



Northern Ireland
Assembly

**COMMITTEE FOR
FINANCE AND PERSONNEL**

**OFFICIAL REPORT
(Hansard)**

**Damages (Asbestos-related Conditions)
Bill**

9 February 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:

Mr Daithí McKay (Chairperson)
Mr David McNarry (Deputy Chairperson)
Dr Stephen Farry
Mr Paul Girvan
Mr Simon Hamilton
Mr Mitchel McLaughlin
Ms Dawn Purvis

Witnesses:

Professor Anthony Seaton) University of Aberdeen

Dr Richard Shepherd) Consultant Respiratory Physician

The Chairperson (Mr McKay):

I welcome Professor Anthony Seaton from the University of Aberdeen and Dr Richard Shepherd, who is a consultant respiratory physician. Professor Seaton has given evidence to the Scottish Justice Committee on the equivalent legislation and has presented evidence to the Ministry of Justice in England. Dr Richard Shepherd recently retired from practice at Belfast City Hospital. Gentlemen, I invite you to make a few short opening remarks.

Professor Anthony Seaton (University of Aberdeen):

Thank you for inviting me, Chairman. In the interests of time, I will not make a statement. I have written down what I believe to be the truth about these matters. I apologise, because my

paper was written for the Ministry of Justice in England; however, it is very similar to what I wrote for the Scottish Justice Committee. I have not adapted it for Northern Ireland, but if there are questions specifically about the population in Northern Ireland, I will try to address them.

Dr Richard Shepherd (Consultant Respiratory Physician):

I do not have anything to say at the moment, unless members have particular questions on definitions, as those sometimes cause confusion in asbestos-related disease.

The Chairperson:

Some of the medical evidence that the Committee received suggests that people with pleural plaques who have been heavily exposed to asbestos at work have a risk of contracting mesothelioma that is more than 1,000 times greater than risk to the general population. In your submission, Dr Shepherd, you note that the plaques are a marker of exposure to asbestos and therefore a marker of a small degree of risk of developing asbestos-related disease in future. Statistically, does a person with pleural plaques have any greater chance of developing a more serious asbestos-related condition than someone who has been exposed to asbestos but who has not developed the plaques?

Secondly, what is your assessment of the risk of someone with pleural plaques developing other asbestos-related conditions?

Dr Shepherd:

The risk of developing asbestos-related disease relates to the degree of exposure to asbestos. Take, for example, two workers who worked at the same job for the same length of time and who were exposed to the same amount of asbestos. Even if one of them develops pleural plaques and the other does not, their risks of developing asbestos-related disease are the same.

The risk of someone with pleural plaques developing other asbestos-related conditions depends on the degree of asbestos exposure; it is a product of the concentration and intensity of asbestos exposure and the length of time that they were exposed to it. Moreover, for mesothelioma in particular, the time from initial asbestos exposure is a factor. You require all that information before you can formulate what you reckon a person's risk of developing mesothelioma might be.

Professor Seaton:

What you said, Chairman, was correct: a person with pleural plaques has a much greater risk of developing a serious asbestos-related disease than someone who has not been exposed to asbestos, which is most of the general public. Pleural plaques are simply an indication that someone has been exposed to asbestos. Their absence is not a terribly reliable indicator that someone has not been exposed to asbestos. In other words, even if you were exposed to asbestos, you may well not develop pleural plaques.

The diagnosis of pleural plaques is not as simple as one might think. A radiograph will not show a lot of pleural plaques in a person who may have them; it may show things that look like pleural plaques but are not. That causes some of the medical difficulties. To be sure that someone has pleural plaques, you do a CT scan, which gives a person — and a population — considerable radiation.

Asbestos exposure, not pleural plaques, causes the risk of those horrible diseases. As well as mesothelioma, there is an increased risk of lung cancer. Lung scarring, which is called asbestosis, is rare nowadays. Asbestos exposure, not the manifestation of pleural plaques, causes the risk.

The Chairperson:

Do pleural plaques have any effect on lung function?

Professor Seaton:

No; they are completely benign. They are very common. I remember early in my career, in the early 1970s, a pathologist who had studied the problem showed me his figures. In Cardiff, where I worked at the time, one in 10 of the male population had pleural plaques. It simply reflected the fact that many people had been exposed to asbestos over the war and post-war periods.

