

WORKING PAPER **287**

**‘I’ve Got the Dust as Well’:
Asbestos Disease, Litigation
and Laggards**

Linda Waldman
July 2007

About IDS

The Institute of Development Studies is one of the world's leading organisations for research, teaching and communications on international development. Founded in 1966, the Institute enjoys an international reputation based on the quality of its work and the rigour with which it applies academic skills to real world challenges. Its purpose is to understand and explain the world, and to try to change it – to influence as well as to inform.

IDS hosts five dynamic research programmes, five popular postgraduate courses, and a family of world-class web-based knowledge services. These three spheres are integrated in a unique combination – as a development knowledge hub, IDS is connected into and is a convenor of networks throughout the world.

The Institute is home to approximately 80 researchers, 50 knowledge services staff, 50 support staff and about 150 students at any one time. But the IDS community extends far beyond, encompassing an extensive network of partners, former staff and students across the development community worldwide.



For further information on IDS publications and for a free catalogue, contact:
IDS Communications Unit
Institute of Development Studies
at the University of Sussex
Brighton BN1 9RE, UK

Tel: +44 (0) 1273 678269
Fax: +44 (0) 1273 621202
E-mail: bookshop@ids.ac.uk
Web: www.ids.ac.uk/ids/bookshop

IDS is a charitable company, limited by guarantee and registered in England (No. 877338).

IDS WORKING PAPER 287

‘I’ve Got the Dust as Well’: Asbestos Disease, Litigation and Laggards

Linda Waldman
July 2007

'I've Got the Dust as Well': Asbestos Disease, Litigation and Ladders
Linda Waldman
IDS Working Paper 287

First published by the Institute of Development Studies in July 2007
© Institute of Development Studies 2007
ISBN: 978 1 85864 658 8

A catalogue record for this publication is available from the British Library.

All rights reserved. Reproduction, copy, transmission, or translation of any part of this publication may be made only under the following conditions:

- with the prior permission of the publisher; or
- with a licence from the Copyright Licensing Agency Ltd., 90 Tottenham Court Road, London W1P 9HE, UK, or from another national licensing agency; or
- under the terms set out below.

This publication is copyright, but may be reproduced by any method without fee for teaching or non-profit purposes, but not for resale. Formal permission is required for all such uses, but normally will be granted immediately. For copying in any other circumstances, or for re-use in other publications, or for translation or adaptation, prior written permission must be obtained from the publisher and a fee may be payable.

Available from:
Communications Unit
Institute of Development Studies
at the University of Sussex
Brighton BN1 9RE, UK
Tel: +44 (0) 1273 678269
Fax: +44 (0) 1273 621202
E-mail: bookshop@ids.ac.uk
Web: www.ids.ac.uk/ids/bookshop

Typeset by IDS, Brighton UK. Printed by RPM Print & Design, Chichester UK.
IDS is a charitable company limited by guarantee and registered in England (No. 877338).

‘I’ve Got the Dust as Well’: Asbestos Disease, Litigation and Ladders

Linda Waldman

Summary

Asbestos diseases are closely associated with cancer and death. They are therefore widely recognised for their insidious, fearsome and tainted nature. Through an examination of stress associated with disease, the paper explores the medical and legal framings of asbestos disease in the UK and complements them with an investigation of ladders’ (or thermal insulation engineers) personal and bodily experience of asbestos diseases. These emic perspectives are then contextualised through examination of the social and political-economic ramifications of disease and litigation in a context of increasing distrust of science and of authority. The paper argues that victims of asbestos-related diseases draw on – and extend – medical and statistical estimations of disease; but also challenge medical notions of cause and effect while advancing their perspective based on lived experience. The paper also shows that ladders are facing uncertain futures as a result of industrial exposure to asbestos, while their way of life and socio-economic standing is also under threat.

Keywords: asbestos, ladders, thermal installation engineers, medical & legal, definitions of disease, science & trust

Linda Waldman is a social anthropologist with experience in African poverty and the related issues of gender, racial classification, ethnicity and identity. She obtained her PhD at the University of the Witwatersrand, South Africa, where her research focused on indigenous identity and nationalism amongst the Griqua of South Africa. She has worked as a research consultant on farm workers and gender-related issues. She joined the Institute of Development Studies as a Fellow in the Knowledge, Technology and science (KNOTS) Team in 2004. Her recent research activities include an examination of how environmental issues are integrated into Poverty Reduction Strategy Statements and a study of international litigation, environmental pollution and the socio-cultural ramifications of asbestos-related disease in both South Africa and the United Kingdom.

Contents

Summary, keywords, author notes	3
1 Introduction	7
2 Working with asbestos	8
3 The official medical and legal views	10
3.1 Case study: Erick Williams	15
4 The ladders' view	18
5 Ladders, masculinity and identity	21
6 Masculinity: family and legality	30
7 Conclusion	31
References	34

Examine our problem as honest scientists with no ulterior motive, in a scientific manner, in a scientific atmosphere.

(Presentation at the New York Academy of Sciences Conference, 1964 by Kenneth Smith, Medical Director, Johns-Manville Corporation)¹

Two sets of values were in distinct opposition throughout the hearings: the physical well-being of the workers and the economic well-being of the asbestos industry.

(Murray 1986: 10)

1 Introduction

Warner argues that the term ‘science’ refers to cumulative knowledge about nature and to claims made in the name of science (1995). This suggestion, that science is both discovery and an authority that extends beyond technical knowledge, is particularly pertinent when medical and legal domains interact and when science is vested with the power of classification (Kohlstedt and Longino 1997). According to medical science, asbestos-related diseases fall into four main categories: mesothelioma, lung cancer, asbestosis (or pleural thickening) and pleural plaques. For all asbestos-related diseases, there is a 20–30 year delay between exposure to asbestos and the onset of disease. Treatment for all asbestos diseases is very limited, with most funding – although not nearly enough – and medical research focusing on mesothelioma which is widely recognised as much more serious and debilitating. As one South African doctor succinctly summarised: ‘[life expectancy is] naught to two years with zero recovery, regardless of treatment’. Pleural plaques, on the other hand, are largely described as ‘benign’ (Mossman and Gee 1989), or as one UK lawyer suggested ‘you’ll die with it, not of it’.

In January 2006, the Court of Appeal of England and Wales declared that Pleural plaques were ‘inert’ and ruled that sufferers could no longer claim compensation, or sue, if diagnosed with Pleural Plaque (*Rothwell v Chemical Insulating Co. Ltd & Anor* [2006] EWCA Civ 27). These assessments of asbestos-related diseases – that mesothelioma is the most debilitating and that pleural plaques are benign – are made by medical experts and, as illustrated in January 2006, influence the legal categorisation of harm. Dangers of unwarranted compensation and increased stress were listed amongst the primary reasons for the decision in *Rothwell*: ‘There is a danger that those ... who make a business out of litigation, will encourage workers who have been exposed to asbestos to have a CT scan in order to see whether they have Pleural plaques for the sole purpose of bringing claims for compensation. Such a practice will tend to create stress and anxiety where none exists’ (*Rothwell* paragraph 67 per Phillips C.J. and Longmore L.J.). This paper explores three ways of framing asbestos disease, namely medical approaches, legal categorisation and emic

1 Attended by scientists from all over the world, this conference ‘stands out as the scientific community’s firm acknowledgement that asbestos is a major health problem, one that causes not merely asbestosis, but also lung cancer and mesothelioma’ (cited in Murray 1986: 2).

perspectives. Each of these understandings of disease have internal coherence, but when viewed in relation to each other, they appear less logical, less certain and open to contestation. The paper then explores the social and political-economic ramifications of asbestos disease and litigation in a context of increasing distrust of science and of authority (Adam *et al.* 2000; Beck 1992; Furedi 1997). It argues that victims of asbestos-related diseases draw on – and extend – medical and statistical estimations of disease; but also challenge medical notions of cause and effect while advancing their emic perspective based on lived experience. Asbestos diseases, alongside other toxic threats, are widely recognised for their insidious, fearsome and tainted nature (Douglas and Wildavsky 1982; Bourke 2005). The association of these diseases with cancer echoes a widespread connection between cancer with death (Balslem 1991). Thus, as explored in this paper, the idea that litigation for pleural plaques is unnecessary or increases stress is completely absurd from the perspective of those men who experience the diseases and for whom the very thought of asbestos disease is linked with death.

Research for this paper has been conducted during 2005 and 2006 in Barking and Dagenham. It has taken the form of interviews with key persons in the Barking and Dagenham Asbestos Victim Support Group and in the Dagenham Branch of the Britain's General Union (GMB). I have also attended monthly drop in sessions at the town hall in Barking where people can come and talk to lawyers or to representatives from the London Hazards Committee. Fortnightly GMB meetings take place in the Dagenham Working Men's Club and these have been the primary source of information for this research. Generally, these sessions are preceded by a pre-arranged interview with a member of the GMB, then I listen to the meeting before having a small, informal, focused discussion with key persons from the meeting. Doing research with ladders provides two basic challenges: firstly I engage with the men very much in terms of their work personas, which provide few opportunities to witness them in other contexts such as at home or socialising with other people. Secondly, the men are inclined neither to write about their experiences nor to talk at length about them. This is partly because the nature of the research topic concerns their potentially imminent death, because the very act of talking about disease is seen to induce the disease. It is also partly related to their masculine identities in which strength and bravery are shown by not discussing fears and concerns with others.

2 Working with asbestos

In 1998, 12 members of the GMB in Dagenham were diagnosed with Pleural Plaque. These thermal insulation engineers or ladders have worked with asbestos virtually all their adult lives and have intimate experience with asbestos-related diseases. Their earning capacity and their identity as men is intricately related to their experiences as ladders in Dagenham, East London. Dagenham is part of the London Borough of Barking and Dagenham located on the river Thames. In its heyday Barking and Dagenham was highly cosmopolitan with companies such as Ford Motors initiating new mass production methods and providing employment opportunities. Shipbuilding, electricity generation, aircraft, chemical and motor manufacturing were all popular industries between the 1930s and 1960s and all

relied heavily on asbestos. Workers in the construction and transport industries were attracted to the area. Today the area remains heavily industrialised, more so than any other London borough. This, accompanied by the decline in the manufacturing sector, has meant that it is no longer an area of opportunity. It is now crisscrossed with motorways and covered with sprawling council estates. Barking and Dagenham borough has the lowest average income in London with most people earning in the region of £13,000 a year, accompanied by low levels of education. It is the back end of London, or 'the whipping boy of the A13' as one Pleural Plaque sufferer described it. In addition to these structural conditions, 'there are high levels of long term illness and men have the third lowest life expectancy in London' (Barking and Dagenham Council 2002: 4).

The ladders have lived in the area all their lives. Their intimate knowledge of asbestos disease has been acquired since their families first moved to Dagenham and Barking to take advantage of the new industrial opportunities. These families formed the industrial labour force of Dagenham and Barking. They were also widely exposed to asbestos. Consequently, they have watched many family members die of asbestos-related diseases: 'We all have brothers, we come from a trade, we are all family. I lost my brother, an uncle who died at 42 and was a ladder like myself. My father died of lung disease. I also had a cousin diagnosed'.

