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Working-class studies, oral history and industrial illness

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Social class was and continues to be a key determinant of health and well-being: materialist interpretations that emphasize the importance of economic power relations have real traction in explaining patterns of mortality and morbidity in industrial and post-industrial societies. Health sociologist Clare Bambra, for example, has recently argued that 'Paid work, or lack of it, is the most important determinant of population health and health inequalities in advanced market democracies' (Bambra, 2012, ix). My argument, however, is that to really comprehend what is happening here we need to understand work-health cultures – that is the way that workers experienced, understood, reacted to and narrated such power relationships in their homes and workplaces. What did ill-health, disability and death signify and mean to individuals, to families, and to working-class communities? What impact did it have? And how did workers react to risk and manage illness, mobilise and organize around these issues? It is the contention here that for the period within living memory these sorts of questions can be elucidated by an oral history approach, developing a dialogue with those directly affected. We

need to listen (and to listen closely) to workers' voices to connect better to their worlds. Recently oral historians Michelle Winslow and Graham Smith commented: 'It is a mark of the contribution of oral history to the history of medicine that studies located within living memory are open to criticism if they fail to include oral history' (Winslow and Smith, 2011, 372). A similar case might be made for working-class studies.

Oral history, working-class studies and illness

Oral history is a method of reconstructing the recent past through tapping in to people's memories, usually these days using an electronic solid state recorder directly in new interviews, and/or consulting the vast archives of existing recordings housed in public record offices, sound libraries and museums. Oral interviewing as a research methodology has been applied to the field of working-class studies since oral history began, emerging as it did from socialist and feminist inspired work – for example in the UK from Paul Thompson and Elizabeth Roberts. Illness featured in such early studies, though was not a primary focus. Subsequently historians deploying an oral history interviewing methodology have drilled down and focused more on health cultures. One example would be Lucinda McCray Beier's 2008 monograph *For Their Own Good* which explored changing working-class attitudes to health and illness in England from 1880-1970. Based on oral history interviews with 239 people from North-West England undertaken in the 1970s and 1980s, McCray Beier's work shows the potential of oral history to inform us about every-day health cultures, behavior and responses to disease and disability in working- class

communities; how people understood and managed their illnesses, and, later, engaged with state services (the NHS).

Other work has shifted the focus to the patient – and here oral testimony is especially vital providing a counter-narrative to hegemonic medical models (Bornat, Perks, Thompson, Walmsley, 1999). An oral history approach essentially enables a *refocused* history centred on peoples' lives, on emotions, on personal experience and on narrators' voices. It informs us about how big processes such as industrialisation and deindustrialisation impacted upon working-class lives and on their bodies. In her work on disability in Alberta, Canada, Claudia Malacrida has argued persuasively that oral history enables people to 'bear witness':

> These narratives provide a politicized reading of relations of power, offering the patient an opportunity to bear witness to harms suffered, and drawing on the perspectives of subordinated individuals to expose the workings of power and domination within the medical encounter (Malacrida, 2015, 322).

And much of the best work is gendered, enriching, for example our understanding of health cultures and the agency, interventions and roles working-class women played as 'guardians' of family health, care and well-being (McCray Beier, 2008, 9). This was a core element of unpaid domestic labour. Working-class femininity, gender relations and the body have been a key focus, for example, in the pioneering work of Ann Oakley (1984), Jocelyn Cornwall (1990), Jan Walmsley (2000) and Joanna Bornat (2000). These writers have drawn heavily upon oral interviews to critically

examine issues around sexuality, ageing, health, disease, disability and illness in working-class communities (see also Fisher, 2006).

An oral history methodology is capable, then, of enriching our understanding of encounters between the environment (work; home; family) and the body. It enables us to locate those affected by illness within the specific socio-cultural spaces they occupied at that time. Whilst oral interview material requires critical and sensitive treatment (necessitating reflective evaluation of how memories are constructed and the past recalled), nonetheless these personal narratives provide a wide range of insights into ill-health.

