why the 1-5 scale proposed by the Bronkhorst Committee was not utilised in these higher appeal cases. Since Bronkhorst and Deenstra embodied the standards used to interpret incapacity for work in silicosis cases, an external template might have been considered unnecessary for them.[328] This can be interpreted as a form of standardisation as well as a means to reach a certain level of equality in the application of the Act, which, as we have seen in Chapter 1, was very important in the socio-political practice of the Industrial Injuries Insurance Act. In addition, it seems that in these cases, Bronkhorst established his authority and made the emerging "border area" his own. Incapacity for work in silicosis cases was what Bronkhorst and/or his successor Deenstra said it was.

This was all the more so because in every single case, the Central Council of Appeal accepted the recommendations of these doctors and considered the worker under investigation to be as incapable or capable of working as Deenstra and/or Bronkhorst had estimated. In itself, this was not unique, since the Central Council of Appeal often followed the conclusions of the expert witnesses. However, in other cases several experts were usually consulted, or their conclusions were compared and contrasted with the findings of doctors who had previously examined or treated the worker under investigation. This then required the court to weigh up the different specialised perspectives, which often resulted in the court simply taking the mean of the proposed percentages. Moreover, although some experts were consulted more often, I have not come across any other set of cases in which the same doctor acted as expert witness on such a regular basis. Since silicosis was only analysed by Bronkhorst and Deenstra, their insights were of great importance to the court.

Although we could say that Bronkhorst and Deenstra sat in the judge's chair, it was not that a medical perspective was being pushed forward as the only version of incapacity for work. Through constant navigation between the medical and legal issues and requirements, their views were shaped and guided by what the legal context demanded of them. In the 1955 case of J.H. Blom it was, for instance, explicitly stated in the verdict

328 As Deborah Stone has claimed: 'Such standards are particularly difficult to establish in the field of medical care, both because physicians often disagree on the diagnosis for a particular case, and because physicians as a group have been very reluctant to establish and use protocols to standardize their behaviour.' Stone, "Physicians as Gatekeepers", 249.

that in cases of silicosis, it was the level of incapacity for work resulting from silicosis that should be the point of thorough investigation. The court added that it no longer used the miner's work as the standard against which a worker's capacity was measured. Instead, the incapacity for work was to be valued on the basis of what could be expected from a worker in terms of their age, their work history and any other disabilities not resulting from silicosis.[329] Jurisprudence required certain measurements and norms against which the outcome of the applied medical techniques should be assessed. The medical insights of Bronkhorst and Deenstra were guided by these legal frameworks, and they adapted their medical analyses to fit their task of considering the nature and severity of a person's incapacity for work. Now let us take a look at how exactly they navigated these issues and requirements.

No silicosis without incapacity for work, no incapacity for work without silicosis

In every verdict, the analysis by Bronkhorst and Deenstra started with a short description of the labour history of the worker. They noted how many years he had worked underground, what kind of labour he performed, and when he was first transferred to a position above ground. This was for instance the case for the miner C.J. van Loon, 57 years old, who had been working underground for 21 years when he started to experience lung problems. The work that he had been doing was heavy and was performed in the dusty environment of the mine. Bronkhorst and Deenstra had examined the miner and found minor silicosis on the X-ray. They added that Van Loon had increasingly suffered from tiredness and shortness of breath. The functioning of his lungs was disturbed and his working capacity had decreased. Bronkhorst and Deenstra claimed that this decreased incapacity for work was partially due to limited lung function, while also related to Van Loon's poor physical condition in general. 'We propose a 50% incapacity for work for the labour that a 57-year-old man can perform', the pulmonologists stated.[330] Here we see that Bronkhorst and Deenstra built their impression of silicosis on a combination of the X-ray image, the working environment and the long period spent working underground as well as the worker's complaints about shortness of breath. Moreover, they measured the lung capacity of the worker through the use of the spirometer and a stress test. In the evaluation of the outcome, they took into account the age of the worker, since this impacted his general condition. In these descriptions, silicosis was analysed together with the worker's incapacity for work.

329 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

330 Wij stellen voor een invaliditeitspercentage van 50% aan te nemen voor werk, dat een 57-jarige man kan verrichten'. Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

Similarly in the case of B.D. van Oost, the report by Bronkhorst and Deenstra mentioned that the worker had been performing mining work for 28 years. When he started to experience 'silicotic complaints', he was transferred to an administrative job above the ground. For the past few years Van Oost had suffered from shortness of breath after exercise. 'Through examination silicosis has been established, at nodulation stage with a silico-tuberculosis inflammation'.[331] The functioning of the lung was clearly disturbed, Bronkhorst and Deenstra wrote, and the worker would not be able to perform any form of heavy work. There was radiologically visible silicosis with a small dimension of silico-tuberculosis, they claimed. Bronkhorst and Deenstra estimated the incapacity for work to be 30%. Here again, incapacity for work was a combination of labour history, the analysis of X-rays and complaints that were labelled as 'silicotic'. None of these forms of investigation would lead to a clear notion of silicosis by itself, or of incapacity for work. In fact, they were constituted in interaction with each other. This is very much in line with what Willemijn Ruberg has found for the concept of hysteria in criminal courts and Geertje Mak for sex in cases of hermaphroditism: it had no ultimate signifier.[332] Although there was a "promise" of a definitive source of physical proof of silicosis, which was a lung full of silicatic nodules, this did not apply in the practice of the claim assessment, because such proof could only be found on a dead person. And so various sources of evidence were referred to and interacted with one other, yet none of them could be conclusive in their own right. The fact that a miner had been working underground for many years and suffered from shortness of breath was a reason to transfer the miner to work above ground. The working conditions were adapted and so there was no incapacity for work. Similarly, the regular medical examinations of miners, which were introduced in the 1930s, sometimes revealed that a worker had silicotic nodules on their lungs, but without physical complaints this would not lead to a claim to benefit. The X-ray picture only gained meaning in relation to the working conditions as well as the physical conditions of the worker. If a worker was no longer able to perform their duties, from 1938 on that was the point at which a worker was examined and silicosis was established. In that sense, Hampe was right: for the Industrial Injuries Insurance Act the severity of silicosis was analysed together with the severity of the incapacity for work. Incapacity for work was legally recognised only when silicosis was diagnosed, which in turn required the worker's

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331 'Door onderzoek is vastgesteld dat hij leidt aan silicose in het stadium van de nodulatie, met een silico-tuberculotische haard'. Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

332 Ruberg, "Hysteria as Shape-Shifting Forensic Psychiatric Diagnosis", 1-17, Geertje Mak, "Doubting Sex from Within: A Praxiographic Approach to a Late Nineteenth-Century Case of Hermaphroditism", *Gender & History* 18 (2006) 360–388.

working capacities to be compromised. Silicosis and incapacity for work were mutually dependent, and were made up together.

Incapacity comes with age

The severity of incapacity for work, the percentage that had to be estimated, was highly dependent on the age of the worker in these particular cases. The capacity for work underground had long gone for these workers, since they had been working above ground for quite some time due to their lung complaints. Although the silicosis had been sustained in the mines, the incapacity for work was measured in relation to a general impression of the working capacity of someone in their fifties or sixties, just as the court prescribed. This meant that Deenstra and Bronkhorst had to take into account a somewhat general loss of working capacity that was assumed to come with age. This provides us with some insights on what risks and physical deterioration were considered to be normal for mineworkers: it was a form of deterioration that came with the job and a risk borne by the miner, not by society. Workers were therefore hardly ever considered fully incapable of working. Often they were roughly considered 50% incapacitated, with the addition that given their age, the silicosis did not cause much disability. In the case of J.H. Blom, Deenstra performed the expert analysis without Bronkhorst. The report stated that Blom had been performing heavy miner's work underground since he was 17. At 31 he was granted a dust-free occupation above ground, and since 1952, at the age of 37, he had worked at a sheltered workplace for disabled workers because of his (then established) silicosis. According to Deenstra, Blom had been suffering from tiredness, shortness of breath and coughing and Deenstra had found silicosis as well as silico-tuberculosis. He stated:

> *'The functioning of the lung was only lightly disturbed and the work capacity on the bicycle ergometer was still very good. However, due to the presence of silico-tuberculosis, the analysed worker will now only be able to perform light to moderately heavy work. (...) We estimate the decrease in the work capacity of Mr J.H. Blom, residing in Simpelveld, to be 50%.'*[333]

Here we see how incapacity for work was made up with both medical and legal norms, against which the functioning of a worker was measured. Based on the results of the X-ray

333 "De longfunctie was slechts zeer licht gestoord en de arbeidscapaciteit op de fietsergometer was nog zeer goed. Door de aanwezigheid van de silico-tuberculose zal onderzochte echter nog slechts licht tot matig zwaar werk verrichten. (...) De door de silicose veroorzaakte afname van de validiteit van de Heer J.H. Blom, wonende te Simpelveld, schatten wij op 50%.' Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

and the ergometer alone, Blom could not have been considered incapable of working. These were outcomes that were assessed in relation with his labour history and his age, as prescribed by the Central Council of Appeal. Incapacity for work was measured against the norm group of miners, compared by age.

Navigating medical and legal spaces

Similarly to what I have discussed in cases of traumatic neurosis, the consulted experts, Deenstra and Bronkhorst, had to navigate their medical knowledge and the legal context in which their findings were used. Like in cases of traumatic neurosis, the outcome of the medical deliberations depended on the weighing of different factors. In cases of traumatic neurosis, in which a variety of psychiatrists were consulted, this led to various outcomes, ranging from 0% to 100% incapacity for work following the diagnosis of traumatic neurosis, depending on the medical perspective of the psychiatrist who acted as the expert. The fact that only Deenstra and Bronkhorst were consulted as expert witnesses in silicosis cases resulted in more uniformity in the outcome. They usually considered a worker to have incapacity for work of between 30% and 50%. The doctors often stressed that it was very difficult to come up with what they believed to be an *accurate* percentage. In some cases they explicitly stated that 'it is difficult to accurately determine the invalidity caused by silicosis.'[334] They emphasised that their estimations were rather rough or on the cautious side, because of the complexity of the analysis.[335] However, since their estimations were always accepted by the Central Council of Appeal, they were not just describing incapacity for work, they were "making it up".

4 CONCLUSION: MAKING UP INCAPACITY FOR WORK WHILE MAKING UP DIAGNOSTIC LABELS

In this chapter I have unpacked the labelling processes in medical experts' determination of a worker's capacity to see how they enacted incapacity for work. For the two case studies, traumatic neurosis and silicosis, I have shown that the consulted doctors had to navigate doubt, medical debates, techniques and standards, legal norms and guidelines. They were granted considerable authority and were required to provide unbiased statements based on their medical knowledge to settle a legal issue. To make their medical insights fit for court, they had to constantly navigate medical and legal requirements and

334 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

335 Deenstra also referred to these difficulties in his inaugural speech. H. Deenstra, *Invaliditeit* (Groningen: Wolters 1959) 3-12.

problems, as a result of which the two areas became entangled. In this process, different things happened: incapacity for work was enacted as illness, the Act became a pathogen and the worker was made up as a patient.

The procedures and techniques with which medical experts arrive at a judgement, the *navigation practices* as it were, were different in cases of silicosis and traumatic neurosis. They were tied to the specifics of the medical discipline in which doctors were embedded as well as to the legal requirements and issues. In both cases, however, medical experts "made up" incapacity for work as illness, but also produced new medical diagnoses. In court, the absence of an illness rendered the incapacity for work non-existent, as it could not be attributed to an accident or an occupational disease. Conversely, without a decrease in the working capacities, traumatic neurosis and silicosis could not be diagnosed as such. Reification processes occurred in court as a result of medical experts' constant shifting between the realm of their medical discipline and the realm of the Industrial Injuries Insurance Act. Medicalisation was thus not a matter of doctors just applying medical labels and enforcing medical standards by which to measure working capacity. Medical labels functioned as a vehicle to navigate the issues that had to be settled, and in the process the labels changed shaped.

What this analysis has moreover shown is that the rationales that were applied by medical experts sometimes coincided with the claims of medical officers in the service of the Rijksververzekeringsbank, or, as I will show in the next chapter, with what workers brought forward as the properties of incapacity for work. Without denying hierarchical structures, the making up of incapacity for work was a "team effort", in which interaction was central and resulted in a variety of enactments. Incapacity for work as illness was not the eventual or true reality, it was one of multiple realities.

The focus in this and the previous chapters has been on the medical officers of the Rijksverzekeringsbank and expert witnesses analysing workers. It is interesting to note that with the shifting enactments of incapacity for work, the workers themselves also changed shape. While the Rijksverzekeringsbank focussed strongly on the worker as citizen, expert witnesses analysed workers as patients. Now let us take a look at the way in which the workers in question considered themselves, how they interacted with the statements by medical officers and expert witness, and how they produced alternative realities of incapacity for work.

Chapter 4

Living with incapacity

Disabled workers take the stand

The history of incapacity for work in the context of social security legislation has been written as a history of increased interdependency between different social groups and of the collective starting to take care of individual misfortune. In the history of medicine, incapacity for work and social security legislation have been associated with the process of medicalisation of individual or social questions. And whereas these approaches differ and highlight different enactments of the incapacity for work, they are all rooted in the notion that having disabilities resulting from workplace accidents is in itself a sad state in which to be. Historians of the welfare state and medical historians alike often consider disability a matter of misfortune, and an individual problem that is treated by doctors and financially compensated by society. The persons who were unable to work are, moreover, often considered victims who suffer socially and economically, due to the impairments sustained during a workplace accident. In this narrative, incapacity for work is considered to stem from a disabled body, and is moreover equated with a miserable existence. Disability scholars have however shown that having disabilities does not necessarily mean that life is miserable.[336] They have argued that this connection between disability, incapacity for work and misery turns social security into a form of charity, while the problem of incapacity for work lies not so much in the bodies of disabled workers but in policies and ideas about productivity and functionality in the context of an industrialised or capitalist workplace.[337] When examining the higher appeals of disabled workers, however, it will become clear that they did express feelings of pain, fatigue and misery when analysing their own capacity for work.

The stories and perspectives of disabled persons in the past have often been neglected, simply because hardly any of their accounts have made it into the archives. As a consequence there are numerous studies focussing on policymakers, institutions and doctors, while the practices, the experiences and the agency of disabled persons are often overlooked.[338] The lack of source material is for instance the reason why Houwaart

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336 Gary Albrecht and Patrick DeVlieger, "The Disability Paradox: High Quality of Life Against All Odds", *Social Science & Medicine* 48.8 (1999) 977-988.

337 See for example: Vic Finkelstein, *Attitudes and Disabled People: Issues for Discussion* (New York: World Rehabilitation Fund 1980), Oliver, *The Politics of Disablement*, Michael Oliver and Colin Barnes, *Disabled People and Social Policy: from Exclusion to Inclusion* (London: Longman 1998), Colin Barnes and Geof Mercer, "Disability, Work, and Welfare: Challenging the Social Exclusion of Disabled People", *Work, Employment and Society* 19.3 (2005) 527-545, Rose, *No Right to be Idle*.

338 Paul K. Longmore, "The life of Randolph Bourne and the Need for a History of Disabled People", *Reviews in American History* 13.4 (1985) 581–587. Paul K. Longmore, "Uncovering the Hidden History of Disabled People", *Reviews in American History* 15.3 (1987) 355–64. As Daniel Blackie and Alexia Moncrieff have pointed out, disability history differs from, medical history in that it explicitly seeks 'to counter harmful stereotypes of disabled people as passive and dependent by documenting their historical agency and amplifying their "voices" within the historiography of disability'. Daniel Blackie and Alexia Moncrieff, "State

and De Boer did not consider perspectives of disabled workers in their study on the history of capacity assessments in the Netherlands.[339] In higher appeal cases, however, disabled workers also took the stand. This chapter will therefore present, for the first time, the workers who applied for benefits and appeared before the highest court. They were not silent sufferers, or passive 'affected persons' (*getroffenen*), as the Rijksverzekeringsbank called them. As this chapter deals with the ways in which disabled workers navigated examinations and legal practices and how, in their appeals, incapacity for work was enacted, I will show that disabled workers played a subversive role. They participated actively and transitioned between positions that could be in conformance with rationales applied by the Rijksverzekeringsbank and expert witnesses, or disruptive. They demonstrate how incapacity for work was not just a paper, legal or medical reality, but also existed in their daily lives.

First I will engage in conversation with the field of disability studies and disability history in particular, in which the social model of disability attributes stigma and socio-economic disadvantages not to impairments, but to social attitudes towards deviation and diversity. Disability does not necessarily equal a sorrowful state of being, or misfortune, the disability scholars Michael Oliver and Rosemarie Garland-Thomson claim. Instead, it is this way of speaking about disabled persons, together with the medicalisation of a diversity in bodies, that has led to a deeply rooted medical or individual model of disability which is at the heart of problems like social stigma and discrimination.[340] However, when examining the higher appeals of disabled workers we can see that they did indeed consider themselves incapacitated by tight workplace schedules and high production norms, as well as the discriminating tendencies of the labour market. They, however, also addressed their feelings of pain, fatigue and misery. This chapter pleads for an adjustment in the social model of disability to take these experiences into account. I conclude that a focus on practices enriches the toolbox of disability historians, and helps to see the room for manoeuvre that disabled workers had in the context of appeal cases.

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of the Field: Disability History", *History* 107.377 (2022) 621-811. Elizabeth Bredberg has explored a variety of sources that are useful for the study of disabled persons in the past: Elizabeth Bredberg, "Writing Disability History: Problems, Perspectives and Sources", *Disability & Society* 14.2 (1999) 189–201.

339 They write: 'Finally, the position of the client has remained underexposed. It indirectly emerges from jurisprudence and other sources, but not directly. This is also regrettable because an important aspect of the assessments is thereby missed. However, the position and role of the client in the claim assessments are poorly documented. It was only in the 1980s that patients began to organise themselves and establish organisations that started making demands and seeking publicity.' See also Houwaart and de Boer, *Geschiktheid Gewogen*, 20.

340 See for example: Finkelstein, *Attitudes and Disabled People,* Oliver, *The Politics of Disablement*, Oliver and Barnes, *Disabled People and Social Policy,* Rosemarie Garland-Thomson (ed.), *Freakery. Cultural Spectacles of the Extraordinary Body* (New York: New York University Press 1996).

With this adjusted social model of disability in mind, I will briefly touch upon some difficulties with writing the history of persons who are poorly represented in historical sources. Following the lead of Joan Scott, I will explain that, to break down their *otherness*, I do not analyse the experiences of disabled workers as an alternative history, in opposition to the discussed socio-political and medical histories.[341] Instead, in focussing on the interaction of workers with social policy and assessment practices, I will demonstrate their role in the "making up", or enactment, of incapacity for work.

Then I will analyse workers' statements in the higher appeal cases and distinguish three of these enactments, namely: incapacity for work as bodily functioning about which they claimed expertise; as the incapacity to perform the required tasks in the specific workplace; and lastly, as daily experience. In the process I will highlight that the incapacity for work in the experiences of the persons who claimed benefit was a complex interaction between the workers in question, the Rijksverzekeringsbank, doctors and the Act itself. And in these enactments the topic of misfortune was more complex than a medical-social model split suggests. My analysis shows how bodily experiences of pain and fatigue, in the context of social policy and higher appeal cases, made up incapacity for work as a relational phenomenon that included impaired bodies, social policies, discriminatory attitudes and non-adjusted workplaces.