Asbestos was first brought into the UK in 1857 with the first processing plants being set up in the 1880s. In 1929 the Barking Council initiated its first enquiry into the dangers associated with asbestos disease. By 1930, members of Parliament were informed of an 'epidemic of asbestos disease among British asbestos workers' and this resulted in the 1931 Asbestos Industry Regulations. These regulations determined a 'safe' level, calculating that a worker who had between 15 and 20 years exposure had a 33 per cent chance of contracting asbestosis. These 'safe' levels were amended in 1960 which increased the legal limit of exposure and as a result enhanced workers' chances of contracting Asbestos-Related Diseases (ARDs). In 1968 standards were again adjusted downwards, and were later estimated to reduce risk of asbestosis to 10 per cent (London Hazards Centre 1995). Since the 1980s official policy has prohibited trade, application and supply of blue asbestos (crocidolite) and brown asbestos (amosite). A host of legislation has been enacted to control work environments and asbestos related risks including the *Health and Safety at Work Act 1974*, the *Asbestos (Licencing) Regulations 1983*, the *Control of Asbestos at Work Regulations 1987*, which was amended in 1992, the *Control of Asbestos in the Air Regulations 1990* and the *Asbestos (Prohibitions) Regulations 1992*. Generally speaking, asbestos is considered to have been banned in 1985/6 (Gee and Greenberg 2002; Kazan-Allen 1999; London Hazards Centre 1995), although this was banning was restricted to amosite and crocidolite. Chrysotile asbestos was only banned in 1999, through the *Asbestos (Prohibitions) (Amendment) Regulations 1999* (Kazan-Allen 1999). The oldest of the GMB ladders began work in 1961, just when exposure levels were legally increased and continued to work with asbestos until the mid-1985s when it was formally banned. Since then, many report involuntary exposure to asbestos, believing that the products or sites they were working with and on were safe and only subsequently finding out about the presence of asbestos.

3 The official medical and legal views

Scientific medicine, or bio-medicine, and Western doctors' positions and knowledge are upheld in the UK's legal system. As such, it is presented as a system of knowledge which reflects and describes natural, biological order and disorder. Medical anthropology, as exemplified in the work of Good (1994) and Kleinman (1974, 1977, 1981), has however argued that medical science is in fact part of a cultural system, a 'highly specialized version of reality' which, instead of mirroring nature, constructs bodies as biological objects which exhibit measurable 'signs' or physiological irregularities (Good 1994: 5, 8). People's conditions can thus only be considered 'real' if they reflect medically recognised physiological conditions which can be empirically documented. Nonetheless, as Helman points out, medical doctors exercise substantial powers over their patients, questioning them, examining them, prescribing dangerous drugs and so forth, based on the doctors' expertise and medical knowledge. More significantly,

they can also label their patients (sometimes permanently) as ill, incurable, malingering, hypochondriacal, or as 'fully recovered' – a label which may conflict with the patient's perspective. These labels can have important effects, both social (confirming the patient in the sick role) and economic (influencing health insurance or pension payments). (1984: 51)

This ability to label patients is reinforced by the way the legal system prioritises doctor's diagnoses and the opinions of medical experts. In the case of asbestos diseases, this is particularly pronounced as there are various forms of compensation associated with the different asbestos diseases. Asbestosis, lung cancer and mesothelioma are all diseases for which legal compensation can be sought, but pleural disorders are not. Mossman and Gee categorise four types of pleural disorders, namely pleural effusion or fluid on the lungs, pleural plaques, pleural fibrosis and rounded atelectasis (1989). The International Ban Asbestos Secretariat presents Dr Abe Reinhartz's definition of pleural plaques as 'well-demarcated usually bilateral areas of fibrosis present on the inner surface of the ribcage and the diaphragm. They are often partly calcified'.² Pleural plaques are informally often described as 'dense bands of scar tissue' or as scarring on the lungs. Mossman and Gee argue that most people suffering from these 'benign' pleural disorders do not experience pain but do experience shortness of breath and some discomfort. This is in keeping with Dr Rudd's perspective. As a leading expert in respiratory medicine, he has appeared in court more than 100 times in the past three years and receives an average of 900 legal instructions a year.³ His contribution to the medical textbook *Occupational Disorders of the Lung* has been invoked in legal battles to bolster up the argument that pleural plaques should not be included in the legal framework of asbestos diseases:

2 www.btinternet.com/~ibas/ar_pleural_plaque_faq.htm (accessed on 8 August 2006).

3 www.expertsearch.co.uk/cgi-bin/find_expert?3604 (accessed on 20 November 2006).

Pleural plaques are not thought to lead directly to any of the other benign varieties of asbestos-induced pleural disease, nor to pose any risk of malignant change leading to mesothelioma. Their presence may indicate, nevertheless, a cumulative level of asbestos exposure at which there is an increased risk of mesothelioma or other asbestos-related disorders. On average, in the absence of any other evidence about exposure it is reasonable to assume that subjects with plaques will have had higher exposure to asbestos than subjects without plaques. The frequency of development of other complications of asbestos exposure in persons with plaques is not a function of the presence of the plaques, but of the asbestos exposure that caused plaques. Since plaques may occur after a wide range of different exposures, the risks of other asbestos-related conditions may differ widely between different populations and individuals with plaques.

(Rudd 2002: 344)

Historically, compensation was awarded for pleural plaques in the UK. In the mid-1980s, the High Court of England and Wales ruled that this disease could be seen as an ‘actionable injury’ because changes in the structure of the pleura were, in effect, a form of damage, because of the risk of further disease and because of the associated anxiety (Steinberg 2006). At this stage, pleural plaques were considered to be one of a range of asbestos-related diseases, less serious than many others, but nonetheless the one which was most frequently litigated. In the following 20 years, the amount awarded in damages rose significantly from £1,250 in 1986 (as a provisional damage) to between £12,500 and £20,000 as full-and-final settlements. This was, in many respects, advantageous to the laggards. For example, in 1988 Mr Edward Freeman⁴ was diagnosed with pleural plaque and emphysema. On commencing an action for damages, he was expecting about £12,000 in compensation, so when he was offered £22,500 as an out of court settlement, he accepted immediately. When interviewed in February 2006, Edward Freeman had experienced no further symptoms. He considered himself lucky, ‘I loved being a laggar and working for a different firm every week’. As Edward had been well compensated and his disease hadn’t progressed, he said: ‘I think I got away like’.

Nonetheless, insurers and companies expressed concern over these escalating payments. They argued that the ‘nationwide litigation of asbestos-related diseases, and *pleural plaques in particular*, was financially ruinous’ (Steinberg 2006: 5, my emphasis) and asked for an investigation into asbestos diseases and their actionability. This investigation took place in the High Court of England and Wales in 2005 through the test cases of *Grieves & Ors v FT Everard Sons & British Uralite Plc & Ors* [2005] EWHC 88 (QB) (note that the appeal of this group of cases is *Rothwell*). The defendants argued that pleural plaques caused only minimal damage, did not result in respiratory complications or pain and were merely indicators of exposure to asbestos as ‘the presence of plaques does not in itself give rise to an increased risk of malignancy’. In terms of the anxiety, they argued firstly that this was related

4 In accordance with the National Health Services (NHS) Central Office for Research Ethics Committees (COREC) requirements, pseudonyms have been used for all participants in this research.

to the exposure to asbestos, rather than to the identification of pleural plaques on their lungs and that it was the anxiety which led them to undergo medical investigations for pleural plaque in the first place. Secondly, given the low level of risk involved, they argued that this anxiety was 'irrational'. Thus, as there was no 'real' physical damage, the claimants' anxiety was insufficient grounds for compensation (Steinberg 2006: 6). The claimants argued however that a breach of duty had occurred, that damage need not produce symptoms, pain or impairment to be real, that 'irreversible structural damage to the architecture of the lungs' had occurred which, in conjunction with the associated risks and anxiety was more than minimal (Steinberg 2006: 7–8). The Judge, Justice Holland, based his case on the previous House of Lords' decision in *Cartledge v Jopling* [1963] AC 758 and concluded the permanent ingestion of asbestos fibres to be the real problem. He ruled, on 15 February 2005, that damages could be awarded where there was an *assessable risk* of further disease. Thus while the claimants won this case and confirmed the actionability of pleural plaque, Justice Holland emphasised the need for 'moderation' and downgraded provisional damages for pleural plaque to £3,500–£4000 and full and final settlements to £6,000–£7,000 (Grieves paragraph 94).

Although this was a partial victory for the claimants, the case was appealed by the insurers who felt that they were not liable to compensate pleural plaques at all, or alternatively that the damages were still significantly higher than what had been paid in the mid-1980s. At the appeal, both parties argued that *Cartledge* set a precedent in their favour. The defendants stressed the implications of the case in terms of policy: amongst other things, they were concerned that Justice Holland's decision would lead to wide scale litigation for the fear of disease, the additional expenses of insurance liability and potential conservatism when testing new drugs. Indeed Justice Holland himself expressed concern that the actionability of pleural plaques would signify to claimants that their anxieties and concerns were justified, despite doctors' reassurance to the contrary. In addition, he argued that the legal process, in itself, created anxiety. The claimants argued that a historical precedent had been set for the actionability of pleural plaques, including decisions by three High Court judges, and that the policy implications were irrelevant. Other considerations included that changing standard legal practice after almost 20 years would bring the law into disrepute, that it would result in an increase in litigation concerning the nature of medical diagnoses, increased cases examining claimants' anxiety of pleural plaque as recognised psychiatric responses and increased medical testing for asbestosis (Steinberg 2006: 11–14). The Court of Appeal recognised that exposure to asbestos had three consequences: (1) pleural plaques, (2) a risk of developing more serious asbestos-related diseases and (3) anxiety linked to developing these more serious conditions; but noted also that taken independently, each of which was insufficient grounds for litigation. Although English law had allowed these three consequences to be aggregated, there was no legal precedent or, it argued, logical reason for doing so. Thus, the claimants lost the appeal and the Court of Appeal determined, in January 2006, that pleural plaques could no longer form the basis for a compensation claim. The case is currently on appeal to the House of Lords and the hearing is scheduled to start on 25 June 2007.

Removing pleural plaques from the litigation process has been seen as enormously beneficial to insurers who estimated that approximately £1–1.4 billion had been

saved (Eversheds Briefing, 23 February 2006). The result is that the possibilities for ladders – and other claimants – to sue for asbestos diseases are considerably more limited with significant ramifications for how ladders experience the medical and legal systems and for how they live their lives once diagnosed (discussed in more detail below). The three diseases for which people can legally claim compensation are asbestosis, lung cancer or mesothelioma.⁵ Mossman and Gee also recognise these three forms of disease to have serious and debilitating consequences (1989). Asbestosis and lung cancer are primarily occupational hazards as contracting these diseases is linked to rates of exposure to asbestos. Mesothelioma (a malignant cancer) is unrelated to dosage and trivial exposure can lead to cancer of the abdominal cavity or lung lining.