Take, for example, the way that employment facilitates health (by providing purpose, identity and income) but also makes people ill. The history of occupational health and safety has been dominated by studies that have focused on the role of the state, policy-making (eg on Factory Acts and compensation systems) and corporate irresponsibility and neglect, in some notable cases forensically exposing the prior knowledge of hazards, neglect, and abuse that resulted in disasters – like the chemical leak at Bhopal – and epidemics of industrial disease—such as "black lung" (coal workers' pneumoconiosis) and asbestos-related diseases. A range of interpretations exist within what is a hotly contested terrain, from those at one end of the spectrum who make a case for corporate irresponsibility (economic violence; corporate killing) and those at the other who defend industry, shift the blame elsewhere, and castigate left-orientated historians and other researchers for inappropriate use of hindsight and failing to contextualize occupational illness in the

period and the prevailing state of knowledge and existing work-health cultures in the past. The historiography of asbestos illustrates this contested terrain very well (see, for example, Bartrip, 2001; Tweedale, 2001; McCulloch and Tweedale, 2008). Company records, court files, and state papers and enquiries were amongst the core source materials for such studies. With some exceptions, the debates tended to pass over or neglect the lived experience of disability and disease and to gloss over the agency of victims and their individual and collective responses.

The shift in research towards the personal and to discourses, influenced firstly by socialist and feminist ideas, then by postmodernism, changed this landscape. The history of work was an early focus of oral historians but a clutch of more recent studies focus directly on work-health cultures, the lived experience of disability and illness and how people directly affected articulated their stories and shaped their narratives. By providing a view from the workplace we gain valuable insights into the limited effectiveness of regulatory frameworks, whilst also getting a sense of the complexity of work-health and body cultures, the interplay of identities (such as gender, race and class), and the agency of workers negotiating paths through hazardous, exhausting, dusty, dirty and toxic work environments. A growing number of studies have turned to oral evidence to elucidate work and occupational health. These include Bloor, Perchard, Walker and McIvor and Johnston, which focus on the UK, High and Storey on injured workers in Canada, Portelli on coal miners in Harlan County, USA and Mukherjee on Bhopal, India. Economic violence and damaged bodies are recurring motifs in these studies.

These investigations have taken place and have been influenced by concurrent developments in the discipline of oral history. Partly in response to criticisms about the unreliability of memory, oral history has morphed from what has been termed 'reconstructive' oral history - typically where testimony was uncritically accepted at face value - towards more 'interpretative' approaches. The latter was influenced by the postmodernist turn and by the influential work of Italian oral historians, notably Luisa Passerini (1987) and Alessandro Portelli (1991). What emerged was a phase of introspection in the discipline, and the outcome was a more theoretically informed and methodologically rigorous oral history. Ideas were borrowed from a wide range of social science and other disciplines (including sociology, anthropology, psychology, and linguistics) and tested against the empirical evidence. Memory studies analysed the working of memory, basically confirming the fundamental reliability of long-term memory whilst the subjective nature of the evidence - formerly criticized as a weakness - became recognized as a strength. Silences in life stories and misremembering were identified as being significant in their own right and judged to be full of meaning. Inter-subjectivities also became a focus. Testimonies were observed to be composed and shaped both by the interviewers' subjectivities (such as gender and class) and in a dialogue with the interviewee as well as by the prevailing wider media and culture - what has become known as 'the cultural circuit' (Thomson, 1994; Summerfield, 1998). The present thus impinges upon the past in oral interviews. It was established that repetitions, metaphors, and anecdotes in oral testimonies have significance and that personal storytelling is subject to prevailing narrative structures and 'rules' within particular societies and cultures. In recalling their past in an interview context, narrators are filtering and

sieving memories, constructing and composing their stories, and mixing factual evidence with their own interpretations as they try to make sense of their lives in an active, dialogic, and reflexive process of remembering. Lynn Abrams recent book, *Oral History Theory* (2010), provides perhaps the best guide through such developments in the oral history discipline (and see Summerfield, 2019).

