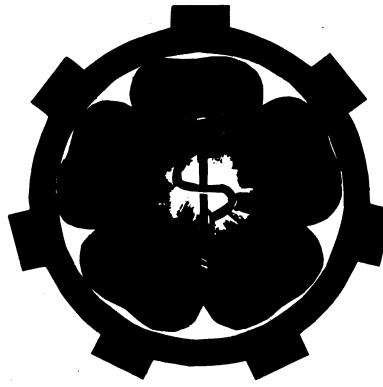
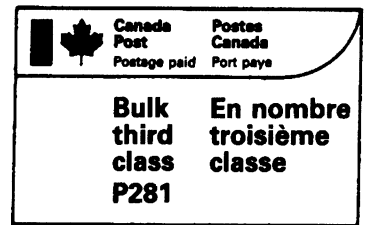


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# ALBERTA OCCUPATIONAL MEDICINE NEWSLETTER

## EDITOR'S COMMENTS:

It is with pleasure that the Department of Community Health Sciences, The University of Calgary resumes publication of the Alberta Occupational Medicine Newsletter. We gratefully acknowledge the funding provided by the Workers' Compensation Board of Alberta, through a grant for continuing medical education, to cover the costs of printing and mailing.

I am sure that most physicians will recognize our distinctive green paper stock and emblem from past issues, and, yes, it will continue to appear free of charge and unsolicited in your mail baskets. Why have we continued with this approach? To explain, I would offer the following definition of occupational medicine:

"that body of medicine dealing with the effects of the work environment on human health, and conversely, the risks and limitations that medical conditions can pose in the course of work."

There are some things 'occupational' in virtually all areas of medicine. Health hazards can be physical, ergonomic, chemical, biological or psychological in nature. Effects can occur at molecular, cellular, organ, behavioral, and social levels, and can occur over nanoseconds or decades. Consequences of work-related illness and injury are measurable in terms of impairment, disability, and handicap, and can affect individuals, family members, communities and populations. And so we have chosen to continue our Newsletter in

the hope that some small opinion or piece of information may prove helpful in your medical practice.

The first issue of the Newsletter was published in March 1983 - we are soon entering our *twelfth* year of publication. Topics have ranged far and wide, and the list of contributors provides a good historical 'who's who' of occupational medicine in Alberta (an index of articles published in volumes I through VI can be found in the December 1989 issue). As editor, I hope to continue several established themes for the Newsletter:

- clinical articles relating to the prevention, diagnosis, treatment, and rehabilitation of occupational illness or injury;
- the educational opportunities and resources available to Alberta physicians;
- articles on the teaching and research activities of Alberta post-secondary educational institutions relevant to occupational health and medicine;
- articles on Alberta governmental policies and programs relating to occupational health and safety;
- announcements of provincial, national, and international conferences and meetings.

Accordingly, I invite all readers to submit critical comments, additional information, and original articles. Articles should be no more than 3000 words in length, contain

no more than two tables or diagrams, and cite up to six key references. Please submit both a hard copy and a 3.5 inch IBM or Macintosh-compatible disk. There are no strict formatting or style guidelines, and any significant editorial changes are subject to your approval prior to publication.

In this issue, an abridged version of Dr. John Weeks' Mastromatteo Oration provides a personal and historical perspective of occupational medicine in Canada since the 1950's. Dr. Weeks made his presentation at the Annual Scientific Conference and Meetings of the Occupational Medical Association of Canada in Winnipeg, June 8, 1993. Our second article is provided by Dr. Tee Guidotti of The University of Alberta and describes their residency training program in occupational medicine.

I hope you enjoy this issue of the Newsletter, and upcoming issues in the New Year. Season's Greetings to all.

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**Prepared in the Department of Community Health Sciences, Faculty of Medicine  
 The University of Calgary, through funding by The Worker's Compensation Board - Alberta**

## GOOD YEAR FOR CANADA'S FIRST RESIDENCY IN OCCUPATIONAL MEDICINE: FIRST GRADUATE AND ROYAL COLLEGE APPROVAL!

Tee L. Guidotti,  
MD, MPH, FRCPC(C), CCBOM\*

This year, the residency in occupational medicine at The University of Alberta achieved two milestones: its first graduate of the four-year program and being awarded unconditional approval by the Royal College of Physicians and Surgeons of Canada. The residency program has been unique in Canada but is expected to be joined soon by other programs in the specialty. As the first training program to have applied and now to have been approved by the Royal College, The University of Alberta residency has had an important role to play in the recent development of the specialty in Canada.

In 1984, the Royal College recognized occupational medicine as a separate specialty with its own fellowship examination. This was a very controversial move at the time, although the specialty had been well established in other countries for decades. When the specialty was first recognized by the Royal College, there was considerable scepticism that it could attract and hold good residents or that it could overcome the logistical barriers to non-hospital based training programs. These concerns have been clearly met by The University of Alberta residency, so that the viability of the specialty as a Royal College fellowship is no longer seriously in doubt. If a strong training program had not emerged during this time, it is likely that the Royal College would have reconsidered its decision.