Medical definitions point out that asbestosis is primarily an interstitial lung disease affecting the ‘internal’ tissue of the lung where gas exchange occurs, whereas pleural plaques are situated on the lining of the lung, or the parietal pleura and diaphragm (Rudd 2004). For a respiratory physician, the two diseases have very different pathologies. These distinctions do not, however, also survive in legal and other descriptions of the diseases. Asbestosis, according to one law firm, is ‘scarring of the lungs, which in severe cases causes extreme breathlessness’ making patients susceptible to pneumonia and other conditions (Field Fisher Waterhouse n.d. 3). The NHS describes the symptoms of asbestosis as follows:

increasing breathlessness, especially when exercising,
coughing,
chest pain, and
a feeling of tightness in the chest.

5 This prolonged process therefore requires that your employers were insured, although compulsory insurance in the form of employers’ liability was only introduced in 1972. Many ladders and other workers were in fact exposed to asbestos long before this date. The Financial Services Compensation Scheme is intended to cover those cases where both companies and their insurers have gone out of business and which therefore cannot be sued. The Scheme pays 100 per cent if the claim was covered by compulsory insurance, and about 90 per cent for cases of exposure before 1972 which are not covered by compulsory insurance. People can also claim from the government Department of Works and Pensions which administers two schemes, namely the Industrial Injuries Disablement Benefit and the Pneumoconiosis etc. (Workers’ Compensation) Act of 1979. The Industrial Injuries Disablement Benefit is for patients who contracted the disease while in employment after 4 July 1958. The Medical Board assesses each case and only provides compensation when disability is judged to be greater than 14 per cent. This generally excludes cases of pleural plaque and pleural thickening. The Pneumoconiosis etc. (Workers’ Compensation) Act provides a fixed rate of compensation (determined from scales for age and degree of disability) for workers whose employers are no longer in existence. Compensation can be obtained for diffuse pleural thickening, asbestosis, lung cancer and mesothelioma. This compensation can also be awarded to widows and other dependants who may claim after the death of the worker (FFW n.d; FFW 2006).

Asbestosis may damage the function of the lungs so much that the condition progresses to respiratory (breathing) failure. At this stage the oxygen supply to the body is so poor that the patient is always breathless and has blue-tinged skin (cyanosis) even when at rest in bed.⁶

The International Ban Asbestos Secretariat argues that 'In asbestosis, lung tissue is scarred and thickened by the action of the asbestos fibres in the alveoli, the air sacks'.⁷ These accounts, with their emphasis on scarring of the lungs, are in many respects remarkably similar to that of pleural plaques although pleural plaques may not be litigated for. Indeed, Steinberg argues that the 'pathogenesis [of pleural plaques and diffuse pleural thickening] is thought to have more similarities than differences' (2006: 1).

The similarity between the definitions of asbestosis and pleural plaque raise, for many sufferers of asbestos diseases, questions about medical definitions and legal categorisation of compensation. In 2000, Wikelly argued that the absence of any 'clear statutory guidance' meant that medical practitioners were exercising individual judgments when making their diagnoses. He further suggested that asbestosis was a term used to cover a 'range of conditions of varying severity', which allowed doctors to make more or less conservative diagnoses, based on 'difficult questions of judgement' (2000: 116). These subjective accounts are then incorporated into legal processes as fact. Indeed, as Reinold Noyes argued in 1940,

(t)he law is primarily a system of value judgement applied to human conduct. In spite of benevolent endeavours to expand its domain, it is quite clear, I think, to most scientists that science does not and cannot determine the judgement of values. Values depend on what (or which) we want. Science may aid us in getting what we want; it may clarify for us the actual alternatives between which we choose; it may show us the 'costs' of our choices; it may predict for us their consequences ... It follows that no application of scientific method can furnish the ethical code which a system of law expresses. (1940: 497)

For the ladders, in particular, these legal categorisations are heavily influenced by political and economic considerations which seek to support powerful corporations and, in so doing, prevent the ladders from obtaining justice. It is perhaps not necessary to point out that the categorisation of disease has massive implications for the people who are diagnosed with asbestos-related diseases. Consider the following comments, all of which come from the GMB ladders, and which represent only a tiny sample of what I heard: 'They diagnose us with pleural plaque', 'They are trying to diagnose it out of the system', 'We do believe they are misdiagnosing us', 'They say pleural plaque is not life threatening, but what it develops into is'; 'Dr Dunne keeps fiddling us by telling us we have pleural plaque'; 'Why are so many men diagnosed with pleural plaque and not asbestosis? Twenty-five years ago they were all diagnosed with asbestosis' and 'Pleural plaque is a trick, they diagnose us with pleural plaque to pay as little as possible'.⁸

6 www.nhsdirect.nhs.uk/articles/article.aspx?articleId=35§ionId=10122

7 www.btinternet.com/~ibas/Frames/f_lka_ards.htm

The following case of Erick Williams shows the complexity around medical diagnosis. As is evident in this case, it was sensations of pain which initially sent Erick Williams to his local doctor. These intermittent pains were, however, disregarded after the categorisation of his illness as benign. The case also illustrates some of the grounds for laggers' suspicions of these medical and legal definitions which frame their experiences. In particular, the rapidity with which Erick's health declines and his subsequent death of mesothelioma, coupled with the way the legal system follows these medical categories, reinforces the laggers' belief that 'the system' is operating to hamper, rather than assist, their claims.

3.1 Case study: Erick Williams

In May 1999, Erick Williams visited his doctor and explained that, following a cough three weeks ago, he had developed pains in his chest. Because he was a lagger who had been extensively exposed to asbestos, he was sent for a chest x-ray. This revealed some 'pleural shadowing'. Eight months later, and several more visits to his doctor, Erick was still complaining of intermittent chest pains. He underwent a second chest x-ray on 11 January 2000 which showed that there had been no change in his condition since May 1999. As the pain continued, Erick underwent tests for ischemia,⁹ and had further x-rays and CT scans.¹⁰ On 31 March 2000, a CT scan conducted by Dr Waterstone confirmed the presence of a 'left pleural node' which was judged 'most likely to be a pleural plaque'. A bronchoscopy¹¹ performed in April 2000 confirmed that there was no underlying mesothelioma. A repeat CT scan suggested that there had been no increase in the pleural node which was, at the time, considered to be benign. These results were confirmed in June 2001 when he had another CT scan at Romford Chest Clinic.

In the meantime, Erick had began legal proceedings. He was advised by his solicitors that 'straightforward claims' could be settled within a year or year and a half, whereas 'large or difficult claims' could take up to two or three years. Erick's solicitors requested that he undergo a medical examination by Dr R.M. Dunne, a leading UK research physician into Lung Cancer. This examination took place on 28 January 2002. Dr Dunne found no evidence of abnormalities in Erick's abdomen, no evidence of clubbing¹² and normal functioning of his pulse, breathing,

8 De Vuyst and Gevenois point out that improved medical technology, particularly high-resolution computed tomography (HRCT) has enabled doctors to detect subclinical cases of pleural lesions and has, as a result, led to fewer diagnoses of asbestosis (2002: 145).

9 Restrictions in his blood vessels and blood supply.

10 Known as computed tomography, a CAT or CT scan uses mathematical and computer technology to transfer information derived from two-dimensional x-rays into a three-dimensional image of the internal organs.

11 This technique of inserting a small scope into the body (often through natural body openings) allows for the examination of the lower airways and for the taking of samples, while ensuring minimum discomfort.

12 Clubbing involves a thickening of the fingers and a softening and rounding of the finger-nails. It is associated with a range of heart and lung diseases.

heart and blood pressure. He also noted the presence of ‘small uncalcified pleural plaques’ but found no evidence of either pleural thickening or of asbestosis. Accompanying lung function tests, not performed by Dr Dunne, also indicated normal lung function. Dr Dunne therefore concluded that Erick Williams was suffering from a ‘minor degree of pleural plaque formation characteristic of asbestos exposure’ which did not cause any disablement and did not affect his ability to work as a logger. At the time, Dr Dunne estimated that Erick had a 3 per cent chance of developing lung cancer, a 6 per cent chance of developing mesothelioma and that his life expectancy had been reduced by two years (R.M. Dunne, 31 January 2002, Medical Report for the Court, Ref W8979).

Dr Dunne argued that Erick’s ability to work as a logger had not been affected by the presence of pleural plaques. On the basis of Dr Dunne’s report, Erick Williams took Falcon Insulations – his first employer in the logging industry – and four other companies to court. In October 2002, the five defendants raised their initial offer of £14,442.15 to £15,000.00. Erick rejected this offer and, as a result, had to be re-examined by Dr Dunne. This examination took place in December 2002 and concluded that Erick’s medical condition was ‘unchanged’. In January 2003, Erick accepted a revised offer of £17,500.00 as a full and final settlement. This was an offer which was considered appropriate because it matched ‘Counsel’s¹³ full valuation’ of his case.

In January 2002, Dr Dunne had estimated that, instead of living to 80 or 81, Erick’s life expectancy was reduced by two years and he would live to about 78 or 79. He confirmed this estimation in December 2002. This estimation was based on Dr Dunne’s medical examination of Erick, on the lung function tests and on statistical calculations using the projected life expectation tables. By all accounts, Erick Williams appeared as a generally healthy man: he had stopped smoking 25 years previously; he had not had any serious illnesses, although he was slightly overweight for his height. The only problem was his ongoing complaints of chest pain. According to Dr Dunne’s report, there was no reason why Erick should not continue working until retirement age. But things did not work out as predicted for Erick Williams. By April 2006 – less than four years later – he died of pneumonia and peritoneal mesothelioma.

The medical explanation of this case is clear cut: Erick Williams did not have mesothelioma at the times when he was examined. Because the average life expectancy, after diagnosis of mesothelioma, is only one year, it is entirely plausible that someone showing no symptoms whatsoever could be dead within two years. Nonetheless, this is clearly not how the loggers interpreted this case and there are observations that explain their unease. In keeping with Western medicine, Dr Dunne’s report is ‘single-case centred’ and is based, not on loggers’ cumulative experience, but on Erick Williams’s personal experience (Pffifferling, cited in Helman 1984). As Stephens has pointed out, there is a big difference between statistical probability and predictability – on which scientific and legal decisions are based, and personal experience (2002). In addition, everything about the medical process Erick

13 Counsel refers to the Barrister who gave expert advice to Field Fisher Waterhouse on this case.

Williams underwrote emphasises a detached, neutral approach. Pfifferling suggests that this might be termed a 'physician-centred' approach in that it is the doctor, rather than the patient, who determines what the problem is and its medical (and legal) severity (cited in Helman 1984). Good demonstrates how the people become objectified as projects and patients within the medical system, a process which 'justifies the systematic discounting of the patient's narrative' (1994: 78). Although Dunne makes reference to Erick's concerns about his ability to continue working, and recognises the associated anxiety, these are largely irrelevant in the legal process. Indeed in the legal system, the patient as a formative agent has 'disappeared' (cf. Palladino 2002: 138).¹⁴ Dunne's focus on physical/bodily health replicates the mind/body dualism so prominent in Western medicine and is directed towards a legal audience. Despite the claim for an erosion of Western medical expertise (McInnes 2005; Durodié n.d.; Palladino 2002),¹⁵ the nature of the expert witness in court cases reinforces the clinical professional knowledge of the specialist at the expense of the patients' more personal, experiential view *even when* the specialist is acting on the patient's behalf.