1 THE SOCIAL MODEL OF DISABILITY AND INCAPACITY FOR WORK AS SOCIAL CONSTRUCT

In the introduction I argued that the social model has been essential to the field of disability studies. Often working from multiple disciplines, disability scholars aim to correct the way disability is analysed as an individual problem and unfortunate state of being, and focus on the exposure of disabling barriers in society. The social model functions as a framework within which this inclusive disability research can be conducted.[342]

The topic of work and welfare has received much attention from scholars in the field. Prominent authors like Alan Roulstone, Colin Barnes and Geof Mercer have written about the social exclusion of disabled persons in this context.[343] They criticise the

341 Joan Scott, "The Evidence of Experience", *Critical Inquiry* 17.4 (1991) 773-797.

342 Michael Oliver, *The Politics of Disablement*., Tom Shakespeare, *Disability Rights and Wrongs* (New York: Routledge 2006).

343 Alan Roulstone, "Disability, Employment and the Social Model", in: Colin Barnes and Geof Mercer (eds.) *Disability Policy and Practice: Applying the Social Model* (Leeds: Disability Press 2004) 18-34. Colin Barnes and Geof Mercer, "Disability, Work, and Welfare: Challenging the Social Exclusion of Disabled People", *Work, Employment and Society* 19.3 (2005) 527-545.

view that disability is a health issue, and instead claim that it is precisely this view that prevents persons with impairments from being considered good citizens in an industrialised or capitalist society. Instead, they claim, we should recognise that there are many disabling barriers in the way paid work and welfare is organised that exclude people with different bodies from the workplace. As Barnes and Mercer have claimed: '[T]he absence of people with impairments from the industrial labour market dictates their wider social exclusion.'[344] Following this line of thought, disability research on the history of incapacity for work should, therefore, critically analyse the social and cultural impact of the historical connection between disability, poverty and misfortune and preferably expose, but at least acknowledge, the exclusionary barriers that stem from this connection.

Disability scholars have shown particular interest in the history of industrialisation. Vic Finkelstein has claimed that disabled persons were systematically removed from economic and social life due to industrialisation, and this, in fact, created the social category of 'disabled'.[345] Scholars like the aforementioned Michael Oliver and Colin Barnes have written about industrialisation as at the heart of the invention of disability. They argue that the consideration of disability as a medical and personal problem, and something which needs to be approached with pity, is inherently capitalist. Since the industrialised labour market demanded things like individual wage labour with strict timekeeping, speedy and standardised production, and separation of the home and the workplace, persons with impairments were deemed unproductive and pushed to the margins of society. In pre-industrialised communities, disabled persons were more integrated in the economy, and despite forms of social stigma, there were more inclusive attitudes towards diversity in working capacity, these scholars claim.[346] Scholars like Finkelstein, Oliver and Barnes have initiated a tradition of disability research that analyses the Industrial Revolution and its ramifications as the most profound, catalysing force in the construction of the notion of disability as an individual problem of the impaired body.

While this 'industrialisation thesis', as David Turner and Daniel Blackie have called it, has become commonplace in the field of disability studies, up until recently it lacked thorough historical substantiation.[347] The work of Sarah F. Rose does, however, provide a social-model analysis of the history of disability and the workplace based on a thorough investigation of historical sources. She shows how, for American history, this industrialisation thesis still holds. In her book *No Right to be Idle. The Invention of Disability, 1840s-1930s*, Rose describes how in America, in the course of the nineteenth century,

344 Ibidem.

345 Finkelstein, *Attitudes and Disabled People*.

346 Oliver, *The Politics of Disablement*, Oliver and Barnes, *Disabled People and Social Policy*.

347 Turner and Blackie, *Disability in the Industrial Revolution,* 4-8.

notions of productivity shifted due to industrialisation from a spectrum varying in terms of gender, age and ability to productivity tied to a specific, interchangeable body. Rose details how disability, as a distinctive category, was an invention, resulting from this shift in thinking about productivity. And this category came with the exclusion of disabled people from the labour market, as well as their degradation to the status of second-class citizens. Rose focusses on the historical categorisation of disability, and how the connection between productivity, poverty and state dependency caused social exclusion. In line with the social model of disability, she concludes that:

> *'(...) the "problem" of disability lay not in their actual impairments or the work they did, but rather in the meanings attributed to those impairments by policy makers and employers, as well as in how those meanings intersected with a rapidly shifting workplace, changing family capacities, policies aimed at preventing dependency, and the complexity of disability itself.'*[348]

By describing the American history of disability and the workplace not in terms of individual misfortune but of social exclusion instead, Rose exposes barriers preventing persons with impaired bodies from participating in the paid labour market, and thus provides the social model with historical grounding. Her work, moreover, shows that socio-economic and cultural circumstances caused people to become unable to work, not their bodies.[349]

Following this line of thought, incapacity for work from a social model perspective incapacity for work is the incapacity of society to incorporate a variety of bodies and work modes in ideas about productivity and the workforce. And, as a consequence, in this history disabled persons are excluded from the labour market, which reinforces this misguided connection between disability, poverty and misfortune.

This focus on social and economic barriers provides important insights into incapacity for work as a cultural subject. It analyses working capacity not as something that is inscribed on the body or defined by fixed properties, but as a social phenomenon instead. It thus differs substantially from socio-political or medical historical analyses of incapacity for work, which were reviewed in the previous chapters of this dissertation.

While acknowledging the analytic value of this shifting perspective on incapacity for work, in this chapter I would like to make some adjustments to the social model of disability. In its focus on the social context that constitutes incapacity for work, the social model runs the risk of perspectivism, of dividing disability into either a social or a biological reality, depending on who is looking at it. As described in the introduction to

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348 Rose, *No Right to be Idle,* 3.

349 Ibidem.

this dissertation, the social model has been criticised for maintaining a binary opposition between nature and culture, and for neglecting the diversity of disabilities, producing an all-encompassing theory in itself.[350] Moreover, by claiming that industrialisation, as a top-down force, produced the category of disability, disabled persons are made into passive victims in this process.[351] As David Turner and Daniel Blackie have shown, disabled people also helped make the Industrial Revolution, at least in the case of British coalmining. 'Rather than passive bystanders or victims of industrialisation, therefore, disabled people were actually active agents of economic change, though this is rarely acknowledged', they claim.[352] Furthermore, in a recent study they have shown how some disabled workers advocated for a socio-cultural understanding of disability long before the social model was invented.[353]

By focussing on the interaction between disabled workers, the Industrial Injuries Insurance Act, medical examination and claim procedures, I will analyse incapacity for work as an enactment that was situated in the specific practices of appeal cases. By doing so, I am still taking into account the particular social barriers that disabled workers encountered, but I am also able to analyse their interaction with these barriers, and make room for how they associated disability with poverty and misfortune. Analysing incapacity for work as enactment, moreover, provides space to not only acknowledge differences between disabled persons and the ways in which they encountered social barriers, but also for the multiplicity of experiences of these individuals. Before I describe and analyse some of these experiences, I will first briefly discuss a few critical reflections on the historical concept of experience in this context.

2 AVOIDING DICHOTOMIES

Writing the history of the experiences of disabled persons is not just a matter of making room for silenced voices. The perspectives and experiences of persons that have long been found uninteresting, irrelevant or non-existent cannot just be brought to light by referring to sources that indicate that disabled persons had their own stories to tell. As Joan Scott has stressed, we need to go beyond these descriptions, otherwise the *otherness* of a marginalised group is kept in place. 'The evidence of experience then becomes

350 Corker and Shakespeare, *Disability/Postmodernity,* 1-17.

351 Turner and Blackie, *Disability in the Industrial Revolution,* 4-8.

352 Ibidem, 7.

353 David Turner and Daniel Blackie, "Disability and Political activism in Industrialising Britain, c. 1830–1850", *Social History* 47.2 (2022) 117-140.

evidence for the fact of difference, rather than a way of exploring how difference is established, how it operates, how and in what ways it constitutes subjects who see and act in the world'.[354] Describing *a different story* of incapacity for work, based on the experience of disabled persons, would then, again, lead to a form of perspectivism.[355] Scott writes:

> *'[W]e know that difference exists but we don't understand it as relationally constituted. For that we need to attend to the historical processes that, through discourse position subjects and produce their experiences. It is not just individuals who have experience, but subjects who are constituted through experience. Experience in this definition then becomes the origin of our explanation, not the authoritative (because seen and felt) evidence that grounds what is known, but rather that which we seek to explain, that about which knowledge is produced.'*[356]

Experience is something that exists in context only. Scott focusses on how discourse produces subjects, and in this chapter I will also take practices into account. The persons who claimed benefit wrote about their experiences with the claim procedure of the Act and with their bodies in the workplace, and thus enacted their incapacity for work. It is not their experience versus the procedure or versus the experience of doctors or policymakers, but an interaction of multiple practices, emotions and procedures that constituted incapacity for work in this specific context

Scott points to the dangers in keeping in place a false dichotomy between a grand narrative and oppressed experiences. And before writing about experiences of the persons who claimed benefit, there are still other dichotomies that need to be addressed, for instance the dichotomy between emotional workers and rational doctors.[357] In the

354 Scott, "The Evidence of Experience", 777. Or as Annemarie Mol has described it '[Perspectivism] broke away from a monopolistic version of truth. But it didn't multiply reality. It multiplied the eyes of the beholders. It turned each pair of eyes looking from its own perspective into an alternative to other eyes. And this in turn brought pluralism in its wake. For there they are: mutually exclusive perspectives, discrete, existing side by side, in a transparent space. While in the centre the object of the many gazes and glances remains singular, intangible, untouched.' Mol, "Ontological Politics", 76.

355 This maintains a binary between what Donna Haraway has called the 'God trick', the idea that there is neutral universal and objective perspective on things, a view from nowhere, and the idea that there is no such thing as objectivity, only matters of opinion. To move beyond this, she proposes to analyse objectivity as a form of situated knowledge. Donna Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective", *Feminist Studies* 14.3 (1988) 575-599.

356 Scott, "The Evidence of Experience", 779-780.

357 Recently, the emotions of doctors have received more attention from scholars of medical history and the history of emotions. See for example: Danielle Ofri, *What Doctors Feel: How Emotions Affect the*

previous chapter we have seen how doctors sometimes pathologised the desire of workers to lodge appeals against the decision of the Rijksverzekeringsbank, often describing the frustration with the claim procedure as a symptom of benefit neurosis, or as a form of work evasion. They analysed workers' emotions as illness or bad character, while cultivating their own neutrality. Moreover, examination reports were often written in highly formalised language, whereas, as we shall see, the appeals of the workers contain a lot of emotional expressions and punctuation. We could say that there is an obvious difference between a person who looks at the case from an expert point of view, with more distance, and the person who has to deal with the consequences of the decision of the Rijksverzekeringsbank in their daily life. Nevertheless, as scholars like Lorraine Daston and Peter Galison have shown, ideals of objectivity and scientific expertise go hand in hand with everyday practices.[358] Similarly, doctors were involved in the cases they describe, building their knowledge on this involvement. Their findings were closely connected with their interaction with the worker in question, and in this respect, their own emotional state and character cannot be disregarded. The medical officer D. Brocx went even further by stating that the examination was dominated by both the personality of the worker and that of the assessor. In a 1920 issue of the journal *Sociale Voorzorg* he wrote:

> *'This cannot be ruled out; in fact, we believe that fluctuating moods, tendencies towards optimism or pessimism, feeling happy or unhappy, and good or bad health are all factors that influence the assessment. (…) And on the other hand, the personality of the disabled person also works in exactly the same way, which will strongly influence the value we attach to unverifiable complaints. Thus, every assessment is the resultant of the work of two personalities.'* [359]

Practice of Medicine (Boston: Beacon Press 2013), Michael Brown, "Surgery and Emotion: The Era Before Anaesthesia," in: Thomas Schlich (ed.) *The Palgrave Handbook of the History of Surgery* (London: Palgrave Macmillan, 2017) 327-348, Kelly Underman, *Feeling Medicine: How the Pelvic Exam Shapes Medical Training* (New York: New York University Press 2020), Bettina Hitzer and Rob Bodice (ed.) *Feeling Dis-ease in Modern History: Experiencing Medicine and Illness* (London: Bloomsbury 2022), Jacob Moses, Agnes Arnold-Forster and Samuel Schotland, "Introduction: Healthcare Practitioners' Emotions and the Politics of Well-Being in Twentieth Century Anglo-America", *Journal of the History of Medicine and Allied Sciences* 20 (2023) 1-11.

358 Daston and Galison, *Objectivity*.

359 'Deze is niet uit te sluiten; wij gelooven zelfs dat wisselende gemoedstemmingen, neiging tot optimisme of pessimisme, het zich gelukkig of ongelukkig gevoelen, een goede of slechte gezondheid alle factoren zijn die de taxatie beïnvloeden. (…) En van de andere zijde werkt precies op dezelfde wijze de persoonlijkheid van den invalide mede, welke op sterke wijze zal beïnvloeden de waarde die we hechten aan niet te controleeren klachten. Zo wordt iedere schatting de resultante van het werk van twee persoonlijkheden.' D. Brocx, "Bestaat Er Een Nieuwe Koers bij de Rijksverzekeringsbank?", 110-139.

Although Brocx's statements faced much criticism from doctors concerned about the arbitrariness of the 'intuitive' approach to estimating a person's working capacity,[360] it nonetheless shows how a mechanical dichotomy between objectivity and subjectivity did not hold in practice. By extension, the same goes for the reason-emotion split. Analysing, for instance, the frustration of workers who dealt with the examination procedure solely as a matter of subjectivity or emotional involvement would again lead to a form of perspectivism and ignores the fact that the frustration and examination procedure interacted with each other.

This brings me to the last dichotomy important for the study of experience, which historians of emotions have analysed in detail, namely the theoretical split between inner experience and outer expression. This divide, often related to as *Cartesian dualism*, suggests that people have true, authentic feelings but their expression is moderated by the social context. Scholars such as Carol Stearns and Peter Stearns have focussed on the ways in which convention, social rules within specific spheres or communities determine the boundaries for when and how people are allowed to express their inner selves.[361] They claim that historians can only analyse this outer manifestation, and map the social boundaries, but do not have access to this inner world of unexpressed emotions. Scholars working on the history of the self, such as Dror Wahrman, Geertje Mak and Elwin Hofman, have, however, shown that this notion of authenticity and true inner core has a history of its own and can also be considered a matter of practice.[362] Instead of taking the cultural divide between the inner and outer world as a given, Monique Scheer proposes analysing emotions as '(...) a product of the way we habitually "do" the experience. Practice may create an "inner" and "outer" to emotion', she writes; '(...) [b]ut practice may also create bodily manifestations seemingly independent from the mind, ego, or subject, depending on historically and culturally specific habits and context.' Scheer stands in a tradition of practice theory that analyses emotions as the engagement in practice with the world, bridging the theoretical divide between inner selves and outer expressions, and that focusses on the constituting effects that emotions generate.[363] In the following

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360 K. Lindner, "Wetenschap of Willekeur?", *Sociale Voorzorg* 2.1 (1920) 353-383, H.P. Berdenis van Berlekom, "Renteschatting", *Sociale Voorzorg* 2.1 (1920) 476-486.

361 Peter Stearns and Carol Stearns, "Emotionology: Clarifying the History of Emotions and Emotional Standards", *American Historical Review* 90.4 (1985) 813-836.

362 Dror Wahrman, *The Making of the Modern Self: Identity and Culture in Eighteenth-Century England* (New Haven, Yale University Press 2006), Geertje Mak, *Doubting Sex,* Elwin Hofman, "How To Do the History of the Self", *History of the Human Sciences* 29.3 (2016) 8-24, Elwin Hofman, *Trials of the Self. Murder, Mayhem and the Remaking of the Mind*, 1750-1830 (Manchester: Manchester University Press 2021).

363 Monique Scheer, "Are Emotions a Kind of Practice (And Is That What Makes Them Have a History)? A Bourdieuian Approach to Understanding Emotion", *History and Theory* 51.2 (2012) 193-220.

part of this chapter I will use this perspective to analyse how in higher appeal cases the workers enacted incapacity for work in their statements. In all the enactments I have identified, experiences and embodied emotions played prominent roles and interacted with the procedures and with doctors and the Rijksverzekeringsbank. These experiences and emotions I analyse as constitutive practices. This approach allows me to contemplate how disabled workers engaged with various enactments of incapacity for work and how they adjusted, transformed or leveraged the enactments to align them with their own experiences.

When an appeal case was heard by the Central Council of Appeal, it already had quite a judicial history. If workers appealed against the decision of the Rijksverzekeringsbank, their case was heard by the local council of appeal. In higher appeal cases, workers therefore already had some experience with legal proceedings. Furthermore, much time had passed by then since the workplace accident happened. They had been living with the consequences of the accident for at least two years, and in their appeal, they often reflected on this period of time in which they were subject to medical examination and monitoring by the Rijksverzekeringsbank, and in which they performed activities in efforts to rehabilitate. Moreover, they often described their experiences with looking for work that suited their bodily functioning.

Since these higher appeal cases were preceded by at least one appeal, heard by the local council of appeal, the statements of workers were infused with ideas about what logic or argumentation did or did not work the previous time. However, I do not analyse this as tactics.[364] Of course, a worker who claimed benefit and applied the required discourse might have been able to make their case with success. After all, as we have seen in the first two chapters, the Rijksverzekeringsbank emphasised the importance of a cooperating attitude and considered it to be a sign of a good work ethic. That does not mean, however, that this was not the true version of their experience of incapacity for work, or that it was solely a cultural construction. As discussed in the introduction of this dissertation, workers could operate within certain cultural, practical and juridical margins, but since not every practice or idea was possible or desired, there were limits to the ways in which incapacity for work could be enacted. I have, for instance, not come across cases in which persons claimed to be less incapable of working than the Rijksverzekeringsbank had estimated. There may be many reasons why these practices did not occur, but it shows that incapacity for work was, to quote Annemarie Mol, 'more than

364 For the analysis and theorisation of tactics in the context of criminal court, see: Willemijn Ruberg, "The Tactics of Menstruation in Dutch Cases of Sexual Assault and Infanticide (1750-1920)", *Journal of Women's History* 25.3 (2013) 14-37.

one but less than many.'[365] Simply considering the statements of workers who opposed the decision of the Rijksverzekeringsbank a matter of tactics would play into a narrative of doubt surrounding the statements of disabled workers, as I described in the previous chapters. More so, it does not do justice to the complexity of incapacity for work in practice, and thus ignores the fact that disabled workers actively participated in the making up of incapacity for work. By focussing on interaction, the aim of this research is not to find a definite truth about the incapacity for work, but to analyse the interaction between people, practices, emotions, procedures and routines. My aim is to move beyond a search for veracity, but instead focus on how experiences helped shape realities of incapacity for work historically. So instead of talking about tactics, I claim that the testimonies *enact* incapacity for work, then and there. And in interaction with the disability benefit act and the practice of claim examination, disabled workers added to, or followed, the practices, and actively participated in the making up of the validation of their claim to the properties of true incapacity for work. By doing so they sometimes reinforced this practice, but often also changed or used it to align with their lived experiences.