The University of Alberta, having already established an academic Occupational Health Program in 1984, drew up plans for a formal residency in 1987. In 1989, the Royal College promulgated the criteria against which residencies would be judged for accreditation. The University of Alberta submitted the first application and received its provisional approval at the same time as The University of Toronto and McMaster University. Dr. John W. Markham was the first residency director at The University of Alberta. In large part for his role in organizing the first active residency in Canada, Dr. Markham received the Meritorious Service Award of the Occupational Medical Association of Canada this year. (Dr. Markham later left for a federal position in Ottawa. Dr. Tee L. Guidotti is currently acting residency director).

Of great importance, however, was the funding received for residency stipends, from Alberta Health (through The University of Alberta Hospitals) and the Workers' Compensation Board of Alberta. Funding of stipends has been the major factor holding back the other proposed residency programs, although McMaster is now reported to have received one stipend for this coming year. Indeed, a large part of the scepticism over the viability of the specialty hinged on who would be willing to pay for the training.

Dr. Vernon G. Lappi was the first resident in occupational medicine. Dr. Lappi did his undergraduate work in engineering and retains a professional interest in ergonomics and biomechanics. After medical school at The University of Saskatchewan, while practicing family medicine, he became deeply involved in part-time occupational medicine practice and later became the medical director of the Saskatchewan Potash Corporation. However, he wanted more advanced training and when The University of Alberta program became available, he became its first resident. He completed his residency training in June 1993 and will write his fellowship examinations this Fall. He accepted the position of regional director with the federal government in Winnipeg and now has responsibility for the health of over 1200 federal employees.

The residency program now has six residents distributed as follows: one in his third year, three in their second year, and two in their first year. Their funding comes from provincial sources, the WCB, and private corporate sponsors. The residency has been given approval to accept two more residents this coming year through the Canadian Intern and Resident Matching Service (CIMS). Last year, at a time when the CIMS system was in a crisis due to a shortage of open positions, there were over 100 applications for a single position under CIMS; that one position, however, was already promised but it could have been filled many times over.

As presently constituted, the residency is very rigorous. The first year consists of an internal medicine in which the emphasis is on developing clinical skills and a sophisticated understanding of pathophysiology in specialty areas that apply to occupational medicine: dermatology, pulmonary medicine, and neurology, in particular. The second and third years are devoted to more specialized activities in occupational medicine,

including rotations in rehabilitation medicine, ergonomics, occupational hygiene. Residents see patients in the busy weekly Occupational Health Consultation Clinic, attend seminars and journal clubs, and become involved in research projects and health hazard investigations. However, the backbone of the middle two years is a sequenced series of lessons based on the Distance Learning Program in Occupational Medicine; this ensures that each resident works systematically through the basics, frees up faculty time for more advanced material, and gives each resident a chance to practice teaching in small groups. The fourth year is a series of two- or three-month rotations through corporate medical departments, the workers' compensation board, and government occupational health and safety offices.

Within the University of Alberta, support for the occupational medicine residency is quite strong. It "won its wings" within the institution by proving that it can attract first-class residents. For example, Dr. Phil Karpluk, the present chief resident, won the annual prize for the most outstanding resident on his pulmonary rotations—in competition with residents in medicine! The enthusiastic response of the Royal College, which praised the residency in its site visit report, has also boosted its image within The University of Alberta medical community.

In the short span of four years, the residency in occupational medicine at The University of Alberta has gone from concept to first graduate and full accreditation. It has demonstrated the viability of the specialty in Canada at a time when this was in doubt. In coming years, it is hoped that McMaster and The University of Toronto will have similar favourable experiences; the specialty will only be strengthened now by the addition of good programs. Its experience should prove valuable to the other programs as they get started. That it started at all when it did may well have saved the specialty within the Royal College.

The year 1993 has been a good one for the residency in occupational medicine at The University of Alberta. There are many more good years coming.

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## OCCUPATIONAL HEALTH AND SAFETY: WHERE DO WE GO FROM HERE?

J.L. Weeks, MD(Lond), FFOM, CCBOM

Ladies and Gentlemen:

It may be useful to review what has happened in the field of occupational medicine in Canada during the past sixty years. In the 1930's, occupational medical services were to a large extent concerned with the treatment of injuries occurring at work and were provided mainly by surgeons. In the period after World War II, emphasis shifted to the provision of screening services aimed at detecting incipient or existing occupational and other diseases by means of pre-placement and periodic medical examinations.