The laggards do not necessarily disagree with the medical categorisation of asbestos diseases, and they draw on this categorisation in their quest for financial compensation. But the manner in which the expert witness is used in court cases reinforces the clinical professional knowledge of the specialist at the expense of the patients' more personal, experiential view. In the laggards' view, legal and medical authority thus manipulates the categories to deny that their personal experience of symptoms is 'real'. Their experience thus reflects Western society's 'erosion in both the confidence placed in expert opinion' (McInnes 2005: 13; Durodié n.d.). Linked to this erosion in confidence has been the declining status of knowledge, which is increasingly viewed as 'biased' or 'unattainable' (Palladino 2002). As will become evident in the following section, this declining confidence in medical experts, strongly associated with the feeling of bias, is particularly evident in the laggards' collective experience of asbestos disease. Doctors are believed to conceal men's positive diagnosis in order to protect companies, to downgrade men's conditions to pleural plaque rather than admitting the full extent of their disease and to substitute older, healthy x-rays for recent, affected x-rays in order to avoid litigation and compensation. Their distrust is thus not of 'science' *per se*, but of the medical profession and the manner in which they perceive doctors to be colluding with the asbestos companies.

14 In his historical examination of colon cancer, Palladino takes issue with this perspective and argues that reforms within the British National Health Service position patients as 'informed consumers'. This transforms them from passive objects within the clinical gaze to 'constitutive figures of a new "discourse"' (2002: 139).

15 McInnes and Durodié argue that there has been an 'erosion in both the confidence placed in expert opinion, and the confidence placed by experts in their own assessments' (McInnes 2005: 13; Durodié n.d.). Linked to this erosion in confidence has been the declining status of scientific knowledge, which is increasingly viewed as 'biased' or 'unattainable'.

4 The laggings' view

In supporting the value of medical science, but questioning doctors' motives and the ways in which medical expertise is represented in court, the laggings maintain a very ambivalent relationship with the medical profession. At the heart of this ambivalence is the issue of validating what a 'real' disease is and locating their bodily experiences within these medical categories. In legal processes, asbestos-related diseases and their resultant aetiologies are supported by psychiatric assessments. As discussed below, these assessments frame patient experience in terms of understandings of 'somatisation', which reinforce the mind:body dualism inherent in medical science (Good 1994; Kleinman 1981). However recent medical anthropology has contrasted the manner in which a patient's body 'feels' and 'demonstrates' distress with medicine's dualist understanding of the body. While biomedical understandings of pain overlook the psychological and social worlds of patients, Kleinman has suggested that bodily experiences of pain and 'social suffering' are integrally related to economic and other resources (1995). Furthermore, both medical and social problems are mediated through the embodiment of distress. The laggings' account of the medical and legal processes thus disagrees with the underlying logic of disease categorisation, with medical expertise about risk and statistical possibility and offers a politically, economically and socially grounded understanding of the processes they undergo. These different perspectives on the psychological experience engendered by both the legal process and by the fear of severe illness and death, further illustrate the complexity of categories.

As is evident from the quotes above and from Erick Williams's experience and contrary to medical and legal opinion, laggings do not accept the categorisation of pleural plaques as 'benign' or 'inert'. These terms are a mockery of their experience of pleural plaque: they 'diagnose us in the beginning with pleural plaque but it becomes asbestosis or mesothelioma either in the hospital or in the following weeks'. The laggings argue that the presence of pleural plaques on the lungs is an indication of their extensive exposure to asbestos. This is in keeping with medical definitions, but the laggings insist – contrary to medical opinion – that the pleural plaques point to the presence of other, worse diseases, as evidenced in the fact that three of the 12 men diagnosed in 1998 have subsequently died. The case of Erick Williams detailed above is a classic example. Furthermore, it is the very presence of pleural plaques which create stress and unease amongst the men. The chairman of the GMB explains that 'the mental stress caused by pleural plaque is very severe. About 80% of the men diagnosed with pleural plaque die of asbestosis ... Its about the mental stress – they think they are on the way to mesothelioma'. Pleural plaques are thus directly linked to mesothelioma which, as a form of cancer, is highly stigmatised. Balshem documents that amongst residents of a 'cancer hot spot' in a Philadelphian working class community: '(a) typical answer to the question "Cancer – what does that make you think of" was: "death"' (1991: 158). Asbestos disease and cancer cannot be conceptualised in terms of gradation of illness nor as a short-term interlude in an otherwise healthy life. Not only is cancer frequently a metaphor of bad, unwanted experiences; it has been seen as 'naturally loathsome' as an 'invisible contaminant' that invades the body (Bourke 2005; Erikson 1990).

The laggards, especially Ben Smythes who was a close friend of Erick Williams, were not prepared to accept the medical explanation. Ben insisted on receiving the coroner's autopsy report, dated 24 April 2006, in which a number of observations are made. The coroner questions why more attention was not paid to Dr Wetherstone's examination in June 2001, during which he confirmed the presence of a pleural nodule and argued that underlying mesothelioma could not be ruled out. He also recommended a repeat CT scan in 12 months time. It is not clear whether this repeat scan was ever carried out. In addition, the coroner argued that more attention should have been paid to Dr Wetherstone's comments. Instead considerable weight was placed on the absence of pleural plaque and the lack of clubbing in Erick's hands and that this resulted led to a prognosis that ruled out mesothelioma. This prognosis indicated that Erick's chances of developing mesothelioma were remote and it is on this basis that his case was settled as a full and final payment. However, as Erick Williams did die of mesothelioma this prognosis was clearly 'misplaced'. The coroner's report therefore argues that the 'body of medical opinion needs to be revised' in order that future assumptions and diagnoses might be more accurate.

Whereas the coroner indicates a problem within medical opinion that requires addressing (although his report gives no indication of how that might take place or happen), the laggards see medical opinion as a deliberate act of obfuscation on the part of medical science. Their belief is reinforced by the difficulty they experienced gaining access to Erick's records and by the doctors' and specialists' reluctance to share their information. Erick Williams decided – on the basis of Dr Dunne's repeated medical examinations – to take a full and final settlement in January 2003. Ben felt, however, that the doctor working for the opposition, for the defendants, must have seen Erick Williams's x-rays and that he would have correctly judged that Erick was about to die. If Erick had known this, he would have been able to sue for something in the region of £300,000 as his full and final settlement. The coroner is said to have told Erick's wife that the mesothelioma had been present in Erick's body for three and a half years. 'He [the coroner] couldn't believe he wasn't screaming with pain. There was 70% in his lungs and the rest in his abdomen'.

Dr Rajiv Menon is a psychiatrist who has been working on stress amongst UK asbestos sufferers and who, like Dr Rudd, frequently gives evidence in court on asbestos litigation cases. He points out that distress is not related to the severity of the illness and that the worst cases in terms of mental health are the people with pleural plaque. He identifies depressive episodes, anxiety and obsessive compulsive disorders with diagnosis of pleural plaque. In his work, he has documented men suspecting their wives of infidelity, men following and accusing their wives, turning violent, being plagued by mental images, force feeding themselves to put on weight, refusing to confront their own images in mirrors and phobias about dust and cleanliness (2006). Nonetheless, his interpretation of the disease, although sophisticated in terms of understanding people's concerns, still reproduces a mind:body dualism of Western medicine. In the above-mentioned High Court of England and Wales case, he argued that '(s)o when people like Mr. Grieves [one of the claimants] were diagnosed with asbestos disease both reality and folklore fuelled ... fears and the psychological distress evoked by the diagnosis often outweighed the actual material risk of serious complications (*Grieves* paragraph 24).¹⁶

In Menon's view, other clinical manifestations of stress include *disproportionate* breathlessness, *unexplained* chest pain, anxiety fears and extreme anger, thus suggesting that he accepts the medical model as normative. He concludes that there is little doubt that there is a psychological condition linked to mental health and those who fared badly were not 'psychologically minded', were emotionally vulnerable – particularly men who felt that they had to put on a strong face and be brave – and were unable to ventilate their feelings. In keeping with this strong, masculine identity, Dr Menon describes his patients as seeing him under sufferance and as not being willing to accept a psychological explanation for their physical experience. In his view, they find it hard to distinguish their physical conditions from their depression.

Before expanding on the ladders' rejection of psychological explanations, it is necessary to examine their second objection to the medical and legal definitions of asbestos-related disease. This is a critique of the political economy and powerful corporate processes that shielded asbestos mining and corporations in the past and which continue to hinder ladders' attempts to litigate for asbestos disease. Asbestos was, in the 1970s, a wonder product and various companies made massive fortunes out of it (Jasanoff 1995; McCulloch 2002; McClintick 2000; Gee and Greenberg 2002). Hundreds of thousands of jobs were generated and all these people were exposed to asbestos. As Jasanoff (1995), Ward (2002) and others have shown, many of these companies are now facing large litigation and compensation claims. Society at large has also benefited enormously from the use of asbestos; in terms of fire protection, and a myriad of other uses for asbestos, including insulation, brake linings, seals (Gee and Greenberg 2002). In addition, nation-states have benefited from the economic success of the industry, from the use of asbestos as a fireproofing material and from its application during wars. Despite the high profile of asbestos litigation claims and the potential financial crisis of insurers such as Lloyds of London (McClintick 2000), asbestos profits have 'suffered little from the ill health and contamination costs of asbestos, which were "externalised" onto workers with disease, their families, the health service, insurance carriers and building owners' (Gee and Greenberg 2002: 58). This perspective is echoed by a recent European United Left/Nordic Green Left publication which argues that:

The fight to gain compensation for asbestos victims and their families is a constant struggle; recent developments show the growing intransigence of defendants who, in the face of an escalation in UK asbestos-related deaths, are mounting coordinated resistance in the courts and media to undercut the rights of asbestos victims. Insurers and defendants worked together on a strategy for the Fairchild case, alleging that where it could not be scientifically proven which asbestos fibre caused a claimant's mesothelioma, a defendant could not be held liable. Fortunately, the UK House of Lords ruled in 2002 that plaintiffs who had experienced asbestos exposure which materially increased their risk of mesothelioma were entitled to recover all their damages from whichever negligent defendant remained. Post-Fairchild an actuarial report

16 In fact, Mr Grieves' condition improved without medication, much to Dr Menon's surprise, and is said to be in part because he had reflected further on Dr Rudd's diagnosis.

(2004) estimated that there could be up to 200,000 UK asbestos claims costing £8–£20 billion in the next three decades.