Before going into detail about enactments of incapacity for work in the appeals of the persons who claimed benefit, I would first like to address a few specifics of these sources. The appeals that I use are from the same court records as used in previous chapters. Whereas in other chapters I could supplement these sources with articles in medical journals or with handbooks, for this chapter I only have the appeals to go by. Also, because there have not been any scholars who have previously analysed the statements of the workers who lodged an appeal, my analysis is entirely based on my own research.[366] By focussing on the ways in which workers enacted incapacity for work in these sources I am able to give some insights into what topic workers addressed and how, in their statements, they described their experiences with incapacity for work. By focussing on a variety of enactments that emerge from the statements that these workers made in court, I am able to shed a light on experiences of the workers involved while in conversation with social policy and the practices of the Rijksverzekeringsbank.

The statements of workers were described in the verdicts, but whereas statements by officers in the service of the Rijksverzekeringsbank were rather similar in tone and focus, the claims of the workers in these cases were more pluralistic in style. The focus of their pleas was much more diverse, since they not only dealt with bodily functioning but also provided descriptions of day-to-day life and workplace experiences,

365 Mol, *The Body Multiple.*

366 In their analysis of the claims process under the Industrial Injuries Insurance Act, Houwaart and de Boer explicitly excluded workers' perspectives from their analysis. See: Houwaart and de Boer, *Geschiktheid Gewogen,* 21-22.

and they sometimes entailed expressions of their feelings about the processes of claim examination and judicial procedures. Not every statement enacted the same incapacity for work. In fact, my aim is to leave in place the multiplicity of enactments of incapacity for work, and therefore I will not group the individual appeal statements of the workers who claimed benefit.

However, I will sometimes mention whether a specific enactment of incapacity for work was more common in cases in which workers hired a lawyer to plead on their behalf. There is a very clear difference between statements made by persons who chose to lodge an appeal by themselves and persons who chose to be represented by a lawyer.[367] The appeals drafted by lawyers were written in formalised legal language, talked about the worker in the third person, and summed up point by point what the specific arguments for the appeal were. The statements moreover focussed on procedural errors, and tried to prove that the claim for more benefit was built on arguments that had been considered legitimate in the system. These appeals often perpetuated or enhanced the focus on bodily functioning. In contrast, statements by the workers who lodged an appeal by themselves were often less structured, combined different arguments, sometimes followed an alternative logic, and, moreover, showed more explicitly what effects a workplace accident could have on an individual in everyday life. For instance, the first section, about incapacity for work enacted as physical dysfunction, is based more on statements concerning workers who were represented by lawyers, whereas the last section, which deals with lived experiences of incapacity for work, is mainly based on the appeals of workers who spoke for themselves. It would be wrong, however, to draw a strict dividing line between enactments depending on whether the worker was represented by a lawyer or not, since the enactments highlight the multiplicity of incapacity for work, as well as the overlap and interaction between different experiences. Just as with tactics, again, the use of a lawyer and the adoption of a more formalised description of experiences with incapacity for work does not make these experiences any less real. It is enactments I am concerned with, and I therefore focus on what and how realities were produced.

367 In 1957 the Legal Aid Act (Wet op de Rechtsbijstand) was introduced, which covered legal aid for people who could not pay for it themselves. Before 1957, legal advice could be obtained through the trade union.

3 CONTESTING EXPERTISE, PRODUCING NEW FORMS OF BODILY DYSFUNCTION

In both the claim assessment and the appeal cases, workers were confronted with medical authority. We have seen how medically trained officers gained the position of gatekeepers in the execution of the Industrial Injuries Insurance Act, and how doctors who were granted the role of experts enacted incapacity for work as a symptom of illness. A looping effect occurred: doctors were consulted based on their knowledge of medical problems, and because of their focus on injured bodies they enacted incapacity for work as a medical problem, reinforcing their expertise over matters of bodily functioning. Of course, this expertise was shared among many different specialists who often disagreed with each other. Incapacity for work certainly was examined as a medical problem, but its nature and the corresponding solution were heavily debated. While the Rijksverzekeringsbank and disabled workers were opposing parties in a legal fight over the right version and calculation of working capacities, they, together with the medical experts, engaged in the search for the properties of incapacity for work. And in this interaction, workers, just like medical officers and medical experts, sought to find the answer in the body. The workers, however, contested who had knowledge about bodily functioning, and brought forward their own experiences as a source of knowledge. I have distinguished three ways in which they did that: by contesting the insights of specific doctors; by questioning the expertise of doctors altogether; and by stressing their own expertise by experience. In doing so they shifted the boundaries between lay people and experts, adhering to different and competing forms of authority.

Medical historians have demonstrated that from the nineteenth century on, due to medical professionalisation and with the introduction of medical practices such as palpation and auscultation, doctors developed a 'changing medical gaze' as Jens Lachmund has called it, and started to emphasise the significance of systemic diagnostic scrutiny.[368] This change not only came at the expense of further therapeutic advancements, but also impacted the relatively egalitarian relationship between physicians and sick or disabled persons.[369] Whereas before, both parties had collaborated in developing an analysis of

368 Jens Lachmund, "Between Scrutiny and Treatment: Physical Diagnosis and the Restructuring of 19th Century Medical Practice", *Sociology of Health & Illness* 20.6 (1998) 779-801.

369 Nicholas Jewson and Michael Stolberg have highlighted the strong position of the wealthy in this collaboration. Because doctors were paid by the sick, treatment was much more tailored to their needs. Nicholas Jewson, "The Disappearance of the Sick Man from Medical Cosmology, 1770–1870", *Sociology* 10 (1976) 225-44, Michael Stolberg, "'Mein Äskulapisches Orakel!' Patientenbriefe als Quelle einer Kulturqeschichte der Krankheitserfahrung im 18. Jahrhundert", *Österreichische Zeitschrift für Geschichtswissenschaften* 7 (1996) 385-404.

the condition, in modern medicine, this relationship became hierarchical. The sick person was transformed into a patient—a person with objectifiable, observable complaints who became the subject of scrutiny by knowledgeable doctors.[370]
Before the nineteenth century, doctors had sometimes been called in court, but according to Lachmund, the transformation of the sick person into a patient meant that doctors were taken out of the consulting room or bedside and into the courtroom to give 'unbiased' insights into a worker's abilities. Lachmund has rightfully stressed that these new medical practices demanded the cooperation of 'patients', and Nancy Theriot has shown that sick persons and their families contributed to the knowledge production of physicians. Similarly, in the previous chapter I concluded that medical experts had to navigate all kinds of problems and tasks, and interacted with disabled workers in their enactment of incapacity for work. All these things show that in practice there was much room to mediate, navigate and negotiate in order to arrive at knowledge and to find the properties of medical categories, but the doctor-patient relationship remained hierarchical nonetheless.[371]

Here, I will address how workers played with this hierarchy and medical knowledge production. Workers interacted with the claims of doctors and added their own insights, values and expertise. They reinforced incapacity for work as a matter of physical function. This reality of incapacity for work, however, was a virtual common object, to use Mol's terms, for while the Rijksverzekeringsbank analysed the body's remaining capabilities and assessed them in a clinical and detailed manner, disabled workers considered what the body could no longer do, and contextualised it within the workplace. By analysing bodily functioning in a different manner, they also made up incapacity for work in a different way.

Contesting the insights of specific doctors

One way of interacting with the question of who was qualified to measure incapacity for work was for workers to contest the expertise of the doctors who substantiated the perspective of the Rijksverzekeringsbank. They brought forward statements and reports

370 Michel Foucault, *The Birth of the Clinic. An Archeology of Medical Perception* (New York: Routledge [1973] 2003) 124-148. Jewson, "The Disappearance of the Sick Man", 225-44, Michael Stolberg, "Heilkundige. Professionalisierung und Medikalisierung", in: Norbert Paul and Thomas Schlich (eds.) *Medizingeschichte. Aufgaben, Probleme, Perspektiven* (Frankfurt am Main: Campus Verlag 1998) 69–86. Lachmund, "Between Scrutiny and Treatment", 779-801, Willemijn Ruberg, *History of the Body* (London: Red Globe Press 2020) 15-19.

371 Lachmund, "Between Scrutiny and Treatment", 779-801. Nancy M. Theriot, "Negotiating Illness: Doctors, Patients, and Families in the Nineteenth Century", *Journal of the History of the Behavioral Sciences* 37.4 (2001) 349–368.

from other doctors, and started a medical-scientific debate about the details of bodily functioning.

In a 1915 case, the worker M.H. Martens considered that he lacked medical knowledge to contest the statements of the medical officer Vossenaar. 'In all modesty' though, he wrote, he claimed to be fully unable to work based on the records of doctor Le Rütte, the head of a psychiatric institution in Deventer. While the Rijksverzekeringsbank asserted that Martens had never been assessed by an 'authoritative' neurologist, the worker emphasised that doctor Le Rütte was, in fact, an authority in the field of nervous diseases, '(...) to whose insights the courts of Zwolle, Almelo, and Zutphen consistently attached the highest importance in the handling of criminal cases and civil lawsuits concerning guardianship.'[372] Martens stated that in the previous hearing of the case, by the council of appeal in Almelo, doctor Le Rütte's insights had, 'without a doubt', been considered the most authoritative of all expert claims. He therefore requested that the Central Council of Appeal accept the decision of the appeal court in Almelo, or at least consult doctor Le Rütte as an expert witness.[373] In a similar vein, in the 1925 case of J.V. Sanders, the worker relied substantially on the insights of several doctors. He did not explicitly mention their views; rather he presented them as references. In the 'considerations' section of the case verdict it can be read that Sanders argued:

> *'That Dr van der Meer examined him for the first time on 3 January 1924. That he cannot walk normally anymore, but drags his left leg along, because of the pain in his left shoulder blade. (...) That his left arm is slower and stiff in movement, and very painful. That when sleeping, the head needs to be in a very high position, because otherwise devastating pain would occur. That for the rest he relies on the insights of Dr van Moorssel, Dr van der Spek, Dr van Ginneken, Dr Caspari, all from 's Hertogenbosch, and on Dr van Alkemade from st. Oedenrode, whose statements will differ from those made by Dr van der Schutte and Dr Stenvers [both in the service of the Rijksverzekeringsbank, ND]. That he asks the Central Council of Appeal to hear these experts as witnesses'.* [374]

372 '(...) aan wiens oordeel door de rechtbank van Zwolle, Almelo en Zutphen by de behandeling van strafzaken en civiele gedingen over curateele steeds het hoogste gewicht wordt gehecht.' NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

373 NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

374 'Dat dr. van der Meer hem voor het eerst op 3 januari 1924 heeft gecontroleerd. Dat hij niet normaal loopt doch met het linkerbeen sleept vanwege de pyn in het linkerschouderblad (...) Dat de linkerarm in de bewegingen veel langzamer en styver is en dan hevig pyn doet. Dat hy by slapen het hoofd zeer hoog moet rusten, daar anders ondragelyke pyn ontstaat. Dat hy zich verder beroept op dr. Van Moorssel, dr. van der Spek, dr. van Ginneken, dr. Caspari, allen te 's-Hertogenbosch, en op dr. van Alkemade te st. Oedenrode,

In 1945, the worker L. Kuijpers complained about a biased surgeon who had suspected him of simulating his injuries. Kuijpers asked for two 'neutral and knowledgeable' doctors to perform a medical examination.[375] Likewise, in 1955 a lawyer from the Dutch Confederation of Trade Unions[376], F.L. Neppérus, requested that his client, B. Pol, be examined by doctor Lammert van der Horst, a professor in psychiatry, in order to provide objective evidence for a claim for benefits corresponding to 100% incapacity for work.[377]

These are just a few of the many cases in which the worker brought in different doctors to substantiate their claim. By the time their case was heard by the Central Council of Appeal, workers had become acquainted with the fact that expertise and knowledge were not absolute but could be contested. During the claim assessment by the Rijksverzekeringsbank, workers were evaluated by multiple doctors, and when they appealed, even more physicians were involved, who often had differing opinions. In appeal cases, workers reference this medical debate by presenting doctors who challenged the insights of the doctors who supported the Rijksverzekeringsbank's evaluation. In these appeals, incapacity for work was enacted in a similar way to the enactment by the Rijksverzekeringsbank: namely as subject to medical expertise. By doing so workers maintained a focus on the body, but contested the knowledge and insights of specific doctors, medical officers in particular, and engaged with a medical debate about incapacity for work. [378]

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wier verklaringen anders zullen luiden dan die afgelegd door door dr. van der Schatte en door dr. Stenvers. Dat hy den Centralen Raad van Beroep verzoekt die deskundigen te willen hooren.' NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

375 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

376 In Dutch: Nederlands Verbond van Vakverenigingen

377 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

378 Their analysis was supported by the research of socialist politician and general practitioner Ben Sajet. In his dissertation, defended in May 1940, Sajet used statistical analysis to show that the Rijksverzekeringsbank was rather reluctant to grant benefits for incapacity for work. He argued that this was partly due to the fact that the Rijksverzekeringsbank was deliberately trying to cut costs, and that the medical officers were under pressure to be as critical as possible. As a result, the medical officers went their own way, independent of medical opinions and standards. They did not rely on the workers' statements and took too little account of the workers' individual circumstances and perceptions of their own functioning, Sajet claimed. They were also too quick to assume that a condition was caused by an underlying illness (and therefore not an accident within the meaning of the Act), without checking this thoroughly. In addition, medical officers too often chose to follow the findings of doctors who shared their views and had a suspicious attitude towards workers, which meant that when in doubt, benefits were not provided. He concluded that the assessment relied too much on the subjective and detached view of the medical officers and argued for a separate medical office independent of the Rijksverzekeringsbank. Ben Sajet, *Bijdrage tot de Geneeskundige Beoordeling in de Praktijck van de Ongevallenwet* (Amsterdam: Scheltema en Holkema's Boekhandel en Uitgeversmaatschappij 1940).

We could say that this might be the most compliant way of engaging with the statements of the Rijksverzekeringsbank and the required discourses used in court. This could also be the reason why this practice can mostly be seen in cases of workers who were represented by a lawyer. However, that does not necessarily mean that workers had no form of agency in this. In fact, by taking medical authority as a starting point, they managed to bring forward the insights of other, more 'knowledgeable' or specialised doctors that were more in line with their own experiences and reflected perspectives or interests. They made use of medical authority and power to substantiate their claim to the true reality of their own incapacity for work.

Questioning the expertise of doctors altogether

Workers did not just contest the medical perspective of doctors. Sometimes they took doctors' medical knowledge as a given, but openly questioned whether their findings should take precedence in the measurement of incapacity for work. This could lead to the claim that a focus on the body was not enough to measure incapacity for work. Workers argued that their specific working conditions should also be taken into consideration when assessing their incapacities. They disputed the expertise of doctors by stressing that doctors lacked the knowledge and skills necessary to properly measure incapacity for work.

For instance, in the 1925 case of C. de Goede, his father demanded an occupational examination for his son, who was not yet of legal age to act on his own behalf in court. In the appeal, his father wondered: 'How it is even possible that a doctor is considered to be able to examine the working capacity of an insured person?' He added 'that there is no question his son has severely injured four fingers on his right hand and cannot perform half of his tasks with this hand; that the doctor should come along and take a look at the tasks his sons performs.'[379] In a similar manner, K.D. Zalm argued that the medical officer Hemmes did not have sufficient knowledge about his work situation. In his appeal case in 1925, Zalm claimed that Hemmes assumed he could manually propel the cargo barge he was working on and therefore concluded that Zalm was fully capable of performing his work as a boatman. Zalm disputed this by stating that propelling the barge was only one aspect of his work and that he could only do it in good weather. And even then he had difficulty performing this task well because he was unable to put his foot flat on the ground, which made propelling the barge more energy- and time-consuming. This

379 'Hoe het mogelyk dat een dokter kan beoordelen wat een verzekerde kan verrichten?' and 'dat vaststaat dat zyn zoon vier vingers van zyn rechter hand deerlyk verwond heeft en hy met deze hand geen half werk kan verrichten; dat de dokter maar eens naar de werkzaamheden van zyn zoon moet kyken.' NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

was problematic as the barge was scheduled to arrive at a specific time. He could only perform his work by starting very early, which required a lot of energy and impacted his ability to complete other tasks.[380] Zalm mentioned several other tasks that he could now only perform with the assistance of colleagues, and explained that the most physically demanding work was primarily completed by others. He concluded his plea by arguing that Hemmes had a limited understanding of his work situation.[381]

Both De Goede and Zalm questioned the ability of doctors to come to a balanced decision about working capacity, since they claimed that the actual working conditions had not been taken into account. In some cases workers would request workplace experts who could testify about the limits of their ability to perform their work. D. de Vries, for instance, requested an independent labour expert to analyse his working performance in his 1925 higher appeal case.[382]

It is noteworthy that the scepticism regarding medical officers' ability to accurately assess claims due to their limited knowledge of the workplace was particularly prevalent in the 1910s and 1920s. In my body of data, after 1925 there were no more cases in which workers openly disputed the ability of medical officers to examine working capacity. This may be due to the fact that the Rijksverzekeringsbank began to place more emphasis on the workplace during the 1920's. As we have seen, with the implementation of the reformed Industrial Injuries Insurance Act, the push towards rehabilitation and the appointment of 14 labour experts, the workplace conditions were taken into account more explicitly. Although in the practice of the higher appeals, the Rijksverzekeringsbank's measurements of incapacity for work still relied heavily on the examination of body parts, their decision was supported by both medical officers and labour experts.

In addition, interestingly enough, workers rarely asked for their employer or for colleagues to testify about their working capacity. This could be related to worries about stigma, or their value in the labour market, which I will discuss in more detail below. As we shall see, workers sometimes tried to hide their struggle to meet productivity standards, fearing that they would lose their job. It is, however, important to note that workers did address the point of incapacity for work as something that was not just a calculation based on theoretical functionality, but existed in the tangible context of an actual and

380 In disability studies, 'crip time' refers to the time it takes for a disabled person to cope with everyday life: the time spent sleeping, recovering from certain treatments, being ill. It also means the time it takes to deal with inaccessibility (for example, waiting for someone to help you on a train) and the time it takes to keep up with productivity norms in a particular field of work. See: Ellen Samuels, 'Six Ways of Looking at Crip Time', *Disability Studies Quarterly* 37.3 (2017) published online https://dsq-sds.org/index.php/dsq/article/view/5824/4684 (last accessed on 22 August 2023), Kafer, *Feminist, Queer, Crip,* 26.

381 NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

382 NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

specific workplace. In doing so, they expanded the debate about who possessed the true expertise on incapacity for work; from disputes between medical specialists (such as whether a surgeon or neurologist was more knowledgeable about the spine) to a debate about which profession was better equipped to measure incapacity for work within the context of everyday work activities. In these cases incapacity for work was still enacted as bodily dysfunction; however, now the body's dysfunction was analysed in specific workplace situations. With this engagement with expertise, the enactment of incapacity as bodily functioning expanded beyond medical expertise to encompass what a body could or could not do in the context of the workplace.