Oral history scholarship and methodologies have thus become more sophisticated and have contributed to widening understanding of working-class health cultures. The unique nature of oral evidence is now widely accepted and its veracity recognized. Oral historians are now much more reflexively critical of their material and acknowledge the influence their own subjectivities have upon the interview and how informants position themselves in the narrative, frequently using the encounter as a way of projecting a sense of self. Oral historians have postulated that *what* is remembered and *how* it is recalled is significant in its own right. The 'new oral history' influenced by postmodernist ideas has challenged and been fused onto the radical tradition of oral history, driven by a desire to give marginalized people a voice and a place, with an equality and democratizing agenda for history.

Work-health cultures, risk and the body

The contribution that oral history can make to the study of illness can be illustrated with reference to occupational health. Eye-witness testimonies lay bare the realities of irresponsible and abusive power relationships - economic violence - at the point of production and the limited resources that workers could bring to bear upon their situation (McIvor, 2015). The space in which workers toiled and the environment in

which bodies were located was frequently vividly recalled in interviews, with dust, death, illness and disability as recurring motifs. Asbestos workers in the UK (and elsewhere) recalled asbestos dust suspended like a 'fog' or falling like 'snow' in their post-war workplaces and of *playing* with the material - for example, making 'monkey dung' (asbestos cement paste), 'wigs' and 'snowballs' (Johnston and McIvor, 2000). Information was withheld from workers, or only selective and sometimes misleading information about hazards was leaked out - such as the erroneous claim that white asbestos (Chrysotile) was benign. (Johnston and McIvor, 2015). Whilst workers often had some intuitive and lay knowledge, they were not informed of the *extent* of the dangers to their health. They recalled feeling pressured to work with toxic and carcinogenic raw materials, or in dusty work environments at the coal face, to 'cut corners', ignore safety regulations, and maximize productivity. An unskilled machine operator who worked at the Turner and Newall Clydebank (Scotland) asbestos factory in the 1960s commented, 'I knew it was dangerous before I went in there 'cause there was people complaining, but when you have two of a family to bring up it was better than walking the streets. I never was idle in my life.' (Scottish Oral History Centre Interview – hereafter SOHC - 1 June 1999, SOHC/016/A26). In the same interview his wife recalled, 'He was frightened to walk out of the job because he was married with a family and he just could not afford to do it.' Motifs of danger and fear, the work ethic and family are evident here. Connections between disempowerment and illness are suggested and affirmed, not least in what happened to Owen and Margaret Lilly, who both subsequently died respectively of asbestosis and mesothelioma. In this sense these workers were victims of a Fordist, culture that exalted hard graft and the maximization of

production and earnings at all costs, including serious cumulative damage to the body.

Occupational disease epidemics have to be understood, however, within a cultural framework - a milieu that facilitated the tolerance and persistence of abusive economic violence. There was a profound acculturation to undertaking dangerous and unhealthy work, a high-risk threshold, and a fiercely independent working-class culture where 'outside interference' could be resented and it was frowned upon for men to complain or 'make a fuss' about their health. A dominant (or hegemonic) mode of 'hard man' masculinity was forged in heavy industry workplaces in the UK and elsewhere (Johnston and McIvor, 2004). Stakhanovite grafting was exalted within working-class communities, where the 'top producers' and highest earners were lauded and praised. Those who sought to protect themselves beyond acceptable workplace norms could be pilloried as lesser men and their sexuality questioned – as 'jessies' or 'sissies' (homosexuals) – and subjected to peer pressure to take risks, to compete, to conform, and to maximize earnings. This was what was expected of men in the performance of their 'provider' role as 'breadwinners', which lay at the very core of working-class masculinities.