(Kazan-Allen 2006: 29)

Thus, while industry, nations and society generally have benefited from the use of asbestos, those people who worked with it – mining it, installing it, using it in manufacture and more recently, removing it – and those who lived in the vicinity of asbestos companies, such as Cape plc in Barking, can be seen to bear both the social and physical costs. From the perspective of the lagggers, the legal establishment, medical science, trade unions and the government are all working to assist business and industry. Their experience – watching family members suffer, dealing with doctors and lawyers – has led to deep suspicion of the medical and legal establishment. Ben and his colleagues are convinced that something is not right and that, in the case of Erick Williams, there has been a cover-up: ‘The diagnosis that took place in 2001 should have said he had mesothelioma’; ‘The doctor said in January 2006, you’re in the clear, don’t come back for the rest of your life, but the rest of his life was only three months’; ‘They [the doctors] will not admit their faults, they will not admit to nothing’.

Because Erick settled for a full and final payment, there is nothing more that can be done in terms of his legal claim for asbestos-related diseases. Searching for new avenues of mobilisation, the lagggers are now considering suing the health authorities for incorrect diagnosis. They have approached the law society, the GMB and other knowledgeable people they know for guidance. They are determined to use Erick’s experience to stop this happening to others: ‘it shows what goes on, because this is gonna come up again with other people, he’s probably not the only one’. His friend Ben Smythes has taken a more personal approach. He wants the doctors to show more respect and suggests that ‘If I can give the doctors one up, they won’t be so f***** snobbish with others’. He is determined to do what he can for his friend ‘he’s lying out there and he knows there’s one geysier who is not f***** giving up and I will do what I can’. This view resonates with those recorded by Burnham (1982) and Brown (1979) on how modern scientific medicine might support capitalist interests and undermine people’s health in USA contexts. Or, as Jasanoff has argued, ‘(p)olitics is never far from view when one is observing science in action around topics of immediate social concern’ (1996: 410). The lagggers’ understanding of their experiences is one which, in contrast to the medical and biological view emphasised by doctors, points to the underlying political economy of health.

5 Lagggers, masculinity and identity

The dismissal of psychological values as influencing their perceptions of asbestos disease and pleural plaque are in keeping with the interviews I conducted. One lagger who had seen Dr Menon commented, for example, ‘I found it a waste of time, it’s not me mind. As long as I can do a day’s work and it doesn’t get worse, I’m okay’. If, as Menon argues, the lagggers are ‘not psychologically-minded’, it is worth exploring what other sociological, political and economic processes are impacting on their lives and how their identity shapes, and is being shaped by, their legal and medical experiences of asbestos.¹⁷ Following Gutmann (1997), the remainder of this

paper links the ladders' psychological experiences with questions of power and inequality. This involves an analysis of ladders as gendered subjects through an exploration of their masculinity.

Connell (1987) introduced the concept of hegemonic masculinity to refer to men in positions of power, and patterns of practice that perpetuated men's dominance over women. He argued that hegemonic masculinities do not 'correspond closely' to men's lives. Instead they are models which convey fantasies, desires and ideals, offer guidance on relationships with women and 'articulate loosely' with men's construction of masculinities and everyday living arrangements (Connell and Messerschmidt 2005: 838). Despite a wealth of research on hegemonic masculinities in relation to gender research, little has been done in terms of understanding the relationship between masculinity, science and technology (Mellström 2002). Hegemonic masculinities, for Mellström, involve a 'certain bonding between men and machines grounded in the embodiment of technology' (2002: 463; also see Faulkner 2000 and Mollona 2005). Although modern technology and hegemonic masculinity have a historical connection with industrial capitalism and, as Wajcman has shown, powerful institutions and political/economic interests underlie the use and control of modern technology, not all men involved in technology are equally positioned (cited in Mellström 2002; Faulkner 2000; also see Connell 1987). It is thus necessary to distinguish different types of masculinities, and their associated degrees of power.

Engineers are often depicted as 'powerful symbols of the equation between masculinity and technology', yet Faulkner argues that engineers are situated in a structurally ambiguous position, at the interstices of capital, labour and the state where they strive for professional autonomy while having to conform to the demands of corporate employers.¹⁸ She also points to the class distinction between professional graduates based in offices, maintaining a remote connection to the artefact through computer technology and who have higher status with those engineers who do manual, greasy and dirty work directly on artefacts (2000: 95).

Lagging is a dangerous, dirty and dusty profession. But it provided these men, many of whom were poorly educated and unable to achieve a profession, with a way to get ahead economically. As Jimmy Croft explained to me, most of the ladders meeting in the Dagenham Working Men's Club were 'from the East End, used in dock yard and dock works. They were not very well educated, I left school and I couldn't hardly read or write. I was in one of the top classes and I'm not the brightest'. Erick Williams provides another example. At the age of 16, he left school and started work. Two years later, aged 18, he entered the lagging trade and started mixing lagging plaster (which contained asbestos) by hand. Lagging offered a way of garnering success outside the formal educational system. Ladders are officially

17 Consideration of ladders' exposure to asbestos, particularly in the USA (for example, Selikoff, Churg and Hammond 1964, 1968; Selikoff and Hammond 1975; Selikoff 1977), is common in the academic literature, but very little attention is given to the sociological impacts of disease or ladders identity more generally.

18 Engineers' collective association with technology is thus seen as a means to present themselves in a neutral light.

classified as thermal insulation engineers (discussed in more detail below), but they do not need high academic grades or to undergo a university education to achieve this. In contrast to other engineers, trained in terms of objectivist rationality, emotional detachment and abstract theoretical approaches to problem solving (cf. Faulkner 2000); ladders are introduced to the trade through an apprenticeship which appropriately trains them through bodily knowledge that is constantly enacted and practiced. During this time, the men are exposed to the skills of the trade, beginning with simple tasks, learning how to work with their hands, getting to know the tools and their application. Mellström suggests that, among mechanics in Penang, Malaysia, this phase of apprenticeship is a ‘never-ending process of continuous incorporation of bodily and cognitive knowledge ... [which] involves seeing, listening, muscular exertion, touching, calculating, and not least competently practicing’ (2002: 464; also see Mollona 2005). In addition to the long apprenticeship, it took nine years of work before one could acquire, through a combination of skill and knowing other men in the industry, a union ticket. As Connell and Messerschmidt argue, based on Bourdieu’s concept of habitus,¹⁹ masculinities should thus be understood to be ‘configurations of practice that are accomplished in social action and, therefore, can differ according to the gender relations in a particular setting’ (2005: 836).

Because of the skills associated with lagging and its classification within the engineering sciences, there is some prestige associated with it. Between the 1930s until the 1980s, ladders were paid as skilled engineers. They did pipe-work and duct-work. ‘It was an absolute trade, you needed the skills’. As engineers, these men established themselves with pride. One of the key comments made by ladders, when asking them about their fathers, was: ‘He was a proud man’. He was proud because of his ability to support his wife and family through his work as a ladder, because he was bringing young men into the industry, protecting them and supporting them and – for many – because of the physical strength and fitness maintained through lagging.²⁰ The responsibility of ‘breadwinner’ and the moral dependability towards young men in the community reflects the significance of the patriarchal family and community structure. This esteem is reinforced by the men’s physical toughness and mechanical skill which, Wajcman argues, creates one of the prevailing forms of masculinity in relation to technology in that it allows men to demonstrate their power over, and manipulation of, both nature and technology (cited in Mellström 2002; also see Hacker 1989).²¹ The embodiment of masculinity, through technology is, as Mellström argues ‘extremely important in the professions

19 Bourdieu examined how people embodied social discourses and how they, through practice, translate discourses into potential or into limiting repertoires.

20 Many of the ladders followed their fathers into the trade and all of them did an apprenticeship, usually lasting about five years. During this time, strong bonds were formed between the apprentices and the ladders. A ladder would often look out for his apprentices; protecting them from bullies, from exploitative or dangerous jobs and helping them find secure work once their learning was complete.

21 Wajcman sees the other dominant form of masculinity to be established through ‘professional calculative rationality’ by men who are trained as technical specialists (cited in Mellström 2002: 462).

of mechanics and engineers – professions in which the body physically enacts change on artefacts. The enculturation of the body, in both occupations, is to be seen as a never-ending process of continuous incorporation of bodily and cognitive knowledge' (2002: 464). Being a lagger thus involves developing a bodily knowledge which is performed and enacted and which constitutes their sense of masculinity and pride.

This sense of pride associated with a trade is, however, rapidly vanishing. Two processes in particular are eroding the ladders' hold on their profession. The first is the opening up of the EU and the increasing numbers of foreign workers willing to take on work at considerably lower rates. The ladders talk, for example, about Cape plc (a company which formerly worked with asbestos and had a factory in Barking) still operating in Poland and training Poles, who then come over with the necessary qualifications and under-quote the UK ladders, forcing them to lose contracts. The GMB has been involved in a number of protests in relation to this, questioning the foreign workers' qualifications, demanding that they be employed at UK rates and trying to ensure that UK labour is employed. In addition, the manner in which ladders subcontract work – operating as small, independent entrepreneurs, has disadvantages which, although they affect both local and foreign workers, are magnified in the case of men who are not familiar with the work sites and who are often not informed that they are dealing with dangerous products. These foreign workers work short contracts before returning home. If they subsequently become ill, it will be virtually impossible for them to trace the connections between their condition, the products they were exposed to and their UK work contracts. Even resident ladders, when trying to process asbestos claims, often find that they have not been formally recorded on a company's books. Gavin Naul, for instance, subcontracted to Cape which paid his wages directly, but which claims that it has no record of his employment. This has implications both in terms of tracing employers in legal cases and in terms of any debates around company restructuring.²²

The second process threatening the ladders' prestige is one that centres around the very nature of lagging and has come up in relation to their annual negotiations with the Thermal Insulation Contractors Association (TICA). This contractors' association deals with all the terms, conditions and working rules for ladders. It also covers all the terms and agreements of engineering construction. Recently negotiations have centred around the suggestion that lagging as a trade no longer be categorised as 'engineering'. Currently most large lagging contracts have a large metal workshop situated onsite. About 50 or 60 ladders will be employed and they will use this workshop to convert large sheets of flat metal into u-bends, elbows, piping and so forth to cover the insulation placed on piping. They call this process

22 Companies facing litigation around asbestos issues are well-known for restructuring as a means of securing their business interests and removing the risk of going bankrupt through litigation. This involves, in part, putting aside a trust fund ostensibly to ensure that future claims will be accommodated. However, as illustrated in the debates around Cape's restructuring in 2006, this is a way of limiting damage with no formalised means of topping up the trust fund once depleted. This process therefore allows companies to place a ceiling on their asbestos compensation expenditure with complete disregard for the numbers of people that they may have exposed to asbestos.

the 'making up of metal'. TICA, and many large companies that employ ladders, are considering removing the workshops and having all the metal 'made up' offsite by specialist firms. This deskilling of the trade²³ and downgrading of the machinery available upsets all the ladders who argue that their expertise involves more than simply installing metal: 'We don't want to be downgraded, but that's what they are doing. They want to take metal synopsis off us. I find it demeaning. If you keep using a Stanley knife and not a piece of machinery, you're a tosser.²⁴ ... Are we just a game? If you go to work and you don't make metal up, you're a tosser'. As Jimmy Croft suggests in this comment, not using heavy-duty machinery is directly linked to experiences of masculinity: a man who masturbates is not a 'real man', he does not have a wife and family. In addition, and as argued above, ladders' machines can be seen as symbolic extensions of their bodies. As Mollona has argued in relation to steel workers in Sheffield, these are 'metaphorical appendages of their male sexuality, and markers of social status' (2005: 533).