This is where I came in and during the fifties it was not unusual for one physician to do more than a hundred preplacement examinations in a day! These examinations were concerned with the detection of conditions that might have a bearing on public safety and were surprisingly effective, but it was a hard way to earn a living and one needed to have some particular interest to keep going. At that time, many would-be employees came from West Africa and bore on their faces the scars of clan markings. Over a period of months, I put together a chart of these markings and caused some surprise by being able to tell a man where he came from by looking at his face. This was a device that enabled me to handle a heavy workload, but it leads me to a point, namely: that if one is practising occupational medicine, it is useful to have some specific and continuing interest in parallel; it may be hypertension, toxicology, epidemiology or any one of a number of other topics but it should provide a focus to one's day.

The preplacement and periodic examinations that I have mentioned were to some extent perceived as employment benefits, but with the advent of universal medical care in Canada this was no longer the case, and the pattern of practice began to change. The provision of occupational medical services was often a function of family physicians, employed on a part-time basis by local industries, but to an increasing extent these services came to be provided by full-time occupational physicians, many of whom had obtained post-graduate qualifications in occupational medicine. Part-time

practitioners, however, are still a large part of those in this field, a fact which has a major bearing on the accreditation standards developed.

An important landmark was the establishment in 1980 of the Canadian Board of Occupational Medicine which provides accreditation for both full-time and part-time occupational physicians. In 1984, occupational medicine was recognized as a specialty by the Royal College of Physicians of Canada and by now, more than forty occupational physicians have received their Fellowships from the College.

While these changes were taking place in the practice of occupational medicine, developments were also occurring elsewhere in the occupational health and safety field. The roles of the occupational health nurse, the industrial hygienist, the toxicologist, the safety professional and the biostatistician have expanded to the extent that the occupational health program of today bears little resemblance to the surgical and medical services provided to industry sixty years ago. The modern OHS program depends upon the involvement of many highly trained professionals and is geared to the prevention of occupational diseases rather than to detection and treatment.

On the face of it then, with integrated interdisciplinary occupational health and safety programs in position, we have arrived; but there are in fact major concerns. We are in the midst of the worst economic depression since the thirties and on all sides health services are being cut back, occupational health services no less than any others. We are faced with massive unemployment as a consequence of which there are fewer places for OHS staff. In part, this unemployment is due to technological changes that have reduced the need for people, but technological change is not new. A few months ago there died a wise and much respected Chief Justice of Manitoba: Mr. Samuel Freedman and, writing in the Winnipeg Free Press, Mr. Val Werier described Samuel Freedman's work as a one-man Commission to enquire into changes of operating practice proposed by Canadian National Railways in 1964. The changes were designed as a response to technological developments and would have resulted in the dislocation of train

crews, change in their hours of work and would have threatened the existence of two railroad towns. It was an issue that affected the fabric of society; how to reconcile automation and technological changes with the dislocation of workers and communities and how to protect human rights against 'progress'. At the outset, Mr. Freedman stated that his enquiry would not be based chiefly on legal points, nor on economics, because the balance sheet does not give all the answers. The human factor must also be considered. Mr. Freedman would have been a good occupational physician; he discussed the issues extensively with unions and management, he rode the railroads in cabooses and diesel locomotives so that he knew what working conditions were like, and in 1965 issued a report that stands as an important document in industrial relations. One statement in particular should be clearly remembered by decision-makers today. It is as follows: "The old concept of labour as a commodity will not suffice; it is at once wrong and dangerous. Hence there is a responsibility on the entrepreneurs who introduce technological change to see that it is not effected at the expense of the working force." Nearly thirty years later these words are more true than ever and it is beginning to be recognized that while people work because they need to earn a living, they have in general a real psychological need to produce, to do something well, something of which they can be proud and this need is not met by the provisions of an increasingly fragile social safety net, important though that safety net most certainly is.

In part, the unemployment to which I have referred is due to the export of industries and their hazards to less developed countries where wages are low and in which safety regulations, where they exist, are poorly enforced. The changes that are happening, technical, social and economic, are rapid and extensive, and society is being slow to adapt in such a manner that it continues to exercise control. It is an area in which we in the OHS community can play a role, bearing in mind that some of the finest work of people like Hamilton, Kehoe and Lane was done during the bad times of the thirties.

Are there then problems for the Lanes, Kehoes and Hamiltons of the 1990's? I think that one of the most difficult problems

must be in deciding on which problem one is going to work. Given that silicosis and lead poisoning are still among the more prevalent occupational diseases in the world and these are conditions about which we do know something, it is clear that there is no lack of challenges for OHS programs. In this province, as in others, injuries and diseases related to agricultural work are a matter for concern, particularly insofar as many of the injuries involve children who are often willing helpers on the family farm. We know little about the real extent of pesticide exposure and of the pathways of disease induction caused by such exposure; there is increasing concern at the incidence of occupational diseases among agricultural workers and we know little about the occurrence of such diseases among the children of agricultural workers.