Experts by experience

A last but rather prevalent way for workers to engage with matters of expertise in higher appeal was not to deny the knowledge of medical officers or medical specialists, but to stress their own first-hand experiences with their own bodily functioning, thus emphasising that they were experts by experience.

Although, as I showed before, workers who referred to the insights of specific doctors did so because these were aligned with their own experiences, in the practice of higher appeals, most workers explicitly claimed their own expertise with respect to their own bodies. In 1925, C. Baarsma appeared in court to make sure that the judge was able to inspect his hand. While showing his hand, Baarsma asked the expert witness several questions: 'Is the state of this hand similar to the state it was right after surgery?' and 'Have you ever, in your position as a doctor, come across a situation in which a hand was injured in similar ways, and in which all working activities could be performed?' He ended his statement by explaining in detail that there had not been any improvement in the flexion of his index finger, nor in the middle finger.[383] In this case is that Baarsma arranged the statements by the expert witness to substantiate his own analysis of the lack of improvement in the functionality of his own hand. He did not say he knew best, but by showing his hand, and asking questions to expert witnesses whose answers were already known, his own impression of the flexion of his fingers gained importance.

Often, workers explicitly contested the findings from physicians by claiming doctors did not know what it was like to suffer from these types of injuries, and were therefore unable to truly estimate the severity of their incapacity for work. C. van de Velden, whose appeal was heard in 1925, wrote that Dr van Assen could not judge his ability to work, because he would not know what it is like to work in a dock and not be able to stand the noise. Or to be in the porter's house, which was supposed to shelter him from this noise, but to then be equally confronted with rowdiness. He explained that he had made an

383 NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

effort to work there for several days, but had to depart prematurely due to the extreme discomfort it caused him. C. van der Velden argued that the medical officer Van Zadelhoff had only assessed him twice, but then accused him of being lazy and deliberately misleading other doctors. The worker claimed that he had a fever every day, which made even the slightest activity challenging.[384] He presented his own experience of his working capacity, based on bodily functioning and the way he suffered from it, and contrasted this with the statements of doctors who lacked first-hand knowledge of what it was like to work and live with such severe injuries.

In cases like these, workers often described their experiences in great detail, using medical terms and sometimes reporting their own search for the medical truth about their bodies. In his letter of appeal, C. Postma gave an account of his medical situation in six points, each with its own subdivisions. In one of the points, Postma wrote that no medical officer or doctor had ever conducted an investigation into the cause of the workplace accident. He emphasised that such an inquiry was essential in comprehending the nature of his injuries and his subsequent inability to engage in work. Postma conducted his own analysis of his capacities and provided detailed responses to the many examination reports.

> *'According to witnesses, I was thrown onto the street, having fallen through an open sliding roof of a car, making a flip of 8 to 9 metres. 1. According to reports skull no abnormalities. 1. Sinus obscured, not mentioned. Head stitched in 7 places and spent the first week in the hospital (unconscious, at least almost entirely unconscious) CURRENTLY: numb spot in the R-skull, tinnitus, amnesia noticeable memory loss, I have become a chronic spectacle wearer and suffer from frequent headaches (which I never had), neck and neck muscle pain. 2. According to hospital reports: left hip, posterior with dislocation, disabled, venous blood vessels clogged. CURRENTLY: Painful hip and numb left leg, unable to walk.'* [385]

384 NA, 2.09.39 CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

385 'Volgens ooggetuigen door open schuifdak op straat gesmakt met een salto van 8 a 9 meter. 1. Volgens rapporten schedel geen afwijkingen. 1. Sinus geluierd niet vermeld. Hoofd op 7 plaatsen gehecht en de eerste week in het ziekenhuis (bewusteloos althans vrijwel onbewust doorgebracht) NU NOG: Dove plek in r-schedel, oorsuizingen, geheugenverlies opvallend vergeet alles, blijvend brildrager geworden en veel hoofdpijn (vroeger nooit gekend) nek en nekspierklachten. 2. Volgens ziekenhuisrapporten: linker lat, achter met dislocatie minder valide, aderlijke bloedleiders gesluierd. NU NOG: Pijnlijke heup en slapend linkerbeen, kan niet wandelen.' Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

He continued with five additional points, and that is just this sub-paragraph. It would be excessive to delve into every detail of Postma's appeal letter.[386] What is crucial to note here is that Postma followed a practice that many other workers also used in their appeals. It involved scrutinising every detail of the medical reports on their situation and then challenging them by describing their current circumstances, contrasting the details with their experiences in their day-to-day working life, primarily focussing on the pain and disabilities they endured. In the previous chapter, we saw how doctors interpreted this scrutiny of medical details as a sign of illness, of benefit neurosis or fixation. However, we can also view it as a way for workers to present their own experience of incapacity for work. Like medical officers, Postma concentrated on specific body parts. However, in his discussions with the medical reports, he created a bigger picture. By bringing together all these fragmented perspectives, he manifested himself as a true expert on his own working capacity.

Incapacity for work is what a body cannot do anymore

In all these different appeals, medical officers and expert witnesses were challenged by workers who contested their knowledge and experience with incapacity for work. And in this process, the incapacity for work enacted in the described cases was a clear product of an interaction. As we have seen in the previous chapters, expert witnesses analysed incapacity for work as a symptom of a medical issue. Being positioned as neutral or objective experts, these doctors reinforced their expertise regarding the subject matter, making up incapacity for work as illness. However, by questioning this expertise, by bringing forward other specialists, or claiming their own expertise by experience, workers engaged with this process. They changed it, they questioned the gatekeeping position of medical officers, or they added different types of knowing to it. In the statements by the workers discussed in this section, incapacity for work was reinforced as a matter of expertise over bodily functioning. The appeal cases functioned as an arena in which the nature of this expertise was contested. This was two-sided. Workers used the findings of medical officers and expert witnesses, instigating a conversation about what incapacity for work actually was and how it could be measured, making room for their own experiences with their bodies. And these experiences were constituted in interaction with claim assessments, medical examination (the use of medical terms and reports), and the realities of working in a dock or in a factory. They challenged what medical expertise entailed and blurred the boundaries between experts and laypeople.

This is a direct example of how incapacity for work was made up in interaction between the Act, the Rijksverzekeringsbank, medical experts and workers. They all added

386 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

to the enactment of incapacity for work as fundamentally rooted in a dysfunctional body. This is an example of what Annemarie Mol calls a virtual common object. Although all parties considered incapacity for work a bodily matter, in the fight over who was most knowledgeable about incapacity for work, it becomes clear that workers referred to bodily functioning in a manner that deviated from how the Rijksverzekeringsbank and medical experts engaged with it. While especially since the 1920s the Rijksverzekeringsbank focussed on what disabled workers could still do with their bodies, workers, when describing their experiences with their own physique, stressed what their bodies could not do anymore. Like medical officers, they considered their injured body parts the source of their incapacities, but they also focussed on the bodily experiences that affected their productivity, such as pain or fatigue. Furthermore, a noisy work environment or tight schedules could have a negative impact on their stamina, potentially resulting in difficulties in carrying out their daily work activities. So while these workers referred to their bodies as the source of their incapacities, they also stressed the working conditions in which this caused problems, pointing to the relationality of their malfunctioning. Here we see that workers enacted incapacity for work as bodily functioning, but this extended the range of functioning (or rather, dysfunctioning). It entailed taking into account not only the measurable functionality of body parts, but also the experiences of bodily functioning, all within the highly specific context of their individual working tasks. This focus on the specifics of the work to be performed, as well as on experiences of disability or impairment, also produced other enactments of incapacity for work, to which I now will turn.

4 INCAPACITY TO PERFORM LABOUR

Doctors provided descriptions of the worker's anatomy and injuries, and incapacity for work naturally derived from these specific bodily descriptions. Workers used similar descriptions, but then extended this by placing their impairments in the context of the realities of the workplace. I will now focus on the emphasis that workers had put on the (often harsh) realities of the workplace, to show that in the higher appeal cases workers considered their functioning to be much more relational than the Rijksverzekeringsbank did. They enacted incapacity for work in a rather literal way: as an inability to perform their old job.

Three incapacitating factors were regularly addressed by workers in appeal cases: reduced productivity in a demanding environment, unequal career perspectives, and exclusion from the workplace. With their focus on incapacitating contexts, I moreover argue that the social model was not just a recent phenomenon, but that enactments

of incapacity for work were actually rooted in a longer tradition of disabled persons stressing the socio-material contexts in which their bodies could or could not function.

Compensation for reduced productivity

In the appeals, workers often explained what their bodies could not do anymore and related this to the actual tasks that were required of them in their occupation. In 1934 the Rijksverzekeringsbank had decided the young man S. van den Berg was fully capable of working again, but Van den Berg himself did not agree. In his appeal he stated that the estimation was largely based on his work at the national postal service (*PTT*); however he had always been dependent on his main job as assistant cigar maker for his income. After the accident, he could not work at the postal service anymore, and he was almost fully incapable of making cigars. Since the last medical examination, he had not been able to make the proper number of cigars, he claimed. The top of his index finger was stiff and could only passively be brought towards the palm of his hand, while remaining at a six-centimetre distance, therefore making it impossible for him to put the stuffing in the outer leaf of the cigar within the required time. He stated that he would never be able to find a job as assistant cigar maker, because he did not have the dexterity anymore to produce even a small number of cigars. The owners of the company for which Van den Berg used to work were willing to confirm this in court,[387] and Van den Berg stated that he would like to demonstrate that he was not able to produce the required number of cigars anymore. In the statement by Van der Born, his incapacity for work derived naturally from the fact that one cannot roll a good number of cigars with a stiff index finger. Like the medical officer, Van der Born described the functioning of his hands, but he aimed to show that in relation to the specific requirements of the job, the hand functioned abnormally and he was therefore fully incapable of working.[388]

Similarly, H. Smit stated in his 1935 case that due to the loss of his little finger, his grip was reduced and his grip strength was weakened. He was expected to have a good pair of hands for the type of work he performed and therefore, he argued, he was now fully incapacitated. In the verdict, his appeal is described as follows:

> *'[he claims] that the ropes have to be pulled hand over hand, which requires two full functioning hands. When driving the electric pile-driver, the left hand*

387 It is interesting to note that he explicitly stated that his employer was willing to testify in court, linking this focus on (lack of) functionality at work with the contested claims to expertise described earlier. When the focus was on work, it was not doctors who could testify in court, but the workers themselves, as well as their employers and colleagues.

388 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

> *in particular is required to exert a lot of pressure, such as constantly pushing down the friction of the motor. [He claims] [t]hat this pressure is exerted precisely with the part of his left hand that has the little finger and the ring finger, and that no other hand position is possible for this work.'*[389]

Smit claimed that the Rijksverzekeringsbank had not taken into account the fact that this type of work was rather rare, and it was therefore very hard for him to find an alternative job.

Van den Berg and Smit both focussed on the specific bodily functioning that was needed for their job, and describe their deficient bodies in that specific context. They identified the problems of their injured hands, just as the doctors did in the service of the Rijksverzekeringsbank. In some cases, workers repeated the detailed medical description or snapshots of the medical reports drawn up by the insurance doctors, as Van der Born did when he stated that the distance between his bent finger and the palm of his hands was six centimetres. However, this medical information was not viewed in isolation, and did not form the basis of their calculation. Instead, it was put in relation to the exact activities that they had to perform with their injured hands, and it was this connection that made them incapable of performing their job.

J. Bravenboer did the same when he stated in 1935 that the doctor in the service of the Rijksverzekeringsbank had claimed that '(...) when relaxed, his fourth and fifth finger do not impact his working capacity. However, this is absolutely incorrect because once the second and third finger are, for any reason, troublesome, the fourth finger needs to step in.' He stated that the medical officer had mentioned a few machines that he could still use. However, Bravenboer argued that these were only the smallest machines that did not cost so much energy to turn on, and furthermore, were not used very often. In contrast, in the leather factory that he was working in, most of the machinery did take a lot of power to drive. He claimed it took a worker with a strong hand to perform his job, and he was not that person anymore.[390] Like Van den Berg, Smit and others, Bravenboer showed that working capacity was not just about performing any task in a workplace setting; it was also about working quickly, forcefully and productively.

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389 '[H]et trekken aan het pantouw moet hand over hand gebeuren, zoodat dus beide handen volwaardig moeten zyn. Dat by het drijven van de electrische heimachine juist van de linkerhand veel wordt gevergd, o.a. het voortdurend omlaag drukken van de frictie van den motor. Dat die druk juist wordt uitgeoefend met het gedeelte van zyn linkerhand waaraan pink en ringvinger zitten, en dat een andere houding van de hand by dit werk niet mogelyk is.' NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

390 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

In many cases, especially situations where workers received piece rates and were expected to produce large quantities of goods, the pace at which they could perform their tasks affected the income they could earn. Some labourers, moreover, added that they used to work alone and now someone had to be hired to help them. This reduced their net income, or increased the personnel expenses of their employer. This was for instance the situation of C.J. Nachtegaal in 1935, who worked as a bricklayer, but could now only perform his work with the help of a foreman (*opperman*), whom he could not pay.[391] In that same year, I. van Balen claimed that before he had been able to grow and harvest vegetables and fruit by himself, and he would put them into boxes and bring them to the cellar. Now, after the accident, he had to hire a servant to do this for him.[392] Both Nachtegaal and Van Balen stressed that considering their physical power and functioning they might be able to do small parts of their work, or do their work entirely but at a slower pace, but to be able to finish their work in time, they needed help, which cost them a salary. Here a connection was made between working capacity and earning capacity, which, as we have seen in Chapter 1, was in line with the initial idea of the Act to help prevent disabled workers from falling into poverty.

These cases show that for workers, incapacity for work was not just about the loss of their mobility or the grip strength of their right hand; it was this loss in the context of a workplace that demanded certain levels of productivity, precision or speed. For some workers it was simply impossible to do the job in the required manner if they could not do it quickly; for others it would be possible to do it with the help of an assistant, but then they lost part of their income. Although the physical injuries were mentioned in these appeals, they stressed that the body was lacking in relation to the requirements of the specific workplace.

Compensation for the lack of equal opportunity

It was not only the disconnect between their disabled bodies and their current working conditions that workers took into account when they described their own incapacity for work. They also pointed out that their future working capacity and corresponding income were affected. If workers were only able to perform their tasks at a slower pace, or with the help of others, not only their income, but also their future career opportunities were reduced. Here, again incapacity for work was linked to the ability to earn a living.

In his 1905 case, 16-year-old H.F. Duif stated through his father, who represented him in court, that the muscle between his right elbow and wrist had been completely shattered, and that he could not use his right hand anymore. Since he was a minor and was

391 NA, 2.09.39 CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

392 NA, 2.09.39 CRvB, Inv. No. 264 uitspraaknummers 33200-34062, 1935, Juli 4 – 1935, December 31.

still learning the trade of a thread maker and spinner, he only earned a small income and, as a consequence, his amount of benefit was relatively low compared to accomplished workers. He added that it was very hard for him to find a new job (*werkkring*) and if he could find one, it would be the type that provided such low income that only disabled people would be willing to join. Duif stated that, taking his age and corresponding small amount of benefit into account, it would only be fair if he were considered 75% incapable of working, instead of the estimated 50%. Duif made explicitly clear that his incapacity for work was something he would have to deal with his entire career: it obstructed not only his current capacity but also his ability to become a more advanced and better-skilled worker in the future. After all, with the loss of his expected professional development came a loss of future income, for which Duif demanded compensation. Here we see a worker who took more into account than just the physical injuries and his possibilities to still use his body.[393]

In the course of the twentieth century, workers kept focussing on the material and enduring impact of workplace injuries on their capacities to perform labour. In 1935, 19-year-old J.D. Vonk stated that due to the accident and sustained injuries, he would never be able to learn the trade of his former occupation, and was therefore now training to become an office clerk. However, he had only ever finished his primary school and had to work very hard to reach the educational level that was needed for his new job. Because of his delay in development and the loss of his hand, he would always be at a disadvantage compared with other office clerks who were in possession of two fully functioning hands and a better educational background. He stated that he was 100% unable to perform his former job, and should be granted the corresponding amount of benefit, at least for the time he needed to retrain himself to become somewhat capable of performing the work of an office clerk.[394] S. van Loenen addressed a similar process in his 1935 case. He emphasised that although he earned the same salary as his colleagues at the moment, in time they would be able to work their way up. The work that he now performed was the easiest work thinkable, he argued, and he could only do it with the help of others. His fellow mechanics would be able to develop and earn better wages, but he lacked that opportunity, and therefore requested compensation.[395] Duif, Vonk and Van Laar all made up incapacity for work in broad manner, again connecting it to the initial aim of the Act to avert poverty and to compensate for the financial consequences of the workplace accident.

393 NA, 2.09.39 CRvB, Inv. No. 129 Uitspraaknummers 487-980, 1905, januari 3-1905, december 22.

394 NA, 2.09.39 CRvB, Inv. No. 263 Uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

395 NA, 2.09.39 CRvB, Inv. No. 263 Uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

This focus on future prospects and future income was especially noticeable in cases of workers who were very young and whose working life had only just begun. It was their bodies, their age and their workplace that together created their opportunities to earn a certain income. However, workers of more mature age, in fact, also claimed to be more affected by the consequences of the workplace accident than others, because they simply had little time or energy left to adjust to their new bodies or were too old to undergo retraining for a new metier.[396] Workers who had already been injured in a previous accident also demanded consideration for their lack of future opportunities, since the consequences of the accident came on top of the already limited functionality. J. Goossens wrote in his 1935 appeal that the effects of the compound fracture of the base of his left thumb had greater impact on his capacities because he was already suffering from disabilities due to a previous accident in which he had fractured his left thigh. He stated that employers considered him useless, because he was not only crippled but also lacked the use of his thumb, which was indispensable. He explicitly asked consideration to be given not only to the injuries resulting from his workplace accident, but also to the fact that he was a disabled worker already, and now had to deal with an increased disadvantage in the labour market.[397] In higher appeal, disabled workers made a plea to regard incapacity for work as a highly contextual matter, moving away from a strong focus on their individual bodies to instead look at the workplace and labour market in which these bodies had to function to be able to earn a living. By pointing out the many disabling factors that influenced not only their current work but also their future capacity to earn a living, they adhered to the initial motives behind the introduction of the Industrial Injuries Insurance Act, making a plea to take into account both their decline in income and the deterioration in their earning potential.

Compensation for workplace exclusion

The relational reality of incapacity for work for disabled labourers becomes even more evident in the third incapacitating factor they addressed, which was exclusion. We have seen how, in the course of the 1920s and with the new version of the Industrial Injuries Insurance Act, medical officers started to emphasise the remaining working capacities and focus their assessment on finding the right percentage that would stimulate people to adjust or adapt to the new, more limited functionality of their bodies. Workers who were found to be eligible for disability benefit had to commit to all kinds of treatments and therapies to heal or train their body and improve the use of their working capacities.