Linked to this deskilling, negotiations are in progress with TICA. These negotiations are aimed at defending benefits the ladders currently have rather than working to expand or enhance their role. A wide range of benefits, such as transport expenses, tea breaks, etc. are being targeted for cutbacks. The result, as one ladder explained, 'is a contradiction because it was a trade, it was excellent money, it paid better than other jobs on a building site. We became used to money, it was good money, but we're still earning what we were earning 15 to 20 years ago'. Thus, with real incomes declining, jobs being taken by foreign workers, deskilling and contracted and unpromising negotiations with TICA, the ladders face an uncertain economic future even if they remain perfectly healthy. These social processes – which reduce earning power, negotiating potential, the significance and pride in thermal insulation as a trade and which enhance their economic vulnerability – have consequences for how the men think about themselves, for their identity and masculinity. Given the slow erosion in their position, it is not surprising that ladders no longer encourage their sons into the trade.

The ladders I interviewed expressed a sense of masculine identity based on two interrelated sets of activity: one concerning the 'public' sphere of economic work and the other located with the 'private' space of the family. Despite the widespread tendency in literature to see identities as multiple, hybrid, fluid and fractured (Connell 1987; Moore 1993), their masculinity was solidly grounded in their experiences as Dagenham ladders and as family providers. Like their fathers, these men identify as workers, husbands and fathers; they are fundamentally concerned with their ability to bring in money and to support their families. Thus, as Timmy Fortune commented, 'our father made us a family unit, this has continued to his sons'. Such sentiments are in keeping with Gilmore's suggestion that masculinity is shaped through the ability to have children, to protect one's dependants and to

23 Faulkner also points to a general demise of the 'golden age of engineering' as engineers are no longer highly respected as pioneers of technology, but are more likely to be seen as nerds (2000: 104).

24 Often linked to the term 'wanker' and masturbation, this is British slang for an incompetent, disliked or stupid person. It can, however, also have positive, affectionate connotations.

provide for one's family (1990) or what Collier refers to as the 'positive' behaviour or men (1998).²⁵

The idea of 'the family' is broader than that conceptualised in a nuclear family and incorporates an extended, largely patrilineal, descent group. This family ideology has grown out of living in the East End of London and is, ironically, linked to the role of large firms such as Cape, Kitchings, and so forth which were seen as being 'like a family'. Many of the people working in these companies were related. In addition, the companies acted as hubs of social activity, they had good sports facilities, had socials, had sports days, celebrated Christmas and provided parties and gifts for their employees and families. Until the late 1960s and early 1970s when some companies ceased to operate, and others became increasingly contractual in their relations with employees, the companies were the primary employers in Barking and Dagenham and they looked after their workers in a paternalistic manner. While the large companies no longer maintain this paternal role towards their workers and workers' families, the ideology of a family remains strongly located in both the laggers' sense of place and in their work. Mollona has, however, recently argued that extended families are being shaped by recent political and economic transformations in the labour market, the manufacturing sector as well as by changes in economic and social policies²⁶ at both the local and national level in the UK (2005). His research, based on informal steel labour in Sheffield, suggests that patriarchal kinship relations have penetrated the factory floors or spaces of production while, simultaneously, capitalist relations of production have infiltrated the family and community and are orientating these spaces towards productive processes. He argues that de-industrialisation has 'fostered household pooling, inter-household production and trading arrangements, and networks of "relatedness" [...] that extend outside the boundaries of the nuclear family' (2005: 542).

In contrast to the steel workers described by Mollona, laggers do not rely on informal work to supplement their wages. As Paul Long said, 'I've never known a lagger to do anything else, I've never known a lagger to work behind a bar or subcontract or try to supplement his wages through other activities'. Nonetheless, most of the laggers are 'normal working class men' who have to support their wives and, as often as not, adult children. Although the laggers interviewed did not live in large extended families, neither did they necessarily resemble nuclear families. Ben Smythes, for example, is divorced. He lives with his adult son, who is also divorced. Ben spends several nights a week with his girlfriend and Ben's son's daughter stays with them every second weekend. Their need to protect and provide

25 Collier is responding to a tendency in the literature that views hegemonic masculinity as predominately negative, associating men with dispassionate, autonomous, neglect of the family and antagonistic behaviour. Connell and Messerschmidt point out, however, that this tendency is associated with personality trait theory and that other interpretations of hegemonic masculinity acknowledge that men's behaviour can work to women's advantage.

26 These include housing benefits which do not incorporate necessities such as gas, electricity, water and building repairs and the reduction in welfare benefits for former industrial workers. The limited financial support provided by these policies force families to provide financial and residential assistance (Mollona 2005: 540).

for ‘the family’ – which may include adult sons and daughters resident with them or divorced wives, sisters and brothers living elsewhere – is one of the primary reasons why the men insist on suing for compensation as soon as they are diagnosed, even if it is pleural plaque that they are diagnosed with.

‘The good news is that Pat’s going to be okay, the bad news is that they’ve offered me £96,000’, said Dick Fortune when he phoned his brother. These two seemingly disparate comments refer to the same thing – the payment of £96,000. This money will help Pat, Dick’s wife, survive once he is too ill to work and after his death. However, the fact that he is being offered £96,000 – is indicative of Dick’s poor state of health and highly reduced life expectancy. As noted above, it is the *diagnosis* of an asbestos disease, even of pleural plaque – rather than the physical effects of the disease – which destroys the men’s ability to continue working as ladders. However, it is the diagnosis along with the physical effects of the disease, which destroys the men’s families. This occurs in several, interlinked ways: there is the sheer number of family members who contract – and die of – asbestos-related diseases which, in turn, results in increased tension within families when some people survive and others do not; there is the inability to support the family economically while the futility and inevitability of it all acts to close down discussion and opportunities for support.

Timmy Fortune explained how, in addition to his father, three of his brothers had died of asbestos disease:

First to go was me brother John, aged 66. He had been under the hospital quite a lot. He was a bit of a hypochondriac. No-one believed him half the time. He said: this is the last time you’ll see me ... Next was my brother Dick. When he was aged 40 they said there are shadows on your lung, but because you are so young, we’ll do a biopsy. Three months later, they said they hadn’t got enough and cut him right open ... Ernie died a year ago aged 72. Ernie’s daughter and son-in-law had taken Ernie and his wife to Turkey for a holiday. Within two days, Ernie fell ill and the local doctor in the hospital asked ‘why are you travelling with mesothelioma?’ Back home, he went straight into hospital and didn’t come out.

The death of individual men threatens the broader family structure. Timmy Fortune keeps thinking about how his brothers died, about how Dick’s daughter was on holiday when her father died. His decision not to interrupt her holiday and not to inform her of her father’s death led to a family row which still permeates their relationship. Dick’s grandchildren now ask him: ‘Why are you still alive and our granddad isn’t?’

The inevitability and futility of their experiences operate to close down discussion. As is evident in Timmy Fortune’s experience above, it is too overwhelming an experience to open up to discussion. There is no answer that Timmy can give his brother’s children. There is no reason why he has lived, despite his exposure to asbestos, and his brothers have not. Indeed, as Timmy comments: ‘I’ve been too concerned looking after the immediate family to worry. It’s like a graph laid out in front of you. You know exactly what’s going to happen and they know what’s going to happen. You have to put things in order, you can’t ask why? Why? Why? What will be will be. That’s the way I cope with it’.

It is as if the very act of acknowledging the possibility of a disease may bring it on. This refusal to discuss the implications of diagnosis or potential diagnosis is part of remaining brave, of fighting 'it' both mentally and physically. For this reason, ladders avoid medical examinations. Indeed, as Balslem has documented, '(c)ancer testing is "looking for trouble" as thinking about cancer tempts fate. The men know that their chances of getting some form of asbestos-related disease are high. As Paul put it, when we discussed whether my research should focus on men with ARD or not: 'I'm sitting here waiting to be diagnosed'. This commitment to fighting the disease – before diagnosis – through refusing to acknowledge future possibilities, also extends to their families and home life. Edward Freeman recounted how most of the men working on a power station suspected that their wives and dependants might be worried, but that it was never expressed verbally.²⁷ His own wife knew of the dangers, but said that he should make his own mind up and did not discuss his work with him. Even once men have been diagnosed with pleural plaque or other asbestos-related diseases, they tend not to discuss it. As Paul Long said, 'my daughter doesn't know anything about it, my wife puts it to the back of her mind'. Timmy Fortune, whose loss of three brothers is described above, said that he watched his sister, 'I can see her thinking what's happening to all my brothers, but we've never spoken about it'. He continued: 'Our family can't talk about it ourselves. They understand it's inevitable, we know its coming, so we only talk about it when it's inevitable. Then you've got to talk about it'.

Given the combination of pride, skill, physical fitness and economic prowess, a diagnosis of pleural plaques signifies a crisis in the ladders' ability to maintain their lifestyle and masculine identity (cf. Moore 1993; Hearn and Morgan 1990). A diagnosis of any asbestos disease – no matter how benign – affects their earning capacity, their social relationships with other men, their roles as husbands and fathers and their masculinity. To begin with their earning power: bringing in enough to live on and providing for a family requires more than simply the purchase of food. It is about a lifestyle. The ladders have become caught up in the housing boom and in the materialistic consumption of the twenty-first century. Despite the fact that the Barking and Dagenham housing prices are the lowest in London, many of these men battle to meet their mortgage and other daily expenditures. They desire, as one man put it, 'a decent lifestyle' which involves not being in debt and 'some money in me pocket'.

In addition, the contractual nature of their business means that they do not benefit from the usual social protection mechanisms available. They have no sick benefits, no injury compensation, no means of surviving if they are not earning. Thus, if they are not working, they are not earning. Men who had been the mainstay of the family, proud men who had assisted everyone financially, found that they could no longer afford their own cigarettes once they stopped working.