The reason that I give evidence on this subject, apart from the fact that I have studied it for many years, is that it became very difficult for us to manage people with pleural plaques once it became a subject of litigation. When you have to write a report on someone who has pleural plaques, the lawyers want you to say what his risk is of x or y, and, inevitably, that brings to the forefront of someone's mind the risk of dying of a very serious disease. Unfortunately, the process of litigation does not help. It does not reduce anxiety; it seems to increase it.

We used to explain to people that pleural plaques are harmless, but the fact that they have been exposed to asbestos, which they by and large knew, implied other risks. Those risks could then be put into perspective. However, that became almost impossible to explain convincingly once people were involved in litigation; that is why I welcomed the House of Lords opinion. It seemed to persuade the English Government, whereas the Scottish Government, on hearing the same evidence, took a completely different view.

Mr McLaughlin:

The Committee is wrestling with the issues that you have been dealing with for a long time during your career. Dr Shepherd's submission indicates that pleural plaques do not normally cause symptoms, nor do they interfere with lung function. You argue that unless asbestos-related disease occurs, pleural plaques in themselves do not give rise to symptoms or cause any interference with lung function. Given your experience and study, can you say that they never cause any symptoms?

Dr Shepherd:

It is true to say that they virtually never do. There are reported stories that people sometimes notice a little scratchiness, for want of a better word. However, I have never known anyone to have symptoms related to pleural plaques; they do not become breathless or have pain in their chest. We do not know whether the scratchiness is related to plaques or to some other asbestos-related inflammation that can cause a pleural effusion that we may notice. However, it is generally medically accepted that pleural plaques do not cause symptoms and do not interfere with lung function.

Professor Seaton:

I support that: I have never seen pleural plaques cause symptoms of any sort. The problem is that there is a different condition called diffuse pleural fibrosis and another condition called acute asbestos pleural effusion, which can sometimes be confused with pleural plaques. Those conditions cause symptoms. In medicine we say "never say never", and I suppose that it is conceivable that something could happen. However, the reason that I can say with confidence that they do not cause symptoms is that they are not on the lung; they are underneath the ribs, and they do not invade the tissues. They simply sit on the pleural membrane, not the pleural membrane that covers the lungs, but the pleural membrane that goes inside the ribs and round the

heart and diaphragm.

Pathologically, they are simply scars, and over the surface of the scar is a lining of normal pleura; they are lubricated just as the pleura is lubricated and so do not interfere with movement in any way. That is different from diffuse pleural thickening, which is a response of the other lining of the pleura, that is, the lining over the lung. It also interferes with the lung and can often cause adhesion of the pleura so that the lung does not move smoothly in the chest wall. In those circumstances, people can sometimes have inflammation, pain and a reduction in the ability of the lung to move, which makes lung capacity smaller. The two conditions are quite distinct. Medically, the more important is diffuse pleural thickening, for which compensation is available.

Mr McLaughlin:

Are you aware of medical opinion that differs from the conclusions that you have drawn?

Professor Seaton:

No. If you look at any text book, you will find that what we say is supported. However, since I wrote some of the text books, that is probably not surprising. Perhaps people who write text books copy from other text books.

Mr McLaughlin:

At least you have read your own books.

Professor Seaton:

I read my own books regularly to remind myself of what I said. *[Laughter.]* I have heard it said that some people have described the occasional case, but that does not really make a story. Things happen that can make people feel that what a patient had was due to a pleural plaque in an individual case. However, epidemiologically, wearing my other hat as one who studies populations, there is no evidence that they cause problems, although there is evidence that they are associated with asbestos exposure. To that extent, they are important and require careful medical explanation when we see patients.

When we see patients with those conditions it is almost always as a result of an incidental finding on an X-ray: the patient will have had a cough, gone to their doctor, had an X-ray and pleural plaques were found. That is the usual reason. Increasingly, however, it comes through

litigation, with people being referred by their lawyers.

Dr Shepherd:

I agree totally. A huge body of medical literature says that pleural plaques do not cause symptoms and do not interfere with lung function; they are simply a marker of previous asbestos exposure.

Dr Farry:

Welcome, gentlemen, and apologies again for keeping you waiting. Is there a consensus in the medical community that pleural plaques are asymptomatic?

Dr Shepherd:

Definitely; it is unanimous. Investigations were done in the UK, and the Industrial Injuries Advisory Council has looked at the issue on several occasions, and all came to the conclusion that there is no evidence to suggest that pleural plaques cause symptoms or interfere with lung function.