This high-risk threshold culture and 'macho' behaviour was invariably condoned by employers and management, but to a surprising degree was also accepted as an integral, immutable part of working-class life. Male workers were socialized into this as kids and youths. Such risks were part of the fabric of manual working lives and rarely questioned. Heavy manual work forged masculinities and men developed a

complex relationship with dangerous, health-threatening manual work. High has discussed how working men understood danger, and contained it by identifying 'danger spots', regarding risk as 'localised', hence they could remember the workplace as relatively safe in their 'accident stories' (High, 2018, 102-22). Whilst attuned to hazards via accumulated lay knowledge on the job, working men were also capable of embracing the very processes that consumed their bodies in order to fulfil manly roles (Connell, 2000; Johnston and McIvor, 2004). You had to be seen to be grafting – as a 'worker' not a 'waster' (Wight 1994) – and as acting like a *real* man. This 'cultural disposition', as Portelli (2010, 139) puts it, contributed to the endemic bodily damage in mining communities caused by managerial economic violence.

Exposure to risk at work was not just confined to male workers, though the existence of a patriarchal dangerous work 'taboo' insulated most women from the highly hazardous and unhealthy industrial jobs. Some evidence suggests working class women in some jobs embraced a high risk threshold and a willingness to put wage maximisation before the protection of their bodies. Abendstern et al (2005) have argued this case for textile weaving in the UK. Recent research has also shown how a sense of patriotic duty in wartime also shifted attitudes towards work-related dangers and potential damage to health, inducing male and female workers on the home front to accept higher risks (Pattinson, McIvor and Robb, 2017). The workers' trade unions might challenge this, during hostilities and in peace time, but also at times tolerated it and legitimized it - as, for example, in their support for the system of extra payments (sometimes referred to as 'danger money') for working in dust and

some trade unions' endorsement of asbestos (even long after the dangers of it were well known). This is an area of considerable debate in the British literature and merits more attention. Trade unions were, on balance, undoubtedly important ameliorative interlocutors responsible for protecting workers' bodies and improving health. Still, there was a tension between on the one hand protecting the body and conserving labour power, and on the other maintaining jobs, taking risks and pushing bodies to the limit to maximize production, earn fatter wage packets and fulfil managerial and (in wartime) national expectations.

The Scottish Oral History Centre (established in 1995) has undertaken under its auspices a series of interview-based projects that explore the historical meanings of work and the ways that work interacted with the body, notably in the heavy industry sectors. Some of the interviews we did metal workers, construction workers, dockers and coal miners fizzed with bitterness and anger over illness, disability and fatalities; in others the tone was quiet stoicism and fatalistic acceptance of damaged bodies. Discovery of and confirmation that employers were aware of the risks long before workers were told were repeated narratives in the oral testimonies, as was the perception that what had happened was preventable killing and disabling of workers predicated upon prior knowledge of the toxic and deadly nature of the raw materials being mined, processed or handled. 'We were murdered' was a common enough refrain amongst interviewed workers exposed to asbestos. Clearly, however, evidence and knowledge that has accumulated since exposure has influenced the way people remember and recount illnesses and trauma – and we do need to be aware of the pitfalls of hindsight and potential distortion and 'contamination' of oral accounts

influenced by the ‘cultural circuit’ (Summerfield, 2019, 118-22; 127). Memories were framed with reference to the media and trade union exposures of coal workers’ pneumoconiosis, bronchitis and the deadly risks of working with asbestos, influenced by awareness of a changing compensation culture and incremental knowledge accumulation since the personal experiences being recalled - sometimes thirty, forty or more years previous. Such critical reflection does not invalidate the oral evidence, but does need to be taken account of in our interpretation of the material.