Secondly, as mentioned above, the ladders meet weekly at Hamilton Hall pub in Liverpool Street, London where anyone working in the area might drop in for a pint or two and fortnightly at the Dagenham Working Men's Club. These meetings

27 Komarovsky, researching masculinity in an American steel town, found a similar lack of communication between working men and their wives (1964).

can be seen as ‘truly gendered spaces’ in which ‘homosocial masculine practices continuously exclude women and perpetuate highly gendered social spheres, in which men form communities’ (Mellström 2002: 475). These are spaces for male bonding (Tiger 1984).²⁸ The GMB meetings are prefaced and concluded with drinks at the bar, general discussion and camaraderie. The meetings are where men maintain their relationships with other ladders, find out what jobs are coming up, whose working with who, who has not paid, and so forth. In essence, the entire conversation is related – in one way or another – to lagging.²⁹ Each week they discuss asbestos diseases: who has been diagnosed, who hasn’t, what the current status of each ladder’s claim is, who has died and whose funerals have been (or have to be) attended. Although the mood is generally jovial and the ladders are full of ironic humour when discussing their problems, there is also a strong recognition that sooner or later they too will be affected. Ladders who have been diagnosed find themselves being constantly watched by the other ladders for symptoms. Every time they come to the meetings, they are reminded of their own situation and they hear about more people dying. Steve Harris, for example, was undergoing medical examinations for unexplained pain and for a tumour in his abdomen, while the men gathered to discuss the case of Erick Williams. Although he has not formally been diagnosed with any asbestos disease, the ‘man’ who did his x-rays asked if he had been exposed to asbestos. When Steve replied that he was a ladder, the man rolled his eyes. Steve then asked if there were signs of asbestos, to which the man replied ‘yes’. Although Steve tries not to dwell on this experience, at the time he compared his tumour to the mesothelioma ‘mass’ in Erick’s stomach. ‘I was coming to the meetings, but I hadn’t told any of the men’.

As suggested in the above quote, the ladders seek to manage the process in so far as possible. The disclosure of an asbestos disease is carefully handled, with each individual deciding how to disclose the information of a positive diagnosis and to whom. This is because the diagnosis of an asbestos disease, even of pleural plaque, may signal the inability to continue work lagging and many men stop attending GMB meetings once diagnosed. This means that they lose touch with their lifelong friends and ‘family’, separating themselves from their support structure. Disclosure of a diagnosis is thus closely related to the destruction of the social person, through a process of self-rupturing that pre-empts the disruption of the body. Moreover, there is no other support structure to which they can turn. Faulkner suggests that engineers’ intimate identification with work and its associated technology provides engineers with a ‘separate reality’ as evidenced in the meetings. Furthermore it prevents them from asserting more positive identities when amongst non-engineers. ‘Indeed, we may view engineering as a fraternity built around this common identity with, and pleasure and pride in, technology’ (2000: 107). Men who have been diagnosed demonstrate this extreme dislocation bodily: they are

28 Although the branch has two women members and I was permitted to attend all these meetings.

29 Even when I tried to initiate broader discussions on the men’s family relationships during these meetings, they quickly changed the subject back to either their own formative experiences as apprentices or to their current work problems or experiences.

seen to change in personality, withdrawing into themselves: ‘they all get the same attitude, they jump at anything, they look out the window, they don’t talk, they go into themselves’. As Menon points out, since the 1970s these men have been aware of the dangers of asbestos and have been waiting for the diagnosis. Once they get the disease, it is a catastrophe for them (2006).

Ultimately the laggings find themselves in a complex situation. On the one hand, the men avoid seeking medical help and confronting diagnosis for all the above-discussed reasons. A positive diagnosis is not merely about acknowledging the disease, it also initiates withdrawal and social and professional ‘death’. On the other hand, and as will be demonstrated in the following section, the laggings take on the legal fight as a fight against authority. Their legal struggles have a communal component and become a further expression of their masculinity.

6 Masculinity: family and legality

Until January this year, when the new legislation was enacted, laggings would initiate a claim as soon as they were diagnosed with an asbestos-related disease. Their approach to this legal process has been remarkably uniform. Although the legal framework compensates more to people who have more severe forms of asbestos-related disease and although laggings are convinced that pleural plaque is an indication that they will succumb to asbestosis, lung cancer or mesothelioma in the future, they all agree on a full and final settlement. As illustrated in the case of Erick Williams above, who was paid £17,500 in full and final settlement for pleural plaque and then died of mesothelioma four years later, this appears to be strangely illogical. It certainly runs counter to the legal position that people will seek to make a business out of litigation, and the idea of a compensation culture which aims to maximise financial terms. The case of Ben Smythes, the only lagging I came across, who took a provisional settlement shows how one might benefit from such an agreement. In 1987, he was diagnosed with pleural plaque. When he went to court, Dr Dunne estimated the degree of damage to his lungs to be 20 per cent while the opposition doctors said 10 per cent. They settled on 15 per cent and Ben received £40,000 as a preliminary settlement for pleural plaque in 1987. As he puts it, ‘I lived to fight another day’. There has been slight deterioration in Ben’s condition since then but no significant changes in terms of the medically defined categories of ARD. Should this happen, Ben can go back to court and claim further compensation.

From an outsider perspective, this seems the most lucrative and logical way of progressing, but further investigation into Ben’s case shows that this is not what he intended: he initially went to court hoping for a full and final settlement, but when he discovered that the defendants had included a second doctor’s opinion (based on his medical records rather than a physical examination), he became worried. Not only did this doctor indicate that it was Ben’s lifestyle which was problematic by including a diagnosis of obesity in his report, but ‘I was going to get slaughtered, it was one against two’. Ben asked for an adjournment – in order that he might have time to find another doctor to support his evidence – but this was refused. He then requested to change his claim from full and final to preliminary, aiming still to find

additional medical support for his claim of 20 per cent. It was on this basis that, once the case resumed, Ben was stuck with the preliminary claim. Today, aged 61 and reflecting back on the case, he says: 'I don't know why I'm not dead, I shouldn't be alive now'.

It is for precisely this reason that the ladders chose a full and final settlement. Once diagnosed – even if with pleural plaque – they have no way of knowing how much longer they are going to survive and they believe that the next phase for them is 'in a hospital bed'. So the men, who think that they are going to die anyway, aim to get the legal process over with and to collect a compensation payment – as soon as possible. Indeed a legal claim can take anything from two to ten years to complete, leaving the men in limbo throughout this time. Their intention is to invest this money as a source of protection for the family, and simultaneously to find a new, easier way of earning an income. This is because, despite medical opinion, many men experience breathlessness from pleural plaque and find it hard to continue the gruelling workload associated with lagging. They hope to continue to be able to bring in some money, albeit less than before.: 'If you get a lump sum you can diversify, get a different job, take a different course in life' but, 'You can't go back, you get your bit of dosh and go and do whatever'. However, although Ben (described above) received £40,000 for pleural plaque in 1987, compensation payments have been going down steadily since then and the average payment in 2005 for a case of pleural plaque was about £6,000–£7,000 (Hazards 2005). Although this is not enough to invest – and to guarantee – a family's economic security; the money is still used to 'put your house in order'. Almost all the men interviewed used the money to pay off their mortgage, to buy new furniture and for a holiday.

7 Conclusion

Ironically, the ladders' approach to asbestos-related diseases is one which enhances their masculinity. They 'fight' the disease through refusing to admit its presence, through refusing to discuss it with their wives and other family members, through engaging in legal court cases and through fighting their deceased friends' cases. So, not only is someone a tosser if he cannot use technical machinery, he is also a tosser if he does not sue for compensation. In this context, the act of suing is also an expression of masculinity. This fight is one in which, although couched in the language of financial compensation, is fundamentally about issues of recognition. It is about the acknowledgement of the ladders' experience, about the recognition that pleural plaques are 'real' and have immediate ramifications. The fight against the medical and legal systems can also be viewed as a metaphor for a certain way of life. It is about the survival of people who have old industrial diseases, about men whose lives are at an end, who are part of the old white working class. Ultimately, the fight is a metaphor for a dying way of life.

There is a postscript to this story: the ladders' concern with Erick Williams's experience led them to request that their solicitor obtain further clarity and 'missing' medical records from Dr Dunne. Dr Dunne responded to a series of

specific questions, provided the 'missing' medical reports and explained his reasoning. Finally, he said:

I can assure the authors ... that there is absolutely no basis whatsoever for the suspicion that evidence of mesothelioma should, or even could, have been detected in January 2002 or in December 2002, the two occasions when I saw Mr Williams. I estimated a 6% risk that Mr Williams would develop mesothelioma and that can emerge at any time ...³⁰

Both Dr Dunne and their solicitor, Martin Longsmith, sought to reassure the men that pleural plaques were not precursors of other, more debilitating asbestos diseases. Martin Longsmith wrote, in his covering letter to the president of the Dagenham Branch, 'It further follows that members of your branch who currently have pleural plaques need not fear that they also have mesothelioma although, sadly, a minority are bound to contract it in the future' (8 November 2006). His response adheres to medical and legal processes which seek to turn uncertainty into ideas about risk and certainty. For this reason, the 6 per cent has come to hold a particular significance. As is evident in the above discussion, the ladders are also working with ideas of certainty and argue that 80 per cent of the men diagnosed with pleural plaque end up with mesothelioma. It is perhaps for this reason that, when reading out Dunne's reassurance to his members, the president misquoted Martin Longsmith and said: 'It further follows that members of your branch who currently have pleural plaques need not fear that they also have mesothelioma although, sadly, a *majority* are bound to contract it in the future'.

What the president did not read out, was Dr Dunne's conclusion:

In my view, the moral to be drawn from this sad case is not that mesothelioma should, or even could, have been detected in 2002 but that individuals in Mr William's position should give very serious consideration to provisional damages rather than final damages because it is simply not possible to know if and when mesothelioma may emerge and if persons who have had heavy exposure to asbestos take final damages for benign conditions it is inevitable that a few of them will develop mesothelioma not long after their cases have been settled.³¹

Bio-medicine, law and engineering all reproduce a mind:body dualism which favours rational, unemotional, individual and positivist ways of problem solving which are, as Good has pointed out, based on the objectification of the body (1994). These dualisms, coupled with the biologically-dominated perspective of medical science, are perpetuated in the legal process of obtaining compensation for asbestos diseases. Simultaneously these processes negate the experience of ladders, who are bodily involved in their trade, who experience their masculinity through the use of machinery and through the processes of male bonding and who therefore experience pleural plaques as a form of bodily incapacitation despite medical expertise and their 'benign' nature. The diagnosis of pleural plaques represents a

30 B. Dunne, letter to M. Longsmith, 1 November 2006: 2.

31 B. Dunne, letter to M. Longsmith, 1 November 2006: 2.

crisis in their masculine identity. Dr Dunne's attempt to resolve the controversy around Erick Williams's death through reference to individual responsibility and the way the ladders make use of the legal system is not surprising. It is part of the way medical practice prioritises 'rational', individualistic behaviour over social constraints and intersubjectivity (Good 1994: 23). However, as this paper has demonstrated, such an approach fails to recognise the manner in which ladders construct their masculinity around the medical/legal frameworks and the socio-economic and political environments in which they experience the disease and enact their masculinity. The legal decision, based on 'scientific medical evidence' that pleural plaques are benign and that sufferers cannot sue for compensation removes the final opportunity ladders have to claim some money – while still alive – in order to provide for their families and for themselves personally; and in so doing to fulfil their role as men. The failure to litigate while still relatively healthy and to be able to invest compensation in ways that allow ladders to feel confident that their families are provided for, increases – rather than reduces – their stress as they struggle to maintain their identity and role as men, ladders and providers. Not being able to sue for pleural plaque means waiting for the disease to progress to asbestosis or mesothelioma. Once this happens, and because of the delayed diagnosis, a ladder's life expectancy is so limited and his quality of life so contracted, that suing for compensation requires too much energy. By this stage, the brutal reality is that the sick men face imminent death.