Dr Farry:

One of the arguments put to us is that because it was a compensable condition before the Johnson ruling, we need to redress what is now seen as an injustice in the sense that what was once compensable is no longer so. Will you give us the background to the medical thinking and consensus? Is it a relatively recent consensus or has it been around since the 1970s or 1980s but was not really taken into account by the courts?

Professor Seaton:

I have been through the process since I was a consultant in 1970. The asbestos story has developed on my watch, as it were.

No one even considered any sort of compensation for patients with pleural plaques in the 1970s and 1980s because we knew that they were harmless; it arose originally because of the interests of certain legal firms. There were rich pickings in the business: I calculated that probably a million people in England and Wales, and perhaps 22,000 in Northern Ireland, had pleural plaques. That was the start of it. After that, it became difficult medically to explain to people. I remember being told by a lawyer in Glasgow that when we saw someone with pleural

plaques, we must tell them that they were entitled to sue. On the industrial injuries benefit side, there has been no equivocation at all: pleural plaques have never been accepted as a condition for which someone should claim industrial injuries benefit for the very good reason that they do not cause any harm.

Dr Farry:

Finally, another argument that can be advanced is that we are ultimately compensating people for their exposure to asbestos. In that respect, is the presence of pleural plaques a reliable way of capturing that population? Of the people who have been exposed to asbestos, what percentage — is it 90%, 50% or 10% — are likely to develop pleural plaques? If we go down that line, is there a potential major injustice of losing a significant number of people who have been exposed to asbestos?

Professor Seaton:

The simplest way of finding out whether someone has been exposed to asbestos is to ask them. A very high proportion of people who have been exposed will never get pleural plaques because it depends entirely on how much asbestos they have been exposed to. I have been exposed to asbestos, but it is unlikely that I have pleural plaques — they have never been seen on my chest X-rays — because I have not been exposed to much of it. Most people of my generation were exposed to some asbestos. We studied the lungs of people who did not know that they had been exposed to asbestos and found asbestos in small amounts.

You are right: the proposed law would compensate people for exposure to asbestos, but it would compensate a small minority who had been exposed. It would perhaps catch some of the people who have been most exposed. However, there is an unfairness because many people who were equally exposed do not have pleural plaques.

On the other side — and this is important — when people claim compensation, which can be substantial sums of money to the average person, many investigations are done. X-rays may reveal things that look like plaques but which turn out not to be when a CT scan is done; they may turn out to be fat pads under the chest wall. CT scans show abnormalities in a surprising number of people. That causes worry, and the person could end up being bronchoscoped or having a thoracoscopy and undergoing all sorts of investigations. It usually turns out to be nothing very serious, but it causes a great deal of anxiety. There are negatives as well as positives

in doing that. That is another reason that I feel strongly about it.

Ms Purvis:

Thank you, gentlemen; you are very welcome. I am struggling a wee bit, because I have met quite a number of my constituents in east Belfast who have been exposed to asbestos through working in the shipyard and who have pleural plaques. That is why I struggle with the view that pleural plaques never interfere with lung function because, having met those people, it is clear that they have severely restricted lung function. I wonder how easy it is to misdiagnose pleural plaques with some of the more serious things that you spoke about. For example, what is the difference between pleural effusion, pleural fibrosis, asbestos-related pleural thickening and asbestosis? Could those people be suffering from something more serious but have been diagnosed with pleural plaques?

Dr Shepherd:

That is one of the problems that occur, because patients, and sometimes other doctors, are confused about the various asbestos-related terminology. When patients have a chest X-ray that shows pleural plaques, they may often be told that they have asbestos on their chest X-ray and they immediately think the worst. They may think that they have asbestosis or have heard of asbestos-related cancers and think that they have one of them.

Medically, the different conditions are easily distinguishable. Pleural plaques are easily distinguishable from diffuse pleural thickening, pleural effusions — whether asbestos-related or not — and fibrosis in the lungs, which is asbestosis. As Professor Seaton said, pleural plaques are not actually in or on the lungs but on the internal surface of the chest wall. Pleural plaques are easily medically distinguishable from the other asbestos-related diseases.

Professor Seaton:

Many people who have pleural plaques also have impaired lung function. There is no doubt about that. In those cases, the impaired lung function is due to something else, most commonly smoking-related emphysema or chronic bronchitis. However, those are distinguishable from pleural plaques, which have no effects.

I expect that you also have constituents who worked in the shipyards who do not have pleural plaques and who have bad chests. They will, of course, wonder why their mate got compensation

when they did not. That is an issue that you have to face when you dichotomise and pay compensation to some people but not to others, because if you pay compensation to people with pleural plaques you are, in fact, paying them for having been exposed to asbestos.