Living with illness, disability and death

Illness caused pain, sapped energies and affected identities and undermined lifestyles. What we now term ‘social exclusion’ was a common enough outcome of serious illness and disability. Industrial injuries and chronic disease in traditional ‘heavy’ industries like coal mining, iron and steel manufacture, shipbuilding, heavy chemicals, asbestos manufacture and the like were capable of destroying lives - leaving in its wake a legacy of disability, premature death, and deep psychological distress somewhat akin to other post-traumatic stress disorders. As a 64-year-old Scottish electrician with mesothelioma reflected, ‘Until now I thought trauma was a fad imported from America and reserved for the middle classes. I am now wiser’ (Interview 15 March 1999, SOHC/016/A13). Oral interviewing methodologies enable this experience to be explored and elucidated - to get behind the sterile body counts to the human dimension, the lived reality. Oral testimonies of those suffering from asbestos-related diseases, pneumoconiosis and bronchitis, for example, illuminate a hidden world of private grief, sadness, anger, frustration, disappointment, pain, and suffering. Ill men’s lives shifted from the workplace to the

feminized space of the home. They spoke movingly of restricted social and physical activities (such as walking, sports, and dancing). They told of relative economic deprivation associated with income reduction, of the trauma associated with medical diagnosis, and of living and coping strategies as people struggled to adapt and survive with the news they were going to die from an incurable cancer. Social exclusion of varying degrees was the outcome, though this could be mitigated in some close-knit working class communities (such as the coal mining villages). Relatively few workers in the twentieth century got any meaningful financial compensation for such damage to their bodies

Speaking to those directly implicated enables a *refocused* history revealing much about the emotional journey involved in the transition from fit and able worker to disabled and dependent, with all that represented for gendered identities. Such conversations take us deep into a personal (and often hidden) domain, informing us about how illness was managed and the impacts on the individual, the family, and the community. What is being recalled is frequently an intimate, personal story of damage, loss, pain, adjustment - and of mutating identities through the illness journey. For working-class men this could involve degrees of emasculation linked to being unable to perform traditional male breadwinner roles and other physical activities associated with masculinity. Male workers experienced loss of independence and dwindling financial resources making it difficult to sustain a consumption pattern commensurate with male identities, such as heavy drinking and smoking. This threatened a loss of work identity and the package of intrinsic and extrinsic rewards that were associated with work (such as camaraderie, pride in the

job, self-esteem). And such disruptions and destabilization could lead to tensions within the family.

Working-class men also appear to have responded less directly to health education and hazards-awareness campaigns than did women and were generally more reluctant to admit they had a health problem and seek medical intervention, and when ill they could refuse to allow help or admit they needed help. A wife whose husband died of mesothelioma reflected after his death that 'he never made a fuss … I was the one that used to see him sitting on the edge of the bed with his arms around himself rocking back and forward in pain' (Interview, 22 March 1999, SOHC/016/A20). A 61-year-old shipyard engineering worker with mesothelioma commented: 'A lot of it's my own problem. Too macho to be shouting out when I should be, you know, when I'm in pain … "just stop this bloody pain will you" ' (Clayson, 2008, 140).

In their oral testimonies, those affected narrated how this was lived in the everyday and how this *felt* to them. A Glasgow sheet metal worker reflected, 'I've had no social life since about 1980. Eh, people unfortunately don't want to know you when you're ill' (Interview 1 May 1999, SOHC 016/A9). Another bluntly commented on his inability to socialize and enjoy activities like dancing: 'I'm buggered' (Interview 22 December 1998, SOHC 016/A2). Emotions might be controlled by many men, except in private moments:

> … he took my hand and said: "I'm not going to see xxx as a bride". Then we went up to bed together and we just cuddled and we both cried. And it's the one and only time that I saw my husband crying (Interview, 22 March 1999, SOHC/016/A20).

This interviewee told of how her husband insisted on driving the car out of the drive 'and then we would pull in and stop and I would take over.' 'Men eh,' she pondered, 'don't like to give in.' Of course, coping capacities and strategies ranged widely, but oral testimonies consistently refer to the psychosocial distress and disruption to lives, commensurate to trauma, experienced by many such illness victims.