396 For instance in the cases of J. Douma 1915 and T. Kersbergen 1915. NA, 2.09.39 CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

397 NA, 2.09.39 CRvB, Inv. No. 263 Uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

As much as they tried to adjust, in the testimonies of the workers we see that this work could all be in vain. Workers who injured their bodies in a workplace accident could manage to regain their energy and strength, but that did not mean they were automatically welcomed back to the workplace, even if medical officers had decided they were fully capable of working. 'No employer will ever hire a person with such crippled hands', said J. Douma in his 1915 appeal. [398] 'My right hand is so severely injured, it does not seem like a hand anymore; it is more like a stump. (...) It does not make sense to go to an employer who requires manual work, because he will see my hand and say "there are plenty of workers with a good pair of hands"', stated D.H. Driessen in 1925.[399] In several appeal cases, workers pointed out that they were rejected by employers because of their physical appearance, and were thought to be lagging behind on production norms. Although a person might have working capacity of 20%, 50% or even 80% according to the Rijksverzekeringsbank, in competition with a person who was fully capable of working and did not have a history with a workplace accident, employers would prefer to hire the non-disabled labourer.

Sometimes workers signalled that companies were openly hostile to disabled persons. C. Harmsen, for instance, wrote in 1915 that his employer, the Nederlandsche Centraal-Spoorweg-Maatschappij (Dutch Central Railway Company), '(...) has a tendency to remove disabled people from service nowadays'. He worried that he would be next.[400] Similarly, C. van de Velden stated that his former employer tried to keep him in service because he felt sorry for him, but this did not work out since his labour 'was not worth two cents'. He elaborated on his statement by mentioning that when he visited other potential employers and entered their premises, they promptly dismissed him, saying that they had no use for disabled people at their dock.[401]

Even workers who were still in employment stated they were very aware of their vulnerable position in the company. In some cases, workers asserted that they felt the need to hide their disabilities, and, for instance, put in more hours to maintain their productivity. The aforementioned K.D. Zalm responded to the Rijksverzekeringsbank's assessment, which was based on the fact that he never sought assistance from his employer. He asserted that he was able to conceal his difficulties in keeping up with the work pace because he worked by himself. Since he did not want to be considered inferior to others, he never asked for help, he claimed. If he happened to be fired due to

398 NA, 2.09.39, CRvB, Inv. No. 263 Uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

399 NA, 2.09.39, CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

400 NA, 2.09.30, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

401 NA, 2.09.39, CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

his 'inferiority', he was uncertain about how a person with a limp like his could secure another employment opportunity.[402]

In these specific cases, workers did not attempt to criticise the exclusionary tendencies prevalent in the job market. In fact, workers frequently displayed a profound understanding of the reality that companies would not consider hiring them. J. Meijer, for instance, stated in his 1915 case that he got his job solely because his employer pitied him, and that he was only able to perform his work with the help of a co-worker. Yes, he argued, he was physically able to perform parts of his work, but it was only because his employer provided a supportive environment that he was able to employ his remaining capacities. And so, Meijer argued, if he were ever to be fired, there was hardly any chance he would find another job.[403] Workers like Meijer highlighted the fact that their bodily working capacity could only be of use if the employer adjusted the workplace to fit their needs, but employers could not be forced to do that. The Industrial Injuries Insurance Act demanded that employers paid insurance premiums, and the Safety Act (*Veiligheidswet*) introduced in 1895 was there to prevent accidents from happening, but there were no laws or rules that required employers to adjust the workplace to fit specific needs. In these cases, workers did not request workplaces accommodations, despite showing what a difference that would make. Instead, they simply emphasised their lack of future perspective in the specific workplace situation or the labour market in general, and demanded compensation for the loss.

Incapacity for work is inability to earn a salary

In higher appeal, workers displayed an acceptance of their exclusion from the labour market, but argued that it should be considered when assessing the reality of their working abilities. They enacted incapacity for work as an interplay between their limited physical capacity and the workplace environment, and wanted compensation for this.

It was not that the Rijksverzekeringsbank neglected the functionality of injured workers in their former job entirely, or did not want to take differences into account. In court the Rijksverzekeringsbank often stated that insurance doctors naturally rounded up their estimation in cases of minors, or were already quite generous in their estimation because of former disabilities. Here the difference in position between the worker and the Rijksverzekeringsbank played a role. While workers naturally considered their own situation, the Rijksverzekeringsbank also had a responsibility to consider the entirety of its capacity assessments under the Industrial Injuries Insurance Act. And although the legislator and the Rijksverzekeringsbank desired an application of the Act that was

402 NA, 2.09.39, CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

403 NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

based on cases, in practice this was not a very tailor-made approach but a focus instead on a somewhat standardised comparison between persons with similar injuries. When focussing on a comparison based on injuries, it was rather difficult to measure a person's former capacity and remaining working abilities, let alone the future capacities or the former future capacities. There were simply too many variables to take into account in a structured manner. Also, it was thought that too much of a personalised approach would lead to inequality in the application of the Act as well as to precedential effects. Here again we see a tension between practices to meet the wish to take individual circumstances into account and the desire to ensure equality between cases.

For disabled workers in higher appeal who focussed on their earning capacity in the context of their workplace situation, it was not the comparison between injuries that should form the basis of the calculation. Instead, a comparison between them and their non-injured colleagues would be more suitable, they considered, and more in line with the formulation of Article 22 of the Industrial Injuries Insurance Act. After all, it defined incapacity for work as a difference between former and current 'powers' and working capacities. Analysing the disparity in capacity between them and their healthy colleagues would provide a more accurate assessment of the extent of the capacity loss, workers thought, because then it was measured in relation to the specific context of their workplace.

Though the motives and practices of the Rijksverzekeringsbank and disabled workers could overlap, and interacted with each other, for instance in their emphasis on comparison and the wish to differentiate and personalise the claim examination, the two groups made up incapacity for work in different ways. In higher appeal the boundaries of what could be considered incapacity for work in the context of the Act were stretched by disabled workers, far beyond what the Rijksverzekeringsbank considered it to be.

Even though the court often disagreed with this extension of the reach of the Act, it still shows that a variety of enactments of incapacity for work were possible. The strong focus on injuries as the key indicator of the appropriate percentage of incapacity for work was in fact an outcome of an interplay in practice between the Act and its everyday application, the position, organisation and concept of tasks of the Rijksverzekeringsbank, and the insights, knowledge and professionalism of medical experts. Workers also navigated these processes and engaged with them. And while sometimes following and applying the reasoning of the Rijksverzekeringsbank, they also referred to different interpretations of the Industrial Injuries Insurance Act, and added their experiences with the workplace and the labour market.

The fact that workers analysed their own inability to work within a highly contextualised framework and emphasised their loss of earning potential demonstrates that the issue of disability as a consequence of social barriers is not a recent invention, but

had already been raised and experienced by disabled workers in this context of capacity assessment.[404] Moreover, these cases highlight the fact that rationales belonging to the medical and social models interacted and could easily overlap. Disabled workers made up incapacity for work as a relational phenomenon stemming from the mismatch between impaired bodies and inadequately accommodated, demanding or exclusionary work environments and job markets.

5 LIVING WITH DISABILITIES

So far we have seen that disabled workers encountered exclusionary barriers and production norms that removed disabled people from the labour market. When analysing what it meant to be disabled, the social model considers these exclusionary barriers as the main source of disability. As stated above, disability historians such as Rose have moreover argued that the connection between disability, incapacity for work and misery turned social security arrangements into a form of charity, while the problem of incapacity for work lay not so much in the bodies of disabled workers but in policies and ideas about productivity and functionality in the context of an industrialised workplace.[405] This was certainly the case for some workers, especially those confronted with tight schedules and high production norms. However, in the higher appeal cases, workers also addressed their feelings of pain, fatigue and frustration. They experienced incapacity for work as a daily reality, where living and working were intertwined, and where aching, tired bodies were not disconnected from exclusionary workplaces or discriminatory labour markets. They made up incapacity for work as a daily experience of a misfortunate constellation of an impaired body, an excluding workplace or labour market and frustrating claim procedures.

I view these experiences as significant in their own right, rather than merely indicating the prevalence of the medical model of disability or reflecting self-stigmatisation. This approach enables a deeper comprehension of the agency that these workers possessed in considering their lived experiences of inability to work. Such experiences encompassed not only exclusionary and discriminatory practices but also actual aching and tired bodies.

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404 This is very much in line with David Turner and Daniel Blackie's observation that self-proclaimed 'factory cripples' in the struggle for shorter working hours in British factories between 1830 and 1850 advocated a socio-cultural understanding of disability. 'The history of the factory movement challenges the presentism that characterises most portrayals of disabled people's political activism', they write. Turner and Blackie, "Disability and Political Activism", 117-140.

405 Sarah F. Rose, *No Right to be Idle*.

Daily experiences of pain, sadness and poverty

When reading workers' appeals, the desperation of some of them seems very pressing. In the 1915 case of S. Veenstra, the worker painted a rather vivid picture of his life with disabilities. He stated:

> *'Yes, I can walk with a cane, but I need it for support, and it is therefore impossible for me to do any loading work. (…) My neighbour lets me collect the remaining potatoes from his garden, but this is not a sign of ability to work, it is a sign of poverty! I had to move to [the island of] Ameland, and leave Amsterdam, because life in the city is now too expensive for me (…) I have heard of people who lost the use of their leg being declared 80% unable to work, and often, that leg had not even been amputated. An injured leg can hardly be considered worse than losing a leg. I am at least 80% unable to work as well.'*[406]

Veenstra pointed to the fact that a person who was able to walk was not necessarily able to do loading work. He could walk, but only when he used a cane, which meant he only had one arm left to lift some goods. Being able to walk was not a matter of bodily functioning alone. Similarly, having two well-functioning arms did not mean a person could automatically do work that entailed heavy lifting. Veenstra also placed his bodily functioning in the context of his poverty. The fact that he managed to collect the remaining potatoes from his neighbours' garden in itself did not provide information on how he did it. Maybe it caused a lot of pain, or maybe he could only do it on a day that he felt energetic. Maybe he needed to recover for three days afterwards. By stating that it was a sign of poverty, not a sign of capacity for work, Veenstra suggested that his functionality should not be considered an isolated thing. Being physically able to collect potatoes was only meaningful for the establishment of the level of incapacity for work when it was analysed in the context of his actual life and work.[407] Similarly, in the aforementioned case of K.D. Zalm, this barge skipper also stressed that his work could only be done on the days he was energetic enough, and when the weather was calm. He also stressed the time needed to recover from the work activities. In the search for the properties of their incapacity for work, workers like Veenstra and Zalm pointed out that medical officers could only analyse a snapshot of their working capacity. A body could function in a certain way, but in the analysis of the Rijksverzekeringsbank, these workers claimed, no account had been taken of how this affected all activities in life and how much time and energy it cost to adjust to everyday standards of time and production.

406 NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

407 NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

They moreover showed that working capacities could be highly fluctuating, depending on material objects and contexts such as mobility aids and weather effects, but also their own energy levels.

Medical officers were not ignorant of this, and they took into account some of these fluctuations. For example, weather effects on scar tissue were mentioned in the assessment of workers whose hands or fingers had been amputated. However, they only incorporated fluctuations that related to bodily recovery; fluctuations in work were of lesser importance in their statements. Medical officers observed workers every now and then, but often lacked substantial knowledge of the actual working conditions. As we have seen, they focussed on impairments, and lacked the time, knowledge and means to take fluctuations in both bodies and working conditions into account. For workers, however, it was impossible to isolate the body from the working conditions, and they could also not separate working life from other day-to-day activities. They were confronted with their working capacity on a daily basis and addressed this in their appeals.

The topic of what today would be called energy management is particularly prominent in these statements, but the workers also addressed things like sensory overload and nervousness resulting from the accident, as well as fear and anxiety about the future. In higher appeal, workers considered their exclusion from their work, but also connected incapacity for work to their deficient, tired or painful bodies. C. van der Velden, for instance, stated that he could not endure working at the dock, and neither could he stay in the porter's house for very long. He had tried to do his work from there, but after several days he had to go home because it took up all his energy. Most days, he was, moreover, feverish, which impacted even the slightest activity.[408] Similarly, in 1935, K.B. Bekker stated that every day and night he suffered great pains from his amputated arm. He therefore lacked any capacity for work and 'all his energy [was] taken up in finding a way to supplement his benefit.'[409] Also in 1935, B.N. Weijers argued that her reconstructed thumb, made from transplanted muscle tissue, was disabling her and remained very painful. Her employers had given her ample room to perform whatever work was possible for her; however, she claimed she just could not keep it up.[410]

Almost every worker stressed their pain, exhaustion or anxiousness. We could say that this was encouraged by a disability benefit system that was grounded in the medical model of disability and in ideas about charity, fuelled by pity. However, I have not analysed emotions as tactics or as a form of self-stigmatisation. Instead, my focus is on how emotions as practice interact with other practices, such as the claim assess-

408 NA, 2.09.39, CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

409 NA, 2.09.39, CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

410 NA, 2.09.39, CRvB, Inv. No. 263 uitspraaknummers 32232-33199, 1935, januari 3 – 1935, juni 26.

ment, and what incapacity for work these emotions enacted. Therefore, I observe that these expressions of pain, fatigue and frustration are connected to a claim assessment that had become rather standardised and heavily focussed on a version of incapacity for work as calculation. As we have seen in the previous chapters, the assessment was not necessarily fuelled by pity, neither was it based on a principle of charity. Medical officers were searching for ways to ensure a "fair" and "equal" application, and made up incapacity for work as a measurable calculation, as well as something that it was your civic duty to overcome. By contrast, and in reaction to these enactments, workers highlighted something that had disappeared from sight: their lives living with incapacity for work, which medical officers did not take into account when they calculated this in a formalised matter. For some disabled workers, the connection between disability, poverty and misfortune was a reality. And this material reality of incapacity for work was composed from the crowded and noisy workplace, fixed timetables and strict production norms, as well as the physical pain and exhaustion caused by their bodies.

Forms, examinations and corresponding frustrations

The fact that the daily and fluctuating experiences of pain, exhaustion and poverty were not very visible in the calculations by the doctors in the service of the Rijksverzekeringsbank could cause a lot of frustration. If a worker was injured in a workplace accident, the administration and examination practices associated with the claim assessment under the Industrial Injuries Insurance Act also became part of their lives and interacted with what it meant to be considered incapable of working. As we have seen in the previous chapter, medical experts often analysed the willingness of workers to cooperate with these practices in medical terms, and could also consider the legal proceedings part of the clinical picture of, for instance, traumatic neurosis. These experts enacted incapacity for work as a symptom of a disease, and the claim procedure of the Industrial Injuries Insurance Act as a pathogen. Workers, in turn, could also take into account the effect that the procedures had on their working capacity. This made up incapacity for work as a result of the very demanding and frustrating assessment processes and claim procedure.

There were simple or practical mistakes that could lead to a lower percentage of incapacity for work than workers or the Rijksverzekeringsbank had initially calculated, such as cases in which the claim form was not filled in correctly,[411] or appeals that were not taken into account because the postal service had lost the letter or had not used the right date for the stamp to indicate when the letter was sent.[412] There were, moreover,

411 NA, 2.09.39, CRvB, Inv. No. 151 uitspraaknummers 16016- 16874, 1925, maart 30 – 1925, december 29.

412 In each sample year there are around 100 cases where the appeal was not heard for administrative reasons, including cases where the deadline for submitting a letter of appeal was not met.

also cases in which misunderstandings had taken place. For instance, there were cases in which a worker exhibited behaviour for social reasons, but was then deemed to display conduct that did not fit with a worker experiencing severe pain. An example was the case of a worker who had continued his work after a workplace accident, even though he was in great pain, because he did not want to cause undue worry to his wife.[413] Or the example of a teenage girl who did not want to be labelled a pretender, and therefore just ignored the pain and continued performing her work in the same way, a coping mechanism that had proven beneficial for her when she endured multiple illnesses as a child. However, in the courtroom, it had to be clarified in order to build a case for receiving benefits.[414] These workers had their reasons for continuing with their work and ignoring their pain. However, due to the procedures of the Industrial Injuries Insurance Act, this effected the denial of any degree of incapacity for work and the corresponding benefits simply because they were expected to undergo an examination immediately following the accident. The workers in such cases explained the misunderstandings and emphasised that incapacity for work was not a paper reality, arguing that their experiences should be a key determining factor in the estimation as well as doctors' measurements.

Sometimes, the assessment of incapacity for work was negatively affected because workers did not adhere to the examination procedures. During the claim process, workers were required to undergo examinations whenever requested by the Rijksverzekeringsbank. Failure to comply or to appear at the designated time and location would result in the denial of any benefits as stipulated by the Industrial Injuries Insurance Act.[415] In the higher appeal cases, it becomes evident that some workers had negative experiences with the examinations and procedures, or disagreed with the methods used by medical officers. Disputes with doctors could significantly influence the estimated incapacity for work, and during the appeals, workers expressed their dissatisfaction with specific doctors, certain types of examinations, or medical opinions. Several workers explicitly refused certain forms of treatment or accused medical professionals of exacerbating their incapacity for work, while at the same time granting them reduced disability benefits. They questioned the motives or the good intentions of the Rijksverzekeringsbank, and challenged the basis of the capacity calculation.

In the 1905 case of C. van der Laan, the Rijksverzekeringsbank had decided to end his right to benefit, according to Van der Laan because he did not comply with doctor Bijleveld's proposal to amputate the top end of his right ring finger. He was, in fact, more

413 NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

414 Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

415 Article 29 of the Industrial Injuries Insurance Act 1901, article 27 of the Industrial Injuries Insurance Act 1921.

incapable of working than this doctor had claimed, and suggested he was simply being punished for not conforming.[416] Similarly, in the case of N. Schröder in 1915, he expressed criticism regarding the motives of the medical officers and, as a result, chose not to co-operate. He argued that as a consequence, he was perceived as more capable of working than he truly was. Schröder stated that:

> *'(...) if he would have been given a treatment corresponding to the impression that doctors were sincerely searching for the cause of his weak condition, he would, albeit reluctantly, have committed himself to examination in an institution; he would be happy to submit himself to an examination that would lead to recovery from his affected state of health.'*[417]

Likewise, in the case of Schouten in 1925, the worker refused to comply with the request to undergo examination at a psychiatric ward and specifically expressed his unwillingness to be examined by a certain medical doctor Rombouts. These workers expressed their disagreement with the examination methods and asked that the 'biased', 'unfair' or 'unsocial' claim assessment be taken into account. For while some medical officers calculated a worker's capacities based on expected future capabilities, and incorporated the effects that certain forms of surgery or therapy would have on the bodies, these workers stressed that they were then punished when they did not comply. After all, they could not be forced to undergo surgery or therapy. In stressing the unfairness or unlawfulness of the calculation, these workers claimed that their working capacity was a present reality, a phenomenon in the here and now. It should not be based on a theoretical forecast, let alone serve as a punishment for non-cooperation. Here we see how workers rejected the enactment of incapacity for work as something to be overcome, and made up present incapacity for work as the basis of a right to benefit.

Especially in the appeal letters in the last years of the application of the Act, workers openly criticised the modus operandi of the Rijksverzekeringsbank, and sometimes expressed frustration and anger. For example, E.K. van Dijk wrote that both the local council of appeal and the Rijksverzekeringsbank had asserted that he would not experience any disadvantages due to his injuries in his current employment. He argued:

416 NA, 2.09.39, CRvB, Inv. No. 129 Uitspraaknummers 487-980, 1905, januari 3-1905, december 22.

417 'Wanneer hem een behandeling was ten deel gevallen waaruit hy had kunnen opmerken dat de doktoren ernstig zochten naar de oorzaak van zyn zwakken toestand, hy zich over den tegenzin om in een inrichting onderzocht te worden wel had heengezet; dat hij nog gaarne bereid is zich aan een onderzoek te onderwerpen dat strekken kan tot herstel van zyn geschokte gezondheid.' NA, 2.09.39, CRvB, Inv. No. 139 Uitspraaknummers 7729-8592, 1915, januari 5-1915, december 30.