Dr Shepherd:

You are paying compensation to some of those who were exposed to asbestos; you are not paying compensation to those who do not have pleural plaques but who have similar degrees of risk.

Ms Purvis:

I am concerned that some of the constituents whom I met only have a diagnosis of pleural plaques, because I asked them whether it was related to some other impairment of their lungs and they do not have a diagnosis of anything else. I can see clearly that they are breathless and in distress, so I am just trying to get it clear in my head. Could there have been a misdiagnosis?

Professor Seaton:

Yes, unquestionably.

Dr Shepherd:

There are other causes of breathlessness: if they have heart disease, they may become breathless; if they are overweight, they may be breathless from exertion. It depends too on their fitness. If they are anaemic they may be breathless. There are many causes of breathlessness; it is not necessarily a form of lung disease.

Ms Purvis:

The first thing that I asked was whether there were any other underlying health conditions that might have caused their lung condition.

Professor Seaton:

I would ask them to see their GP and get them referred to — well, Richard is retired now, but they could see someone else. A chest physician would have no difficulty in sorting that kind of thing out.

Dr Shepherd:

Given the information that people with pleural plaques have and their understanding of what is

going on, they merit referral to an experienced chest physician so that they can have an explanation of what pleural plaques are and what they mean and so that the risks of developing an asbestos-related disease in future can be put into perspective. It is very common, initially, for people to think the worst. However, when you explain that they only have pleural plaques, they immediately say “Thank you very much, doctor; I feel so much happier now, because I thought that it was inevitable that something was going to happen to me.”

Ms Purvis:

Professor Seaton, in your submission you referred to pleural effusion and pleural fibrosis, suggesting that they are more serious than pleural plaques and that, in those cases, compensation is not in dispute. Are those conditions compensable in England and Wales?

Professor Seaton:

Yes.

Ms Purvis:

Clause 2 specifies two other asymptomatic conditions: asbestos-related pleural thickening and asbestosis. Do —

Professor Seaton:

I am sorry to interrupt, but they are not asymptomatic. They are symptomatic and important conditions. In essence, compensation for an industrial disease is paid for the pain and suffering that an individual has suffered as a result of tortious injury. If you add up the pain and suffering of someone with pleural plaques, medical opinion would always be that there is none and that any symptoms that the person may have are unrelated to the pleural plaques but related to some real condition. That, in essence, is what it is all about.

Asbestosis is potentially a very serious disease, although nowadays, as I said, we do not often see it. In Northern Ireland, there are about 40 cases a year, which is rather a lot. However, they are mostly the mild form of asbestosis, resulting from heavy exposures in the 1940s and 1950s in people who are now old. The old form of asbestosis, which I saw in my younger days, has disappeared. It just does not happen, because you require daily exposure to heavy doses of asbestos for years to get it.

Ms Purvis:

Do you have a view on clause 2, which would make provision for paying compensation for the conditions listed?

Professor Seaton:

If anyone has an occupational disease that causes them impairment in some way or, obviously, loss of life, they are fully entitled to claim for it in the courts. However, it depends on the seriousness of the condition. Doctors do not regard pleural plaques as a disease; they regard them as an anatomical abnormality of the chest wall, which, strictly speaking, is what they are.

Dr Shepherd:

What you are getting at is that, as Professor Seaton said, when we see asbestosis now, it is mild and usually non progressive. In some cases, insurers have tried to argue — on the basis of what is done in England and Wales, where pleural plaques are not compensable — that having very mild asbestosis or mild pleural thickening may not give rise to any symptomatology. Courts award damages for disability. If someone has some very minor CT scan changes that might suggest mild interstitial fibrosis, but there are no other physical signs on examination and their lung function tests are normal, insurance companies will try to argue that that person does not have a disability and should not, therefore, be compensated.

At some stage, we must ask what distinguishes a sub-clinical disease from a clinical one. However, in general, if you have an asbestos-related disease such as diffuse pleural thickening, asbestosis and mesothelioma and a disability as a result of them, you will be compensated.

Professor Seaton:

I would not want to appear unsympathetic to those who have been exposed to asbestos. I have seen many patients over the years with mesothelioma and asbestos-related lung cancer; they are terrible diseases and they attract appropriate compensation. The halfway house of unpleasant diseases such as pleural fibroses also attract compensation for the disability, pains and suffering that a patient experiences.