From Adversity to Advocacy: Building an Occupational Disease Movement

Those affected by illness were not just passive, inert victims but active and vocal agents in these processes that were consuming their bodies. In regions with a radical, socialist tradition, like Glasgow and many of the UK coalfields, levels of protest and resistance were high and powerful injured and diseased workers' movements emerged. A sense of injustice could be channeled into activity through mobilizations with advocacy groups, alliances with sympathetic doctors, physicians and environmental health activists and campaigning for more effective preventative measures, fairer compensation, and better palliative care. An oral interviewing approach enables the dynamics of such resistance, advocacy and mobilization within working-class communities around illness to be elucidated. For example, whilst national, industry-wide strikes on occupational health and safety issues were virtually unknown in the UK, in oral history interviews a hidden, subterranean

history of struggle at plant-level and even work-group walk-outs (and *threats* of industrial action) when health was jeopardized has been revealed (McIvor, 2017b).

And there was significant collective mobilization around health issues. The first known asbestos victims' advocacy group in the world (the Society for the Prevention of Asbestosis and Industrial Diseases) was established in London in 1978 by Nancy Tait, the wife of a post office worker who had died of mesothelioma. Tait was a tireless advocate for victims' rights and an outspoken campaigner against the asbestos industry lobby until her death in 2009. Now around thirty-five such ARD victims groups exist across the globe and the global Ban Asbestos Network, headed by the tireless campaigner Laurie Kazan-Allen, coordinates the anti-asbestos campaign.

The role of trade unions on health, illness and disability, explored recently by Vicky Long (2011) has been neglected and merits more attention. There is some evidence that the unions in Britain were investigating illness more extensively from the 1930s, including marshalling alternative epidemiology to challenge medical orthodoxies around workers' chronic diseases (including silicosis, pneumoconiosis and tuberculosis). The appointment of the first full-time Medical Advisor to the Trades Union Congress in 1933 (Thomas Legge) marked something of a turning point.
In coal mining, the trade unions spearheaded the injured and diseased workers' movement, campaigning to improve safety underground, to prevent illness in the pits and to establish coal mining-related diseases as linked to occupation (and hence subject to compensation). The mobilizing capacity of injury, illness, harm, and a

burning sense of injustice has been apparent across the globe, evident, for example, in the oral history-based work of Robert Storey on the injured workers movement in Canada (Storey, 2017) and in recent work on tuberculosis as an occupational disease (McIvor, 2012). One area that remains particularly neglected and merits more attention is the role of trade unions as advocates of improved mental health. The UK Trades Union Congress was an active player, for example, in identifying and campaigning on the late twentieth century stress at work epidemic. Nonetheless one constituent TU general secretary noted in an oral interview that a 'blind spot' for the National Union of Mineworkers was mental illness (Nicky Wilson, oral interview 28 April, 2014; SOHC Archive).

Blighted Lives: Deindustrialisation, job loss and illness

Whilst work could be toxic and dangerous, job loss and unemployment was also capable of causing illness in working-class communities. A series of path-breaking studies – particularly focusing on North America and Britain - have deployed an oral-history based methodology to reconstruct the impact that deindustrialization and unemployment have had on workers' identities, health and sense of well-being. The work of Steven High (2003; 2018) and Tim Strangleman (2004) are amongst those studies that stand out here. Still, there is scope within deindustrialization studies for a sharper focus upon the body, illness and disability (McIvor, 2017a). The research agenda here might embrace both how deindustrialization added to stressors - through work intensification, the pressure of mass unemployment and 'cutting corners' with

health and safety endangering and undermining further the health of those 'survivor' workers trying to hold down their industrial jobs during rationalisations and contraction.

Given the power of the work ethic in working-class communities (Wight, 1994) identity disintegration is central to unemployed workers 'scrap heap' stories. Job loss resulted in a range of illnesses and adverse health impacts, from anxiety-induced depression, to heart problems, to suicide. Deindustrialising communities sought consolation in drink and drugs – heroin use, for example, shot up in deindustrialising working-class communities, including ex-coal mining villages, as did dependency on anti-depressant pills (Perchard, 2013, 80). And oral interviews in some working-class communities suggest that people were very aware of the illness caused by loss of work and directly attributed this to the neo-liberal political onslaught on labour in the 1980s and 1990s (Mackenzie, Collins, Connolly, Doyle, McCartney, 2015). This health-eroding crisis of identity was a recurring motif in oral history collections of interviewed ex-heavy industry workers, evident, for example in the work of Walkerdine and Jimenez (2012) on Welsh steelworkers. Deindustrialising regions in post-socialist countries registered similar patterns, as David Kideckel's oral-history based work on Romanian chemical workers and coal miners indicates. 'Stress about the present and uncertainty about the future is written in their bodies in anger, resignation and ill-health' (Kideckel, 2008, 235). But there was a complex relationship between job loss and health. In their testimonies redundant manual workers express both a dominant narrative depicting tangible negative consequences imprinted on their bodies *and* a less evident but persistent underlying story of