'But gentlemen, it's not about the position here, but about my handicap. When I asked whether I could still appeal if I changed jobs, they said yes, but to me, this seems like a system where one issue is simply replaced by another. Apparently, the Council is completely unaware of the fatigue that my disability causes me.'[418]

Van Dijk firmly opposed the way the Rijksverzekeringsbank analysed his incapacity for work and blamed the council of appeal for not taking his situation seriously. In the appeal letter of M. van der Graaf, the tone was less restrained. He wrote sarcastically that he was 'very pleased' to hear that:

'Here in our socialist and democratic Netherlands, it is a triumph that an institution such as the Social Rijksverzekeringsbank, which collects 100% of the premiums from all workers every week, is granted the right by a Council of Appeals to withhold benefits from an injured worker when the doctors messes up and the patient may never be able to work in their profession again. In order to protect their reputation, and helped by the Rijksverzekeringsbank, the doctors try everything, whether it works or not, to get the patient back to work and withhold benefits from him. This results in the poor wretch, the unfortunate patient, being moved from one employer to another because he is unable to meet the demands of any job. Because he is not even able to do a fraction of the work, which is the case in my situation, and so his family is robbed. The undersigned [Van der Graaf] has been studying the laws for 12 years, and finds it strange that a body like the Council of Appeal only considers the interest of the non-payer and ignores the patient for whom this whole system was created, and neglects his protest, which is justified in this case, given that the various doctors do not deny the problem.'[419]

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418 'Maar mijne heren het gaat hier toch niet om de functie maar om mijn handicap. Wanneer ik van betrekking mocht veranderen, zo zei men op mijn vraag, kon ik alsnog weer in beroep komen, maar dit is volgens mij een aanschuifsysteem. De Raad is er blijkbaar totaal niet van doordrongen welke vermoeidheden deze handicap mij bezorgen.' Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

419 'Hier in ons socialistische democratische Nederland zegeviert een instelling als de Sociale Rijks verzekeringsbank, die met de 100% premie elke week van alle arbeiders opstrijkt, het recht krijgt van een Raad van beroep om wanneer zulk een arbeider het ongeluk heeft een kwetsuur op te lopen met zijn werk, en de artsen verknoeien de boel, zodat zo'n patiënt misschien nooit zijn vak meer kan oefenen. De artsen om hun goeden naam te redden met de Rijksverzekeringsbank alles proberen of het gaat of niet gaat aan het werk te krijgen, zijn uitkeringen in te houden. Brengt dit dan de stumperd, zo'n patiënt van de ene werkgever naar de andere omdat hij nergens meer kan voldoen. Omdat hij nog niet half in staat is of enig ander goed werk te leveren, hetgeen nu met mij eveneens het geval is, waardoor zijn gezin wordt bestolen. Ondergetekende heeft zelf ongeveer 12 jaar de wetten gestudeerd en vindt het vreemd dat een

Van der Graaf stated that there was nothing more he could do other than protest against the 'unsocial' decisions of the Rijksverzekeringsbank, which he furthermore called 'unlawful and cruel'. He added that he was not counting on a fair process anyway, 'but as a Dutch labourer I will always resist everything and everyone whose acts are unfair and not socialist, although I realise that, at the moment, this is fighting a losing battle.'[420]

Van der Graaf was by no means the only worker who claimed that the analysis of their incapacity for work was unfair or unsocial. J.M. de Vries, for instance, stated in his 1966 appeal letter that he had found that 'even in a democratic and social country, strange things could still happen.' He stated that while the newspapers reported that everything was getting more and more expensive, his benefit was reduced from 12.58 guilders per day to 11.01 guilders per day. 'I'm baffled', he argued, and added: 'well, that is democratic and social. I did not ask to become ill and have an accident.'[421]

Neither Van der Graaf nor de Vries asked for pity. Instead they made a case to take the individual consequences into account, and compensate for the pain or poverty they were confronted with. Van der Graaf moreover emphasised that he paid a substantial amount of money for his insurance, making disability benefit not a charitable system or a pathogen, but a right to which he was entitled. The narrative of disability benefit legislation was that the collective would take care of the individual. In the practice of claim examination, however, this turned into a process in which individuals were regarded with distrust and had to prove their incapacity for work while at the same time commit to rehabilitation practices and adjustment. These workers stated that they were at their wit's end and expressed frustration over their treatment and claim procedure. They stressed their highly frustrating experiences with the claim assessment, and made up incapacity for work as something that was not a paper or clinical reality but a lived experience.

Making up incapacity for work in experiences of pain, fatigue and frustration

Everyday experiences with incapacity for work formed the foundation of every worker's appeal in higher court. Whereas medical officers kept focussing on bodily injuries and

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lichaam als de Raad van Beroep alleen de belangen van de niet-betaler bestudeert en de patiënt waar toch dit hele stelsel voor in het leven geroepen is, negeert en zijn protesten die in dit geval toch gegrond zijn gezien hetgeen de verschillende artsen toch niet geheel ontkennen, over het hoofd ziet.' Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

420 'Op een eerlijke beslissing rechtswege de Raad van Beroep behoef ik niet te rekenen, maar als Nederlandse arbeider zal ik mij blijven verzetten tegen alles en iedereen die oneerlijk en onsocialistische handelt ook al weet ik dat dit op 't ogenblik vechten tegen de bierkaai is.' Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

421 'Ja, dat is democratisch en sociaal. Ik heb om die ziekte en ongeval toch niet gevraagd?'. Archive in possession of the Central Council of Appeal Utrecht, accessed with permission.

measured working capacities in comparison to other disabled persons, these workers stressed that for them, incapacity for work was not just about their bodily functioning, or the exclusionary barriers of the workplace. It was also about the pain and exhaustion, worries about money, anxiety about the future, and frustration with the assessments and the claim procedure. This focus on everyday experiences is eminent in the workers' appeals, yet remarkably absent in the statements of the Rijksverzekeringsbank. This could have to do with the fact that these experiences were difficult to measure and compare. As a consequence of the focus on rehabilitation, especially from the 1920s on, insurance doctors began to emphasise what workers could still do. This was supposed to encourage them to make adjustments and persuade them engage with their own recovery. It was a context of rehabilitation demanded by the 1921 Industrial Injuries Insurance Act and the Rijksverzekeringsbank, but this made up incapacity for work as something to overcome, a future or coerced reality. By contrast, in these appeals workers emphasised what they could not do anymore, enacting incapacity for work as the result of a deficient, aching body in a demanding day-to-day life, which included the claim assessment and the appeal procedure.

6 CONCLUSION: MISFORTUNE AS GROUNDS FOR BENEFIT?

As Sarah F. Rose and others have rightfully pointed out, disabled workers encountered all kinds of exclusionary barriers and production norms that removed disabled people from the industrialised workplace. For some workers, especially those confronted with tight schedules and high production norms, this was how they enacted incapacity for work: as a problem with non-adjusted workplaces and labour markets. However, many workers in the higher appeal cases also addressed their personal experiences of pain, fatigue and frustration.

By analysing these experiences as practices, their constituting effects become clear, as does the way in which they shaped incapacity for work in higher appeal cases. I conclude that workers produced incapacity for work as a daily reality in which living and working were intertwined, and where aching, tired bodies were not disconnected from exclusionary workplaces or discriminatory labour markets, but in fact, constituted each other. Whereas medical officers enacted incapacity for work as a calculation based on the measurement of the functioning of the injured body part, or enacted incapacity for work as the symptom of a disease, workers stressed that their incapacity for work was not an isolated thing, but a daily reality. These experiences were related to impaired bodies, but also to exclusionary barriers and discriminating attitudes, as well as 'unfair' or 'unsocial' claim procedures. Workers emphasised what they could not do anymore,

enacting incapacity for work as the result of a lacking, aching body in a demanding and highly disrupted day-to-day life.

Although I have analysed the statements of workers as producing three distinct enactments of incapacity for work, there is much overlap between them. A focus on incapacity for work as bodily functioning in the context of required tasks related to specific work often came with a request for the hearing of the statements of different experts, or more particularly, the claim of a worker's own expertise. Similarly, the fact that the Rijksverzekeringsbank did not take into account daily fluctuations in energy and workload could give rise to frustrations about the neglect of day-to-day experiences of exhaustion or pain, making other enactments of incapacity for work 'unlawful' or 'unfair'. These enactments were, closely connected to enactments of incapacity for work as deriving from the statements and practices of the Rijksverzekeringsbank. For while workers and the Rijksverzekeringsbank were opposing parties in court, in their testimonies they engaged in a shared conversation about what was true about incapacity for work, often pointing to similar grounds for vindication. It was a difference in their interests, position and responsibilities that led to different enactments, for while workers and the Rijksverzekeringsbank navigated a system of ideas and explanations to substantiate their claim, in their appeals workers tried to slightly change the analysis or add their personal experiences, negotiating what should be taken into account when measuring working capacities.

It is especially in these personal experiences with incapacity for work that workers stressed their miserable or misfortunate state of being. The nature of this misfortune was layered and consisted of physical pain and exhaustion (and their fluctuations), as well as discrimination and exclusion from the workplace. It could sometimes also include frustration over the fact that this was not taken sufficiently into account in the assessment of incapacity for work by the Rijksverzekeringsbank. The statements of workers who lodged an appeal against the decision of the Rijksverzekeringsbank are very difficult to understand in terms of a medical-social model dichotomy, for while they sometimes perpetuated the notion of incapacity for work as a miserable state of being closely connected to the individual experiences of pain and exhaustion tied to their injured bodies, they also identified exclusionary mechanisms in the workplace, and defined the limits of their capacities to change or adapt. As Scott has shown, experiences are situated. I add that they are practices and do not form a fixed identity. And thus, disabled workers stressed that there was a connection between injured or deficient bodies and incapacity for work, and by doing so they described themselves as victims of the accident. This was not the type of victimhood that was used as an identity or a tactic to generate empathy, although it sometimes would; instead they stressed the eligibility of their proposed properties of incapacity for work.

These appeals by workers show how the search for the true properties of incapacity for work built on intensive interactions between the Industrial Injuries Insurance Act, the Rijksverzekeringsbank, medical experts and disabled workers. As workers navigated a system of practices and ideas that was informed by what disability studies have identified as the medical model of disability, disabled workers placed their experiences at the forefront. They demonstrated agency, and simultaneously expanded the enactment of incapacity for work with a focus on exclusionary barriers in the workplace. Their enactments included frustrating examinations and misapprehension, as well as fluctuations in energy and work, painful and exhausted bodies, and exclusion and discrimination in the workplace. Moreover, all these aspects were considered in a variety of measures.

When shifting the focus from the social construction of disability to a perspective centred on daily practices and experiences, there is room to see that for workers, incapacity for work, a deficient body and misfortune could be connected, as an experience that intersected with exclusionary barriers for which they demanded acknowledgement and compensation.

Conclusion

Disability benefit arrangements require a category of intended beneficiaries, and it is often assumed that such categories are natural entities, with a fixed set of characteristics. Incapacity for work is such a category. It is considered the result of an impaired body or a troubled mind, and benefits are intended to support those who are incapable of performing labour. This is why histories of welfare states usually focus on why societies started to take care of 'individual misfortune', or provide comparative analyses of the development of different types of welfare structures. They do not question the category of incapacity for work itself. Scholars and activists in disability studies, however, have criticised this notion of disability as individual misfortune, arguing that incapacity for work is not the result of a dysfunctional body but a cultural construct, the product of industrialisation and capitalism, which made workplaces unsuitable for the diversity of ways in which people work.

This dissertation has shown that incapacity for work existed as real in the context of the Dutch Industrial Injuries Insurance Act (1901-1967). As such it can be understood alongside the development of welfare arrangements, medicalisation and experiences of disability, and despite the contested nature of incapacity for work. It was measured, quantified and experienced by three groups of actors, namely government officials, independent medical experts and disabled workers. It was not a singular, definite natural or cultural category. Incapacity for work was adhered to in many ways and had multiple different realities. As Ian Hacking and other scholars in science and technology studies have argued, classifications of human kinds do not possess fixed properties; rather, investigations prompt a constant modification or adjustment of characteristics through which the classifications are brought into being.[422] My aim, therefore, was not to join the historical actors in their search for the true properties of incapacity, but to unpack how they brought these realities into being. While the law aimed to compensate the intended beneficiaries, the medico-legal practice brought into being the very category of persons incapable of working. Incapacity for work was, to use Hacking's wording, 'made up'. I have similarly embraced the work of Annemarie Mol, who has argued that categories find their existence in situated practices and result from interactions between the actors involved. Categories are not discovered, they are *enacted*.[423] Using this so-called praxiography as a tool, I have explored enactments of incapacity for work in the specific medico-legal context of higher appeal cases concerning the Industrial Injuries Insurance Act. Like Geertje Mak, I have analysed historically the making up of categories. Mak has shown how doctors and patients together settled doubted sex in a clinical setting.[424] With this

422 Hacking, *Historical Ontology*. Hacking, "Making up people", 23-26.

423 Mol, *The Body Multiple*.

424 Mak, *Doubting Sex*.

dissertation I have applied Mak's historical praxiography to a new medico-legal context in which the managing of doubt was done in the context of legal rationales and financial stakes. And while historians of the body and forensic knowledge have mainly focussed on the role of experts and the use of medical labels in criminal law, this is one of the first studies to take as its context the medico-legal practices of social security law.[425]

In higher appeal cases, workers or government officials had lodged an appeal against the decision of a lower court setting the worker's incapacity for work at a certain percentage. In these cases, the search for the properties of incapacity for work was central, as a worker's capacity for work had to be determined. I have studied the Act that provided the framework in which this issue had to be settled, but my focus has been on the complex interactions that derived from this legal arrangement. In court, three parties were heard: the government officials charged with implementing the Act, the physicians who testified as to the nature and veracity of the workers' bodily functions, and the individuals who applied for benefits and whose capacities were under review. Each of these actors in the making up of incapacity for work came with their own values, rationales, knowledge, interests and stakes, which sometimes conflicted but could also influence each other. They sought to solve legal problems with medical knowledge, and individual functions and behaviour were measured in order to ensure equal application of the law. Over time, the Act underwent significant reform, which not only broadened its legal scope but, as I have shown, also affected assessment techniques, ideas about rehabilitation, and experiences of incapacity for work. In short, each actor navigated their own search for the properties of incapacity for work, resulting in a variety of different enactments. This unpacking of the making up of incapacity for work and my focus on practices has resulted in a new understanding of how welfare arrangements work. It provides insights into the relationship between citizenship, health and individual capability, as well as into the intricate process of medicalisation and complex experiences of disability. In keeping with the structure of this dissertation, I will address these findings separately for each of the actors involved.

I LINKING BODILY FUNCTION AND CITIZENSHIP: CAPACITY FOR WORK AS CIVIC DUTY

With the introduction of the Industrial Injuries Insurance Act in 1901 a new government organisation, the *Rijksverzekeringsbank*, was set up, and was staffed with medically trained government officials who were charged with assessing claims. These medical

425 See for instance: Ruberg, "Hysteria as Shape-Shifting Forensic Psychiatrist Diagnosis", 1-17.

officers, as they were called, sought to take account of the specificities of each case, while at the same time maintaining the legal principle of equal application. In line with rationales embedded in their medical training, they sought to find the properties of incapacity for work mainly in the body; in the dysfunction of an isolated injured part of the body, in the measurement of, for example, joint flexion or grip strength, in the standardisation of examination procedures, and in the grouping and comparison of workers with similar injuries. Prompted by the Act, these measurements were quantified, which led both medical officers and disabled workers to consider incapacity for work as a specific percentage.

The practice of isolating, measuring, comparing and quantifying the functionality of injured body parts stemmed from medical training, and also functioned as a way of objectifying the assessment of claims, in order to prevent or detect possible fraudulent expressions of pain or impairment. In their assessment, the morality of the worker was always under scrutiny, and a suspicion of workers was cultivated and acted upon; this was a practice. Concerns about undeserving workers benefiting from the welfare system were already enshrined in the law itself, which decided that in the case of total incapacity for work, the benefit would not be the equivalent of the full wage, but 70% of the last daily wage earned. Medical officers constantly assessed the sincerity of the complainants to ensure that the workers in these cases were truly deserving. With the extension of the law in 1921 and the availability of rehabilitation therapy, the Rijksverzekeringsbank began to see incapacity for work as a 'social question'. Medical officers focussed on the individual's responsibility to do their best and adapt to their disability. This can be understood in terms of class differences and seems to be rooted in an image of working-class people essentially being lazy. Medical officers went to great lengths to emphasise the mental health benefits of a working life, approaching workers as if they needed to be persuaded to see it as such. By emphasising the idea that work brings happiness and improves the wellbeing and health of the worker, medical officers isolated the ability to work and made it into an individual issue. Incorporating the use of rehabilitation techniques, which became more widely available after World War I, medical officers calculated a timeline, measured and shaped a future capacity for work and in the process linked up individual functionality and capacity not just to employment but also to citizenship, making up working capacity as a civic duty.

I conclude that a dichotomy between deserving, hard-working people and undeserving, lazy profiteers has not only been a rather persistent narrative in capability assessments, but has actually functioned as a practice that has shaped the making up of the category itself. Medical officers put much effort into channelling suspicion, working around it or getting ahead of it, adapting the techniques used, reinterpreting the measures, and changing the properties of incapacity for work. Moreover, with the

extension of the law and the availability of new medical techniques and instruments to rehabilitate and readjust the workers' bodies, incapacity for work changed shape from a description of a current incapacity to a prediction of a future incapacity for work, which could now also result from an unwillingness to overcome one's disability. Concerns about fraud were not just a perspective outside the capacity assessment, but interacted with medical rationale, the availability of rehabilitation techniques and legal reform, and thus had a constitutive force. By revealing this making up of capacity for work as civic duty, this dissertation has shown that from the introduction of the first welfare arrangement in the Netherlands on, the individual's health and capacity for work moved out of the realm of the employer-employee relationship and into a citizen-state affair. While others have claimed that this was a process that occurred in most European countries after either the First or the Second World War, and is often linked to an increase in the number of war-disabled, my study of the Dutch context has shown that in this instance it resulted mainly from an interaction between an inherent suspicion of those claiming benefits, the employment of medically trained government officials and an incapacity for work that was detached from the workplace. With this, I complicate the chronology as espoused by other historians.