It is difficult to explain clearly to those with pleural plaques that the condition is not, in itself, harmful. It is equally difficult to explain to those who do not have pleural plaques but who have been exposed to asbestos the implication of exposure to asbestos. I have tried for many years to

estimate how much asbestos patients have been exposed to and tell them roughly their risks of contracting those serious diseases. I do it better now, because the data are better. The worst instances in trades with a heavy exposure to asbestos have a 10% risk of mesothelioma, which initially sounds frightening. It means that one in 10 people like the patient will get mesothelioma, which would frighten you and me. I then ask them what they think their chances are of getting cancer. I ask the Committee that same question today. I know that it is not for me to quiz you, but the Chairman could probably take a guess.

The Chairperson:

Is it one in three?

Professor Seaton:

Yes; that is correct. Therefore, we all have this horrible great thing looming over us that one in three of us will get cancer. Mesothelioma shifts the odds of the type of cancer you may get, but it shifts the odds of your getting cancer at all only slightly. Funnily enough, people generally find such an explanation helpful, as it stops them thinking that they will get mesothelioma and worrying about that horrible disease. It is a horrible disease and so is lung cancer.

There is much confusion in people's minds about mesothelioma, pleural plaques and asbestosis. It is complicated; people think that if they have pleural plaques they will die of asbestosis. That is the usual thing now, although it was not the case in the past. You can handle pleural plaques medically, but it becomes much more difficult in litigation, because litigation focuses the mind, and a doctor writing a report may emphasise the risks to help to maximise the settlement or vice versa. We are not meant to do that, but some doctors do.

Ms Purvis:

At present, people can pursue compensation for asbestos-related pleural thickening and asbestosis as symptomatic conditions. Clause 2 specifies the same conditions for which people can pursue compensation as asymptomatic. Am I right that you are saying that the cut-off point for being able to pursue compensation is decided by the level of disability?

Dr Shepherd:

Courts assess damages on the effect that a condition has on the individual.

Professor Seaton:

It is a legal issue; it is not for us doctors to tell the courts how they should do things. We can give advice. The House of Lords decision was very well argued; it is a logical statement of the legal situation.

Ms Purvis:

What would your view be if clause 2 were to name those two conditions as asymptomatic and, therefore —

Professor Seaton:

I am sorry, but which two conditions do you mean?

Ms Purvis:

Asbestos-related pleural thickening and asbestosis.

Professor Seaton:

Those are not asymptomatic.

Ms Purvis:

I am taking that from what Dr Shepherd said.

Dr Shepherd:

People may not have noticeable breathlessness. What I said was that the insurance industry is trying to argue that people whose lung function is normal should not get compensation because although they may have the disease they have no disability. That is very difficult to argue simply because the tests assess lung function while a person is static; they do not assess people's lung function when exercising. People will have lost some lung reserve, but it may not yet be apparent through marked breathlessness. It is then an argument of what is a disability. From my point of view, virtually everyone who has been diagnosed with asbestosis or diffuse pleural thickening will have some degree of disablement or loss of lung reserve.

Professor Seaton:

I was not aware that the insurance industry is arguing that people who have those conditions should be prohibited from taking legal action. That is completely wrong. Someone may have

acute pleurisy, for example, as a consequence of asbestos exposure; it is very painful, but it may not impair lung function. Pleurisy is a recognised medical condition. People who have recognised medical conditions that cause symptoms or serious prognosis — or even those without symptoms — should be entitled to compensation. They should certainly not be prohibited from taking legal action. That would be quite wrong.

There were some subtleties about what is a disease, and the House of Lords decided that pleural plaques are not a disease. I agree: pleural plaques do not cause disease. The argument continued about whether they cause anxiety. Of course, many things cause anxiety. The fact that people worked with asbestos and read newspaper reports causes anxiety, but paying people compensation will not cure their anxiety. From many discussions with patients, I have found that the investigation process makes people more anxious.

There are serious asbestos-related conditions; in Northern Ireland, there have been 44 mesothelioma cases per annum over the past nine years. I am afraid that there is nothing that we can do to prevent or cure such cases at the moment, and there will probably be nothing that we can do in the foreseeable future. That is a terrible legacy of an industrial era that has now largely finished, thank goodness. However, there is a long tail of people who have been exposed and who will develop those diseases, and some of them have pleural plaques.

Mr Hamilton:

I was going to ask about misdiagnosis, but Dawn raised that and I am happy with the responses.

The Chairperson:

Gentlemen, I thank you for your evidence to the Committee, and, once again, I apologise for the delay.