liberation and escape from alienating, physically exhausting, stressful, dangerous and toxic work environments. K'Meyer and Hart's (2009) oral-history based investigation of deindustrialisation in the USA captures this brilliantly. As one worker made redundant from International Harvester, Kentucky, USA commented: 'I was overjoyed, I was sad, I was hurt' (K'Meyer and Hart, 2009, 97). In British coal miners' oral narratives there was definitely a deep sense that pit closures and job losses induced illness but also that there could be health benefits escaping from dangerous and polluted work environments.

Concluding comments: What does oral history contribute?

The argument advanced here is that an oral history methodology can add other important dimensions and insights on the history of illness in working-class communities. This is one approach in what Tim Strangleman has referred to as a 'social industrial archaeology, the seeking out of intangible aspects of culture' (Strangleman, 2017, 479) and one that could fruitfully be deployed more systematically in working-class studies of illness as we move forward. It provides a different focus through the lens of those affected. This is discussed here with reference to some of the literature and some of my own work in the field on occupational illness. Workers' own narratives inform us of their own understandings of how work affected them and their often sensitive awareness of how processes such as deindustrialisation, plant closures and neo-liberalism directly affected their bodies, increasing illness and disability levels in their working-class communities and hence widening health inequalities. Oral interviews provide workers, patients and survivors perspectives on economic violence, enabling the latter to be

understood within the prevailing and mutating cultures of the time and place. In the 'heavy' industry workers' interviews we have conducted at the Scottish Oral History Centre, what stands out is the frequency of stories about bodies - fit and honed bodies; diseased, disabled, and injured bodies; dead bodies. This is paralleled in other recent oral-history based work such as that of Portelli (2010) on Harlan County USA and Selway (2016) on accidents in the South Wales coal mines.

In interpreting such oral evidence, narrative analysis is important, as researchers such as Kleinman (1988) and Reissman (2008) have noted in relation to illness and disability. However, we can become too preoccupied with language, narrative, and intersubjectivity. In their moving and earnest articulation of their illness experiences in oral interviews, workers are bearing witness and revealing something of themselves and much about their bodies, including how they were affected - directly and indirectly - by the productionist ethos and cultural norms of their workplaces. 'Each of us has only one body,' Carol Wolkowitz has noted, 'and it feels the pinch' (Wolkowitz, 117). Much remains to be done and there are whole swathes of working-class experience of illness that still requires investigation and which would benefit from an oral history approach. For example, we know little about the shop floor, grass roots environmental health movement that Mackinnon has investigated in his work on steel communities in Nova Scotia, Canada (Mackinnon, 2017). Mental health merits more attention – and here Ali Haggett's nuanced oral-history based study of the neuroses of housewives comes to mind (Haggett, 2012). The modern-day epidemic of work-related stress might also fruitfully be the subject of a systematic oral history based investigation, as would a series of ailments evident

within working-class communities, such as alcohol and drug dependency, tuberculosis, bronchitis, obesity and diabetes. And the lived experience of disabled people in working-class communities is still also woefully neglected. Whether interest lies in the narrative discourse or lived experience, oral testimony is revealing at many levels. Developing a dialogue through oral interviews with those directly involved and affected, and those who shaped advocacy and the building of injured and diseased workers' movements deserves to be utilized more widely within studies of health, disability and illness in working-class communities.

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