My dissertation exemplifies the fact that the welfare state brought about all kinds of new socio-material realities into being. Welfare arrangements are usually studied by socio-economic and political historians, and have been approached by sociologists in terms of broader processes. In line with what Pertti Haapala, Minna Harjula and Heikki Kokko have introduced as 'the lived welfare state', I consider a focus on day-to-day experiences a valuable advancement of welfare studies.[426] The notion of the lived welfare state brings to the fore how welfare societies not only functioned through institutions, laws and arrangements, but also have cultural implications and are experienced by recipients of welfare. In line with the outcome of my dissertation, I propose to go beyond the social construction of experiences of welfare arrangements, and focus on how these arrangements brought new categories into being. I have shown how all kinds of rationales, values and ideas were negotiated. A bottom-up focus on the interactions reveals the messiness of broader processes like the implementation of welfare arrangements in day-to-day practices, and also stresses the way categories such as 'the sick' or 'the poor' are not just social constructions, but are made up as real categories.

426 Pertti Haapala, Minna Harjula and Heikki Kokko, "Introduction", in: Pertti Haapala, Minna Harjula and Heikki Kokko (eds.) *Experiencing Society and the Lived Welfare State* (London: Palgrave McMillan 2023) 1-13, Heikki Kokko and Minna Harjula, "Social History of Experiences: A Theoretical- Methodological Approach", in: Pertti Haapala, Minna Harjula and Heikki Kokko (eds.) *Experiencing Society and the Lived Welfare State* (London: Palgrave McMillan 2023) 17-40.

As the analysis of the statements of medical officers has shown, all such practices, moreover, have histories of their own. It was beyond the scope and purpose of this dissertation to analyse each rationale or value in detail, if only because all of these practices are the product of interactions with other rationales and values and actors. This is also a result of my use of praxiography as method. My focus has been on the making up of incapacity for work, which left out enactments of other categories that would deserve their own study. In the further expanding of lived histories of the welfare, the study of enactments of work could be very relevant. For example, the rationale of work as a meaningful and health-advancing part of life would be an interesting starting point. Especially in the context of the current labour shortages, concerns about precarity, neo-liberalism and migration and in relation to rationales about care and leisure, a praxiographic analysis of work would inform the ways in which work has taken shape in twentieth-century welfare states. In addition, it is important to note that my study of incapacity for work has uncovered how it is brought into being, but as is the case with praxiographic analyses, it does not offer prescriptions for how enactments should be made. Although this study does not provide direct answers as to what policies are desirable or just, it can be a starting point for further reflection on how this insight can be used to inform future policy. This is an ongoing and political reflection that deserves further inquiry.

II MEDICALISATION IN PRACTICE: INCAPACITY FOR WORK AS ILLNESS

While the medical officers of the Rijksverzekeringsbank approached the disabled workers as citizens, the medical experts consulted in court turned disabled workers into patients. By using praxiography and focussing on the making up of incapacity for work in the legal testimonies of medical experts, I have come to the conclusion that medicalisation was a process that took place through a constant navigation of the medical and legal domains. In this process not only was incapacity for work made up, but medical labels were also brought into being.

In higher appeal cases, a legal dispute over the veracity and severity of incapacity for work had to be solved, and medical experts were called in to settle the issue. Like the officers of the Rijksverzekeringsbank, medical experts were doctors by training, but unlike the medical officers they worked in a clinical or a medical-scientific profession. In court they were drawn from the consultation room to give unbiased, knowledge-informed testimonies. In this dissertation, I have shown that these experts had to constantly move between a medical and a legal domain, while dealing with domain-specific problems and rationales. Thus, expert testimonies were not the result of a linear process, of experts

providing their expert point of view on the issue. Instead, this was a rather messy and circular process in which doubts had to be mediated and medical knowledge had to be made fit for court. A medico-legal liminal space emerged in which legal questions were answered in medical terms, and legal terms also determined medical knowledge.

In cases of traumatic neurosis, this new medical label was used to describe pain and impairment that could not be located in the body. Behaviours and complaints that medical officers had regarded as unwillingness to work were analysed by medical experts (often psychiatrists) as a symptom of an illness instead. The diagnostic process was used to manage doubt, and traumatic neurosis, while constantly changing shape, became a means of transferring incapacity for work from the domain of medicine to the domain of the Industrial Injuries Insurance Act. Medical experts transferred incapacity for work back into the domain of medicine by suggesting a reduction in benefits as a form of therapy. They saw the law and the claim procedure as a pathogen itself that made workers fixated on their pain and impairment.

Like traumatic neurosis, silicosis emerged as a new disease that changed shape in the context of the higher appeal cases and was used to describe workers' incapacity for work. Silicosis was a lung disease that workers often developed during mining work. The medical label was added to the list of occupational diseases covered by the Industrial Injuries Insurance Act in 1938, and so the Act already merged the legal and medical context for this disease. Although silicosis could be located in the body, the results from the techniques used could also point to diseases such as tuberculosis, which was not covered by the Act. Here, again, doubt had to be managed, and the legal question was settled with the use of medical diagnostics. In the diagnostic procedure the incapacity for work was taken into account as a sign of the disease, so while expert witnesses had to establish that a person was incapable of working due to silicosis, silicosis could only be established if there was incapacity for work. The diagnostic procedure was entangled with the assessment of a miner's ability to perform labour.

Physicians' knowledge and expertise were formed and applied in a medical context, but had to be changed and adapted to be suitable for statements about a worker's capacity for work. To this end, incapacity for work was made up as a symptom or the result of illness. This could be understood in terms of medicalisation, medical reasoning intruding realm of policy, but my analysis of the intricacies of the formation of the experts' statements has shown that this was not a top-down or linear process of doctors gaining the position of gatekeeper and providing medical answers to social or legal questions. In the process, new medical knowledge emerged in interaction with rationales provided by the Act, and medical labels were brought into being.

My focus on practices has helped to bring to the fore the ways in which medical knowledge was used and applied in the context of social security law. I believe we can only fully

understand why and how doctors have been, and still are, placed in expert positions if we move beyond the consultation room, as many scholars have already done, and trace more diverse spaces in which medical knowledge was employed to settle social, economic or political questions. In particular because although medical history has shaken off its "great doctors" approach for the most part and focussed on the social history of medicine, there is still a tendency to regard persons who are on the receiving end of the doctor-patient relationship as 'sufferers' in need of a 'cure'. As Catherine Kudlick has argued, this is in conflict with disability history, which is inherently rooted in 'a need to challenge the prevailing assumptions about disability, and the importance of granting people with disabilities historical agency.'[427] So while medical historians have usually studied the treatment in the past of disabled or sick persons, disability historians have studied how disability as such became identified as a medical problem. With this dissertation I aimed to bring the fields of medical history and disability history closer to each other. My practice-focussed analysis has brought to light the ways in which medical labels were enacted in relation to the requirements of the legal domain of the Act. This is the result of a complex interaction between the various values, rationales and stakes, in which both doctors and disabled workers participated. I have highlighted the fact that incapacity for work and medical labels were neither natural entities nor cultural constructs, but emerged in practices and through interaction. Especially since there is a shared aim within medical history to include more histories from below, praxiography and the making up of medical labels could be an excellent starting point for medical historians to further explore the intricacies of medical categorisations and become informed by disability theory.

III SITUATED EXPERIENCES OF INCAPACITY FOR WORK

For disabled workers the stakes were very high. Being denied benefit could mean they had to spend their lives in poverty. In court, they stressed their individual experiences of not being able to work. I conclude that by focussing on negative embodied experiences such as pain, fatigue and frustration, while placing these experiences in the context of non-adaptive workplaces and labour markets, disabled workers enacted incapacity for work as a daily reality.

427 Catherine Kudlick, "Comment: On the Borderland of Medical and Disability History", *Bulletin of the History of Medicine* 87.4 (2013) 540-559.

In this dissertation I have demonstrated that all the parties involved in the higher appeal cases had to navigate rules, values and doubt. They made up incapacity for work not in a vacuum, but in interaction with the Act, as well as the situated rationales, values, stakes and practices of the other actors involved. This makes it even more striking that in the higher appeal cases, the percentage based on medical assessment and calculated by medical experts was often accepted by the court, and in most cases the ruling was in favour of the Rijksverzekeringsbank (appendix I, table 2). Although all parties shared a search for the properties of incapacity for work, there was a clear hierarchy. This, however, did not mean that disabled workers were passive victims of the claim assessment and the higher appeal. They did not silently accept this hierarchy; they participated in the making up of incapacity for work. Through using a praxiographic approach, by focussing on the diverse ways in which workers enacted incapacity for work, I was able to highlight the space occupied by disabled workers in the claim procedure and the room for manoeuvre they utilised.

Workers engaged with rationales of incapacity for work as bodily function and comparison, and adhered to the topic of expertise. In their statements, disabled workers used medical evidence and engaged in medical debates about their bodily functioning, but then added their own experiences of that dysfunction and related it to the context of their workplace. Like medical officers and medical experts, they compared themselves with others, but not with workers with similar injuries but with their able-bodied colleagues instead. They also sought to identify the properties of incapacity for work in the labour market where they had lost productivity. This labour market sometimes explicitly excluded them and made it impossible for them to earn a salary. Finally, and most importantly, they analysed their pain, fatigue and frustration as an integral part of living with disabilities and made up working capacity as something that could not be compartmentalised or isolated, but was, in fact, an experience in which everyday life, the claim procedure and work were intertwined. In doing so, they sometimes reinforced the making up of incapacity for work as bodily function, as a quantifiable phenomenon, as a civic duty or as an illness. By emphasising that capacity for work was situated in and required support from an accommodating work environment, they used their position to bring forward their experiences with incapacity for work in day-to-day life. This was not necessarily a counter perspective, but rather an adaptation of the rationales used by medical officers and medical experts. In the process, they stretched the boundaries of what incapacity for work could entail.

Through the statements of disabled workers, I discovered that although employers were absent in court, they were actors in workers' making up of incapacity for work. While medical officers and medical experts focussed on workers' dysfunction, their willingness to rehabilitate, their civic duty to cooperate and adapt themselves to new ways

of functioning or to retrain to perform a different occupation, workers highlighted the limited room they had to function or to rehabilitate in a working environment that was not accommodating. By pointing out the context in which they had to regain their capacities, they revealed what remained obscured in the statements of medical officers and medical experts, namely that although employers were hardly involved in the claim procedure, they formed part of the context in which incapacity for work took shape. So while the medical officers in the service of the Rijksverzekeringsbank focussed on individual bodily functions, enacting incapacity for work as civic duty, these workers brought the search for the properties of incapacity for work back into the realm of the employer-employee relationship.

My practice-focussed analysis of workers' statements has, moreover, revealed that disabled workers enacted incapacity for work as a lived experience that was not a matter of bodily dysfunction alone, but was tied to the specific context of the workplace, the labour market and their day-to-day lives. I conclude that this enactment is very similar to what disability studies and activists have called the social model of disability, in which disability is the result of social barriers and excluding environments. This shows that considering incapacity for work as a social matter is not a recent invention, but was already a lived experience and a practice of disabled workers in these higher appeal cases. In their aim to deconstruct disability as a matter of individual misfortune, disability scholars have stressed the politics and ideas of productivity and functionality in the context of an industrialised or capitalist workplace, but have demonstrated unease with the aching and injured or tired body. In higher appeal cases, disabled workers considered themselves incapacitated by tight schedules and high production norms, as well as discriminating tendencies of the labour market, but always in relation with their painful and tired bodies. By studying workers' expressions of pain, fatigue and frustration as practices, I have highlighted their constitutive effects. I conclude that disabled workers enacted incapacity for work as a daily reality in which living and working were intertwined, and where aching, tired bodies were not disconnected from exclusionary workplaces or discriminatory labour markets, but in fact constituted each other. Workers emphasised what they could no longer do, enacting incapacity for work as the result of a lacking, aching body in a demanding and highly disrupted day-to-day life.

Through this research, I have aimed to highlight historical forms of what I consider disability activism. Disabled workers did not simply resist any individual responsibility or a medical enactment of incapacity for work, but in interaction, navigation and negotiation with the techniques, rationales and values of government officials and doctors they brought forward incapacity for work as a situated experience. I have shown that through the higher appeals, disabled workers have, from the introduction of the first form of social security in the Netherlands on, advocated for a situated understanding of incapacity

for work. This enactment brought together impaired bodies and disabling barriers and attitudes, and saw incapacity for work not just as an individual problem but as a social and situated phenomenon. It adds to David Turner and Daniel Blackie's thesis that the important work of disability rights activists has a history that goes back far beyond the 1970s and the disability rights movement that originated in that decade. When analysing the histories of disabled persons, I propose that we should not just look for organised forms of resistance. In the face of the difficulties of finding sources on persons not represented in the archives, this dissertation has shown that the use of legal documents provides new perspectives on the ways in which disabled workers participated in society and how they experienced living and working in the past. Their advocacy was a form of finding agency in the shaping of categories.

IV CATEGORIES ARE MADE IN THE PRACTICES OF WELFARE ARRANGEMENTS

When it comes to the fair and equitable application of disability benefit legislation, the current political tendency is to simply ensure that the right people get the benefits. The focus is often on streamlining the procedure, involving yet another group of knowledgeable, impartial experts, or reducing benefits to a subsistence level to prevent fraudulent claims. My study has revealed that each assessment required mediation, navigation and negotiation of different rules, values and stakes. Each actor had to manage doubt and employed their own rationales and techniques, and did so in interaction with the other actors involved. In the process, the properties of incapacity for work were changed and modified. This dissertation has shown that there is no such thing as the pre-existing category of people who are incapable for work; instead, this category is made in the process of claim assessment.

This once again demonstrates that the study of disability history is not a niche topic, nor another "other" to be added to the intersection of identities.[428] I have aimed to enrich insights from disability studies and activism with theory from science and technology studies, and I have applied this to subject matter that is usually studied in the realm of socio-economic or political studies. In doing so, I have provided a fresh perspective on the ways in which categories gain shape and how this is connected to the linking of health and capacity to citizenship, the intricacies of medicalisation, and

428 As Catherine Kudlick has already argued in her famous article in *American Historical Review*. Catherine Kudlick, "Disability History: Why We Need Another "Other"", *The American Historical Review*, 108.3 (2003) 763–793.

the way in which the socio-material context of the workplace, for which employers were hardly held responsible, was excluded. I have aimed to depict how such abstract topics had effects and were experienced in day-to-day life. This is a practice that concerns all of us. Not just because the stories of workers who were injured in accidents remind us of the fact that, in the words of the disability rights activist Judy Heumann, 'disability is a family you can join at any point in your life.'[429] Through studying disability history with a focus on practices, we can further explore how societies work and how individuals are shaped. Disability scholars are right in pointing out that incapacity for work is not a matter of states taking care of misfortunate individuals. But, I conclude, incapacity for work is not just a social category either: it is enacted in situated practices, and it has material consequences.

This conclusion has far-reaching implications for the ways in which welfare provision should be regarded. It is much more than the allocation of money: it establishes categories that come with all sorts of socio-material realities, and shapes the way we look at ourselves and others. By acknowledging that people who are incapable for work are made up in the process, we can further explore the hierarchical dynamics at work, how the stories and perspectives of the actors involved are valued and whether they are taken seriously, and what rationales and preconceptions about those applying for benefit inform examination practices. We can reflect on how to *remake* the category of incapacity for work in such a way that it enhances the quality of life for disabled workers and leads to resilient and equitable welfare societies.

429 Judy Heumann, "Our Fight for Disability Rights - and Why We're Not Done Yet", Filmed October 2016 in Washington, United States. TED Video, 21:15, www.youtube.com/watch?v=ABFpTRlJUuc&embeds_referring_euri=https%3A%2F%2Ftedxmidatlantic.com%2F&source_ve_path=MjM4NTE&feature=emb_title (last accessed 22 August 2023).

Appendices

APPENDIX I

Table 1. Number of higher appeal cases per sample year

Year	Total number	Concerning incapacity for work	Mentioning amputation	Mentioning traumatic neurosis	Mentioning silicosis
1905	459	276	15	12	0
1915	863	467	36	13	0
1925	858	638	16	9	0
1935	1547	1321	61	14	0
1945	219	107	8	2	0
1955	287	243	16	4	110
1965	103	72	3	5	10

Table 2. Number of appeals and outcome, divided by party

Year	Appeal by Bank	Appeal by worker	Verdict in favour of Bank	Verdict in favour of worker
1905	192	84	150	112
1915	158	309	315	152
1925	162	474	469	165
1935	249	1072	1096	225
1945	22	85	79	28
1955	58	185	192	51
1965	19	53	63	11

Table 3. Incapacity for work put into percentages, per worker mentioned

Name	Worker	Bank	Court
Baarsma	15	0	0
Bakker	20	10	20
Balen, van	30	20	20
Bekker	100	60	60
Berg, van den	15	10	10
Beukers	10	0	0
Beveren, van	More than 20	20	20
Biets	100	50	50
Blom	100	50	50
Bos	No percentage	0	0
Bosma	60	40	40
Born, van der	More than 25	25	25
Bravenboer	No percentage	25	25

Table 3. Incapacity for work put into percentages, per worker mentioned *(continued)*

Name	Worker	Bank	Court
Broer	100	75	75
Dijk, van	40	25	40
Douma	20	0	15
Driessen	More than 50	50	50
Duijf	75	25	50
Duits	70	60	60
Gent, van	80	0	0
Goede, de	35	25	35
Goossens	More than 15	15	15
Harmsen	40	35	40
Heuvel, van den	75	50	50
Jacobs	100	0	Retrial
Janssen	10	0	0
Kersbergen	80 to 90	10	15
Kleine	20	10	10
Korporaal	100	0	0
Kuijpers	100	35	50
Laan, van der	10	0	0
Loenen, van	At least 10	0	0
Loon, van	50	0	50
Maas	100	80	80
Martens	100	60	60
Meer, van der	50	30	30
Meijer	More than 35	35	35
Molen, van der	More than 25	25	25
Mulder	65	50	50
Müller	100	30	30
Nachtegaal	65	50	50
Nieuwkerk, van	40	35	35
Oost, van	40	30	30
Pol	100	0	0
Ruiter, de	10	0	0
Sanders	50	25	50
Schouten	No percentage	0	0
Schröder	No percentage	0	0
Slot	10	0	0

Table 3. Incapacity for work put into percentages, per worker mentioned *(continued)*

Name	Worker	Bank	Court
Smeets	25	0	0
Smit	85	15	15
Veen, van	25	0	0
Veenstra	80	50	50
Velden, van de	80	50	50
Verbeek	50	25	25
Visser	More than 20	20	20
Vliet, van	100	0	0
Vonk	75	65	65
Vogelzang	10	0	10
Vries, de	No percentage	0	0
Weijers	75	30	30
Willems	80	0	0
Zalm	15	0	15