References

- Adam, B., Beck, U. and van Loon, J. (2000) *The Risk Society and Beyond: Critical Issues for Social Theory*, London, Sage
- Balshem, M. (1991) 'Cancer, Control, and Causality: Talking About Cancer in a Working-Class Community', *American Ethnologist* 18.1: 152–72
- Barker V Courus (UK) plc (formerly Saint Gobain Pipelines plc)* [2006] UKHL 20 (transcript)
- Barking and Dagenham Post* (2006) 'Dying of Anger', 22 March
- Beck, U. (1992) *Risk Society: Towards a New Modernity*, London: Sage
- Bourke, J. (2005) *Fear: A Cultural History*, London: Virago Press
- Brown, E.R. (1979) *Rockefeller Medicine Men: Medicine and Capitalism in America*, Berkeley/ Los Angeles: University of California Press
- Burnham, J.C. (1982) 'American Medicine's Golden Age What Happened to It?', *Science* 215: 1474–9
- Collier, R. (1998) *Masculinities, Crime and Criminology: Men, Heterosexuality and the Criminal(ised) Other*, London: Sage
- Connell, R. (1995) *Masculinities*, Cambridge: Polity Press
- (1987) *Gender and Power*, Cambridge: Polity Press
- Connell, R.W. and Messerschmidt, J.W. (2005) 'Hegemonic Masculinity: Rethinking the Concept', *Gender and Society* 19.6: 829–59
- Douglas, M. and Wildavsky, A. (1982) *Risk and Culture, An Essay on the Selection of Technical and Environmental Danger*, Berkeley: University of California Press
- Durodié, B. (nd.) *Risk Case Studies: The Concept of Risk*, The Nuffield Trust Global Programme on Health, Foreign Policy and Security; The Nuffield Health and Social Services Fund; UK Global Health Fund
- Erikson, K. (1990) 'Toxic Reckoning. Business Faces a New Kind of Fear', *Harvard Business Review*, January–February: 118–26
- Eversheds, (2006) *Briefing: Landmark Court Decision Chips Away at Asbestos Compensation Claims*, 23 February [www.eversheds.com/Documents/Insurance/BriefingAsbestos23Feb06\(8705\).pdf#search=%22landmark%20court%20decision%20eversheds%22](http://www.eversheds.com/Documents/Insurance/BriefingAsbestos23Feb06(8705).pdf#search=%22landmark%20court%20decision%20eversheds%22) (accessed 10 October 2006).
- Faulkner, W. (2000) 'The Power and the Pleasure? A Research Agenda for "Making Gender Stick" to Engineers', *Science, Technology & Human Values* 25.1: 87–119
- Field Fisher Waterhouse (2006) *Asbestos Disease Claims: A Client's Guide*, Summer, London: FFW
- (n.d.) *Mesothelioma: A Patient's Guide to Compensation*, London: FFW

- Furedi, F. (1997/2002) *Culture of Fear: Risk-taking and the Morality of Low Expectation*, London: Continuum
- Gee, D. and Greenberg, M. (2002) 'Asbestos: From "Magic" to Malevolent Mineral', in P. Harremo, D. Gee, M. MacGavin, A. Stirling, J. Keys, B. Wynne and S. Guedez Vaz (eds), *Late Lessons from Early Warnings: The Precautionary Principle 1896–2000*, Copenhagen: European Environment Agency
- Gilmore, D. (1990) 'Men and Women in Southern Spain: "Domestic Power Revisited"', *American Anthropologist* 92.4: 953–70
- Good, B.J. (1994) *Medicine, Rationality, and Experience: An Anthropological Perspective*, Cambridge: Cambridge University Press
- Grieves and others v FT Everard & Sons & British Uralite plc and others* [2005] EWHC 88 (QB)
- Grieves v FT Everard & Sons* [2006] EWCA Civ 27 (transcript)
- Gutmann, M.C. (1997) 'Trafficking in Men: The Anthropology of Masculinity', *Annual Review of Anthropology* 26: 385–409
- Hacker, S. (1989) *Pleasure, Power and Technology: Some Tales of Gender, Engineering and Cooperative Workplace*, Boston, Unwin Hyman
- Hazards (2005) *Burying the Evidence* 92, November, www.hazards.org/cancer/report.htm (accessed on 7 November 2006)
- Hearn, J.I and Morgan, D.H. (1990) 'Men, Masculinities and Social Theory', in Hearn and Morgan (eds), *Men, Masculinities and Social Theory – Critical Studies on Men and Masculinities*, London: Unwin and Hyman
- Helman, C. (1984) *Culture, Health and Illness*, London: Wright PSG
- Jasanoff, S. (1996) 'Beyond Epistemology: Relativism and Engagement in the Politics of Science', *Social Studies of Science* 26.2: 393–418
- (1995) *Science at the Bar*, Harvard: Harvard University Press
- Kazan-Allen, L. (2006) *Law Lords Crucify Asbestos Victims*, electronic mailing, International Ban Asbestos Secretariat
- (1999) 'Asbestos Finally Banned In The United Kingdom', *British Asbestos Newsletter* 36, Autumn, www.ibas.btinternet.co.uk/Frames/f_ika_uk_ban.htm (accessed 2 June 2006)
- Kleinman, A. (1995) *Writing at the Margin: Discourse Between Anthropology and Medicine*, Berkeley: University of California Press
- (1981) *Patients and Healers the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine and Psychiatry*, Berkeley: University of California Press
- (1977) 'Depression, Somatization and the New Cross-Cultural Psychiatry', *Social Science and Medicine* 11: 3–10

- (1974) 'Cognitive Structures of Traditional Medical Systems', *Ethnomedicine* 3: 27–49
- Kohlstedt, S.G. and Longino, H. (1997) 'The Women, Gender and Science Question. What do Research on Women in Science and Research on Gender and Science have to do with Each Other?', *Osiris, 2nd Series, Vol 12. Women, Gender and Science: New Directions*, 3–15
- Komarovsky, M. (1964) *Blue Collar Marriage*, New York: Vintage
- Lohan, M. (2000) 'Constructive Tensions in Feminist Technology Studies', *Social Studies of Science* 30: 895–916
- London Hazards Centre (1995) *Asbestos Hazards Handbook*, London: London Hazards Centre
- McClintick, D. (2000) 'The Decline and Fall of Lloyd's of London', *Time* 155.7: 36–58
- McCulloch, J. (2002) *Asbestos Blues: Labour, Capital, Physicians and the State in South Africa*, Oxford: James Currey
- McInnes, C. (2005) *Health, Security and the Risk Society*, The Nuffield Trust Global Programme on Health, Foreign Policy and Security; The Nuffield Health and Social Services Fund; UK Global Health Fund
- Mellström, U. (2002) 'Patriarchal Machines and Masculine Embodiment', *Science, Technology and Human Values* 27.4: 460–78
- Menon, R. (2006) 'Psychological Effects of an Asbestos Related Disease', presentation Mesothelioma Conference at the London School of Hygiene and Tropical Medicine, 11 May 2006, London
- Moore, H. (1993) *A Passion for Difference: Essays in Anthropology and Gender*, Cambridge: Polity Press
- Mossman, B.T and Gee, B.L. (1989) 'Asbestos-Related Diseases', *New England Journal of Medicine* 320: 1721–30
- Mollona, M. (2005) 'Factory, Family and Neighbourhood: The Political Economy of Informal Labour in Sheffield', *Journal of the Royal Anthropological Institute* 11: 527–48
- Murray, T.H. (1986) 'Regulating Asbestos: Ethics, Politics, and Scientific Values', *Science, Technology and Human Values* 11.3: 1–13
- Palladino, P. (2002) 'Between Knowledge and Practice: On Medical Professionals, Patients, and the Making of the Genetics of Cancer', *Social Studies of Science* 32.1: 137–65
- Reinold Noyes, C. (1940) 'The Law and Scientific Method', *Political Science Quarterly* 55.4: 496–521
- Rudd, R. (2006) 'Asbestos Related Lung Cancer', presentation at the Mesothelioma Conference at the London School of Hygiene and Tropical Medicine, 11 May, London

- (2004) *Pleural Plaques*, report prepared for the court in the *Grieves & Ors v FT Everard Sons & British Uralite Plc & Ors* [2005] EWHC 88 (QB) case
- (2002) 'Benign Pleural Disease', in D. Hendrick, W. Beckett, P.S. Burge and A. Churg (eds), *Occupational Disorders of the Lung: Recognition, Management and Prevention*, London: Saunders Ltd
- Selikoff, I.J. (1977) *Disease Prevention in Asbestos Insulation Work*, International Symposium on Safety and Health in Shipbuilding and Ship Repairing, Helsinki, Finland, 1971. Geneva, ILO, 1972. Occupational Safety and Health Series 27: 13–26
- Selikoff, I.J. and Hammond, E.C. (1975) 'Multiple Risk Factors in Environmental Cancer', in J.F. Fraumeni Jr (ed.), *Persons at High Risk of Cancer – An Approach to Cancer Etiology and Control*, New York, Academic Press
- Selikoff, I.J., Churg, J. and Hammond, E.C. (1968) 'Asbestos Exposure, Smoking and Neoplasia', *JAMA* 204: 104–10
- (1964) 'Asbestos Exposure and Neoplasia', *JAMA* 188: 22–6
- Steinberg, Harry (2006) *Pleural Plaques – an Update*, Personal Injuries Bar Association, January www.piba.org.uk/assets/docs8/pplecture_PIBA_draft4_170106.doc (accessed 8 August 2006)
- Stephens, S. (2002) 'Bounding Uncertainty: The Post-Chernobyl Culture of Radiation Protection Experts', in S.M. Hoffman and A. Oliver-Smith (eds), *Catastrophe and Culture: The Anthropology of Disaster*, Oxford: James Currey
- Tiger L. (1984/1969) *Men in Groups*, New York: Boyars
- De Vuyst, P. and Genevois, P.A. (2002) 'Asbestosis' in D. Hendrick, W. Beckett, P.S. Burge and A. Churg (eds), *Occupational Disorders of the Lung: Recognition, Management and Prevention*, London: Saunders Ltd
- Ward, H. (2002) *Corporate Accountability in Search of a Treaty: Some Insights from Foreign Direct Liability*, Royal Institute of International Affairs Briefing Paper 4: 1–11
- Warner, J.H. (1995) 'The History of Science and the Sciences of Medicine', *Osiris, 2nd Series, Vol 10. Constructing Knowledge in the History of Science*: 164–93
- Wikely, N. (2000) 'The Victim and the Law: Problems in Social Security Adjudication' in T. Gorman (ed.), *Clydebank: Asbestos the Unwanted Legacy*, Clydebank Asbestos Partnership, Glasgow: Clydeside Press