APPENDIX II

Illustrations

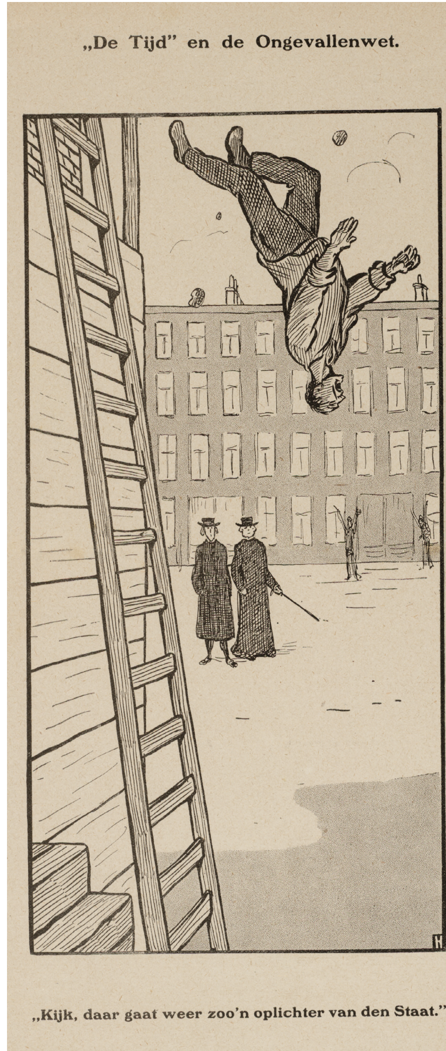

Figure 1. Political cartoon drawn by Albert Hahn, published on 2 February 1908 in the political-satirical socialist weekly magazine The Nutcracker (*De Notenkraker*). The image shows a worker falling from a ladder. In the background are two onlookers (neatly dressed, one possibly a priest) and the caption says: 'Look, there goes another crook of the state.' (International Institute of Social History BG C13/584)

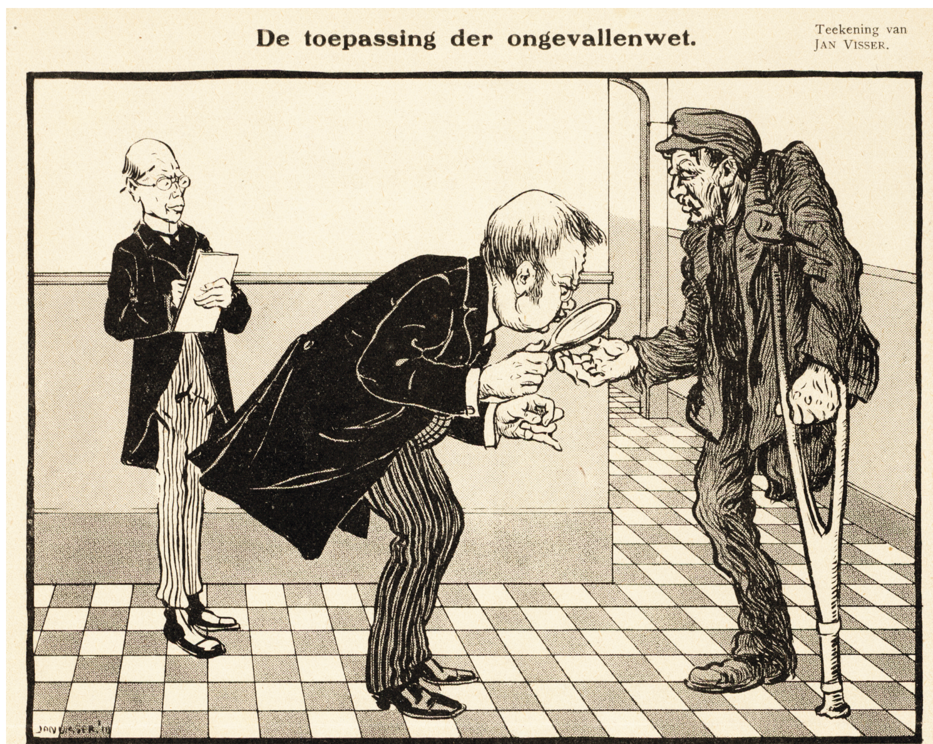

Figure 2. Cartoon by Jan Visser, published in The Nutcracker (*De Notenkraker*) on 10 March 1910. The image shows two neatly dressed medical officers and a worker who's leg has been amputated and is leaning on a crutch. One of the doctors is examining the worker's hand with a magnifying glass. The published version included a caption that read: 'What, calloused hands? So you can still work. Jansen, take him off the list!' (International Institute of Social History BG C13/99)

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NEDERLANDSTALIGE SAMENVATTING

Arbeidsongeschiktheid wordt vaak in verband gebracht met een gehandicapt lichaam of psychisch leed, en wordt veelal beschouwd als een kwestie van individueel ongeluk dat onvermijdelijk tot armoede leidt. Historici van de verzorgingsstaat hebben zich dan ook vooral afgevraagd hoe gemeenschappen ertoe zijn overgegaan om dat individueel leed gezamenlijk te dragen. Onderzoekers en activisten binnen *Disability Studies* hebben dit idee van arbeidsongeschiktheid, en in bredere zin handicap, als individueel probleem betwist en wijzen op de sociale constructie van deze categorieën. Arbeidsongeschiktheid komt voort uit een geïndustrialiseerde en kapitalistische werkomgeving die niet erkent dat werk op allerlei verschillende manieren verricht kan worden.

Ondanks de betwiste aard, is arbeidsongeschiktheid een concept dat mensen gebruiken. Het wordt gemeten en gekwantificeerd. Het is het onderwerp van medische training, zorg en revalidatie. Het biedt een grond voor het ontvangen van uitkeringen. Het is een fenomeen dat mensen geheel of gedeeltelijk kunnen belichamen. Het kan worden overdreven of gesimuleerd. Het kan ook een bron van verdriet, pijn of medelijden zijn. Kortom, arbeidsongeschiktheid bestaat en het fungeert als menselijke classificatie op basis waarvan iemand recht heeft op een uitkering.

Maar zoals onderzoekers en filosofen in Wetenschaps- en Techniekstudies hebben vastgesteld zijn menselijke classificaties geen vaststaande natuurlijke fenomenen. Ian Hacking stelt dat in onderzoek naar classificaties van mensensoorten, de kenmerken voortdurend veranderen en worden aangepast. Classificaties worden zodoende niet ontdekt en beschreven, maar *gemaakt*. Op eenzelfde wijze stelt Annemarie Mol dat zieke lichamen geen natuurlijke fenomenen zijn, en evenmin culturele constructies. Het zieke lichaam wordt in werkelijkheid gebracht in (onderzoeks)praktijken en neemt bovendien verschillende gedaanten aan. Met deze zogenoemde *praxiografie* als hulpmiddel heb ik de realiteiten van arbeidsongeschiktheid onderzocht in de specifieke medisch-juridische context van hoger beroepszaken van de Ongevallenwet.

Dit proefschrift vertrekt vanuit het idee dat ook arbeidsongeschiktheid gemaakt werd en biedt een nieuwe kijk op de manieren waarop arbeidsongeschiktheid historisch tot stand werd gebracht in de medisch-juridische praktijken van de eerste sociale zekerheidswet in Nederland, de Ongevallenwet (1901-1967). Ik ben niet meegegaan in de zoektocht naar de eigenschappen van arbeidsongeschiktheid, maar heb mij toegelegd op de beantwoording van de onderzoeksvraag: hoe werd arbeidsongeschiktheid tot realiteit gemaakt in de context van de Ongevallenwet?

De Ongevallenwet was de eerste sociale zekerheidswet in Nederland en verzekerde werkers tegen de financiële gevolgen van arbeidsongeschiktheid na een bedrijfsongeval. De wet werd uitgevoerd door een nieuwe overheidsinstitutie, de Rijksverzekerings-

bank, die moest vaststellen of en in welke mate gehandicapte werkers nog arbeid konden verrichten. Werkers konden bezwaar maken tegen het oordeel van de Rijksverzekeringsbank, en tegen het vonnis van de lagere rechtbank konden beide partijen vervolgens in hoger beroep gaan. Het hoger beroep was de plek waar arbeidsongeschiktheid betwist en bevraagd werd, en dus ook *gemaakt* moest worden, en vormt dan ook de historische plek waar dit onderzoek de schijnwerpers op richt. Drie partijen kwamen aan het woord: de medisch geschoolde ambtenaren van de Rijksverzekeringsbank, medisch experts die geacht werden een onafhankelijk oordeel te vellen, en de gehandicapte werker wiens arbeidsongeschiktheid het onderwerp van discussie was. Hoe navigeerden deze actoren het wettelijke beleid van de Ongevallenwet? Hoe pasten ze het toe, veranderden ze het of gebruikten ze het om het af te stemmen op hun waarden, kennis, ervaringen of belangen? Welke realiteiten van arbeidsongeschiktheid kunnen uit deze interacties worden afgeleid? Welke praktijken zorgden ervoor dat deze bepalingen in de loop van de tijd verankerd raakten of veranderden, en welke materiële gevolgen hadden ze? De antwoorden op deze vragen onthullen wat arbeidsongeschiktheid historisch gezien was en bieden bovendien nieuw inzicht in de historische relatie tussen burgerschap, gezondheid en werkcapaciteit, en ook in complexe medicaliseringsprocessen en gelaagde ervaringen van arbeidsongeschiktheid.

De Ongevallenwet werd uitgevoerd door de Rijksverzekeringsbank en in hoofdstuk 1 beschrijf ik hoe de medisch geschoolde ambtenaren arbeidsongeschiktheid in wording brachten. De wet had bepaald dat wanneer iemand volledig arbeidsongeschikt was, deze persoon een uitkering zou krijgen van 70% van diens laatst verdiende loon. Door niet het volledige loon te compenseren zou er voor werkers minder reden zijn om te frauderen, zo was het idee. De regeling was daarmee niet alleen geworteld in een wantrouwen naar de beoogde begunstigden, maar deed zo ook een aanzet om arbeidsongeschiktheid als een berekening te benaderen en het om te zetten in percentages. In de hoger beroepszaken wordt duidelijk dat arbeidsongeschiktheid werd gemaakt tot een berekening van een individueel functionerend lichaamsdeel in vergelijking met een groep mensen met hetzelfde ongevalsletsel. Angst voor fraude en, meer nog, voor overdrijving van klachten, maakte dat werkers voortdurend op hun welwillendheid werden beoordeeld en op een sociale plicht werden aangesproken. Hoewel arbeidsongeschiktheid tot iets meetbaars werd gemaakt, waren de uitkomsten van de gebruikte methode altijd ook het resultaat van de medewerking van de werker in kwestie.

Toen de wet in 1921 werd hervormd legden de controlerend geneeskundigen een nog grotere focus op het aanpassingsvermogen en -bereidheid van gehandicapte werkers, zoals ik heb beschreven in hoofdstuk 2. Met gebruikmaking van nieuwe revalidatietechnieken en met inachtneming van het functioneren in de werkcontext, stippelden controlerend geneeskundigen een revalidatietraject uit en baseerden hun berekening

van het arbeidsongeschiktheidspercentage op de te verwachten uitkomst van dit traject. De focus lag nog steeds op het functioneren van het verwonde lichaamsdeel, maar arbeidsongeschiktheid was nu iets wat werkers moesten overwinnen en waartoe zij zich moreel verhielden. Historici van de verzorgingsstaat hebben vastgesteld dat met de invoering van een meer uitgebreid systeem van sociale zekerheidsvoorzieningen na de Tweede Wereldoorlog, de individuele gezondheid en het lichamelijk functioneren van de burger een overheidskwestie werd. Waar het eerst een thema in de werknemer-werkgevers-relatie was, werd het nu een kwestie van goed burgerschap. Uit de praktijk van de hoger beroepszaken blijkt echter dat dit proces al met de invoering van de eerste sociale zekerheidswet plaatsvond. De werkgever moest een premie betalen, maar speelde geen rol meer in de vaststelling van arbeidsongeschiktheid. De focus kwam te liggen op de sociale verantwoordelijkheid van de werker om diens gezondheid en productiviteit te beschermen en verbeteren. Dit laat zien hoe gezondheid en burgerschap met elkaar vervlochten raakten en hoe de werker in de claimbeoordeling tot burger werd gemaakt.

In hoofdstuk 3 is duidelijk geworden dat medisch experts, in hoger beroep opgeroepen om op onafhankelijke wijze een oordeel te vellen over arbeidsongeschiktheid, de werker maakte tot een patiënt. Hoewel artsen gevraagd werden op basis van hun medische expertise, kregen zij de opdracht om een juridische kwestie te beslechten. In dit hoofdstuk heb ik laten zien hoe zij voortdurend navigeerden tussen een medisch en een juridisch domein, elk met eigen domein-specifieke problemen en rationalisaties. Er ontstond een medisch-juridische "tussenruimte" waarin juridische vragen in medische termen werden beantwoord en juridische termen ook medische kennis bepaalden. In gevallen van traumatische neurose werd dit nieuwe medische label gebruikt om pijn en gedrag te beschrijven waar geen lichamelijke oorzaak voor gevonden kon worden. Wat door de Rijksverzekeringsbank als een teken van werkschuwheid werd beschouwd, werd door medische experts geanalyseerd als een ziektesymptoom. Het diagnostische proces werd gebruikt om twijfel over arbeidsongeschiktheid op te lossen en het ziektelabel traumatische neurose, dat steeds weer andere eigenschappen kreeg, werd een middel om arbeidsongeschiktheid te verplaatsen van het domein van de geneeskunde naar het domein van de Ongevallenwet. Medische experts zagen de wet en de claimprocedure bovendien als een ziekteverwekker die ervoor zorgde dat werkers gefixeerd raakten op hun pijn en beperking. Door voor een verlaging van de uitkering te pleiten om daarmee therapeutische doelen te dienen, brachten sommige artsen arbeidsongeschiktheid weer terug naar het domein van de geneeskunde. In gevallen van de longziekte silicose zorgde de hervormde Ongevallenwet in 1938 zelf al voor een koppeling tussen een medisch en een juridisch domein door de ziekte op te nemen als beroepsziekte waarmee arbeidsongeschiktheid in de zin der wet werd aangenomen. Hoewel de ziekte zichtbaar was op röntgenfoto's, kon silicose niet eenvoudig worden onderscheiden van

tuberculose, wat niet als beroepsziekte was aangemerkt. Ook hier moest twijfel worden opgelost en werd de juridische kwestie beslecht met behulp van medische diagnostiek. In de diagnostische procedure werd arbeidsongeschiktheid beschouwd als een teken van de ziekte. De getuige-deskundigen moesten vaststellen dat iemand arbeidsongeschikt was door silicose, maar tegelijkertijd kon silicose alleen worden vastgesteld als er sprake was van arbeidsongeschiktheid. De diagnostische procedure raakte zodoende verstrengeld met de beoordeling van het vermogen van een werker om arbeid te verrichten. De kennis en expertise van artsen werden gevormd en toegepast in een medische context, maar moesten worden veranderd en aangepast om uitspraken te kunnen doen over de arbeidsgeschiktheid van een werker. Arbeidsongeschiktheid werd zo *gemaakt* als een symptoom of het resultaat van ziekte. Dit maken van arbeidsongeschiktheid als medisch-diagnostisch traject laat zien hoe een groter proces van medicalisering in de praktijk van sociale zekerheid tot stand kwam. Het was niet iets wat van bovenaf aan werkers werd opgelegd, maar was eerder een rommelig geheel waarbij artsen voortdurend heen en weer bewogen tussen medische redeneringen en technieken, juridische eisen en rationalisaties. En in dat proces veranderde niet alleen arbeidsongeschiktheid, maar ontstonden ook ziektelabels.

In het vierde en laatste hoofdstuk komen gehandicapte werkers aan het woord. Met de analyse van hun beroepschriften en verweren heb ik laten zien dat zij in discussie gingen met de rationalisatie van arbeidsongeschiktheid als individueel probleem met een disfunctionerend lichaamsdeel. Ze brachten inzichten van andere artsen naar voren of claimden ervaringsdeskundigheid over hun lichaam. Deze werkers plaatsen het disfunctioneren van hun lichaam daarbij ook in de context van de eisen die aan hen werden gesteld op de werkplaats en benadrukten ook de uitsluiting van gehandicapte mensen op de arbeidsmarkt. Zij *maakten* arbeidsongeschiktheid eveneens tot lichamelijk functioneren, maar veranderden en verruimden de eigenschappen door haar te plaatsen in een uitsluitende werkomgeving. Ten slotte brachten zij arbeidsongeschiktheid in wording als een realiteit waarbij werk en dagelijks leven met elkaar vervlochten waren. Zij wezen naar de pijn en vermoeidheid, maar ook naar frustratie over de claimprocedure, als eigenschappen van een geleefde arbeidsongeschiktheid. Deze analyse laat zien hoe werkers een handelingsruimte vonden in de hiërarchische structuur van de claimbeoordeling. Ze *maakten* arbeidsongeschiktheid tot een dagelijkse realiteit waarbij lichamelijk disfunctioneren in relatie stond met een uitsluitende werkomgeving en waar pijn en vermoeidheid niet alleen particuliere ervaringen waren maar ook samenhingen met sociale en materiële obstakels. Hiermee is duidelijk geworden dat een sociale benadering van arbeidsongeschiktheid en van handicap niet slechts een recent inzicht is, en dat belangenbehartiging van gehandicapte mensen niet alleen plaatsvond in de vorm

van luid protest, maar ook al tot uiting kwam in de context van de Ongevallenwet en in interactie met controlerend-geneeskundigen en medisch experts.

In dit onderzoek heb ik laten zien hoe deze drie actoren op verschillende manieren en met inachtneming van hun positie, kennis, belangen, (professionele) rationalisaties en waarden, arbeidsongeschiktheid *maakten*. Elke actor bewoog in diens eigen gesitueerde zoektocht naar de eigenschappen van arbeidsongeschiktheid, wat resulteerde in een verscheidenheid aan realiteiten van arbeidsongeschiktheid. Als het gaat om de eerlijke en rechtvaardige toepassing van sociale zekerheid en het verstrekken van uitkeringen, ligt de focus vaak op het stroomlijnen van de procedure, het inschakelen van nog een groep deskundige, onpartijdige experts of het verlagen van uitkeringen tot een bestaansminimum om frauduleuze claims te voorkomen. Mijn onderzoek heeft aangetoond dat elke beoordeling bemiddeling, navigatie en onderhandeling vereiste tussen juridische kaders, waarden en belangen. Elke actor moest omgaan met twijfel en gebruikte diens eigen rationalisaties en technieken, en deed dit in interactie met de andere betrokkenen. In dat proces veranderden de eigenschappen van arbeidsongeschiktheid voortdurend. Dit proefschrift heeft aangetoond dat er niet zoiets bestaat als een vaststaande categorie van mensen die een arbeidsongeschiktheidsuitkering verdienen; in plaats daarvan wordt deze categorie gemaakt in het proces van claimbeoordeling. Deze conclusie heeft verstrekkende gevolgen voor de manier waarop we naar sociale zekerheid kijken. Het is veel meer dan de toewijzing van geld: het proces stelt categorieën vast die gepaard gaan met allerlei sociaal-materiële realiteiten en vormt de manier waarop we naar onszelf en anderen kijken. Door te erkennen dat de beoogde groep van mensen die een uitkering verdienen in het proces worden gevormd, kunnen we verder onderzoeken welke hiërarchische dynamieken er aan het werk zijn, hoe de verhalen en perspectieven van de betrokken actoren worden gewaardeerd en of ze serieus worden genomen, en welke rationalisaties en vooroordelen over mensen die een uitkering aanvragen de onderzoekspraktijk bepalen. We kunnen nadenken over hoe we de categorie van arbeidsongeschiktheid opnieuw kunnen vormgeven op een manier die de levenskwaliteit van gehandicapte werknemers verbetert en die leidt tot een veerkrachtige en rechtvaardige verzorgingsstaat.

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