There is a parallel here with the occurrence of non-Hodgkin's lymphoma in radiation workers, many of whom have had very little exposure to ionising radiation and in whom a chemical factor may be at work. Similarly, the incidence of leukaemia in the children of fathers who have had mixed radiation and chemical exposures is a problem for continuing thought. It is a line of thought that brings us to the health of women at work, particularly in occupations related to electronic technology and the manufacture of such technology. Electromagnetic fields and carcinogenicity, monetary compensation for occupational emotional stress, the service needs of small workplaces, the impact of resurgent tuberculosis, the epidemiology and causation of thyroid cancer among children exposed to radiation after the Chernobyl disaster. These are but a few of the questions that confront us today, some are relatively soft, others are hard and will be difficult to resolve — all are challenging.

One of the first Memorial Lectureships awarded by the Canadian Board of Occupational Medicine went to Allen Kraut of the University of Manitoba Medical School, and at the OMAC meeting in Edmonton he gave a paper on the mortality and morbidity due to occupational disease in Canada; this paper is now in press in the American Journal of Industrial Medicine. In it, Dr. Kraut extrapolates from Bureau of Labour Statistics data and data from the State of California to conclude that the incidence of occupational disease in Canada in 1989 was between 78,000 and 112,000 cases and that the number of occupational disease deaths was between 2,000 and 6,000. Even if one takes the low estimates, the probably under-reported toll due to occupational disease is disturbing.

An equally disturbing point has been made by Teschke and Barroetavena and by Ross who, in two papers published in the Canadian Medical Association Journal of November 15, 1992, describe the deficiencies in the reporting of occupational disease in Canada and by consequence, the under-estimation of the prevalence of such diseases. Dr. J. Barrie Ross concludes his paper as follows:

"The surveillance of the health of the general public by medical officers of health has long been accepted. Surely the time has now come for national and regional programs to monitor occupational health and hygiene. The prevention of hazards in the workplace would then have the same status as the prevention of illness in the general population."

I agree strongly with the conclusion made by Dr. Ross and will return to it later.

In addition to there being many industrial diseases about which we have much to learn, we have also to develop ways of identifying precisely the real incidence of diseases attributable in whole or in part to occupation, while at the same time recognizing the perils of a philosophy that would attribute much of occupational disease to lifestyle factors. In large part we are dealing with a question of recognition and those of us who teach occupational medicine, especially when we are teaching medical students among whom will be the family physicians of the future, must place particular emphasis on cause/effect relationships, not only for current occupations, but for occupations in the distant past. However, the recognition of individual cause/effect relationships, while of great value to the individual patient, will not solve the problem of occupational disease on a nation-wide basis. So we need to examine the ways in which OHS services are operated in Canada and to produce some ideas on the manner in which such coverage as now exists might be improved.

Now to change direction a little: one of the topics discussed during the time of this meeting concerns the relationship between the broad field of OHS and the environment. Insofar as the environmental effects of industry: chemical, nuclear, heavy engineering and the like are concerned, it is, I think, self-evident that OHS people are better placed than any other to be involved. The environmental effects of industrial activity do not stop short at the plant fence. OHS workers have the knowledge and skills needed to identify and measure environmental effects and by means of dosimetric and epidemiological

techniques to quantify impact. But the problem is wider than any individual industry or locality.

For many years now, the continuing degradation of the environment has caused anxiety: large and costly international meetings have been held, impressive statements have been made by politicians and weighty reports have been issued to gather dust on the bookshelves of the world. But environmental degradation continues. The environment is a slowly changing system and it is unlikely that the world will become uninhabitable during the lifetimes of those who now practise medicine, nor may it become uninhabitable during the lifetimes of their children and grandchildren. One is much less confident about the habitability of this planet during the lifetimes of our great-grandchildren.

The arrest of environmental degradation is, then, a long-term process applied to a long-term problem and if measures adopted today are successful, it is not likely that anyone now alive will be able to appreciate the true degree of that success. In a democracy this creates a problem as democratic governments are dedicated to those measures likely to ensure their re-election in the short-term. Given the long-term nature of the environmental problem, it requires a special sort of wisdom for a government to adopt difficult, costly and sometimes unpopular measures, the impact of which may not be apparent until the end of the next century. It is, however, the "hard to do, high impact" actions: the control of industrial effluent and the effective regulation of the transportation of environmentally hazardous materials such as chemicals and oil, that are essential if the world community is to survive. In an area of international activity it is sometimes suggested that little can be done by the concerned individual, but this counsel of despair must be rejected. Just as physicians early in this century doggedly treated the then often fatal disease of diabetes and were eventually rewarded by the development of insulin which radically altered the prognosis, so must we in the community work doggedly to ensure the survival of this environment, and few are more fitted for this work than those in the OEHS field.

I have described to you a number of occupational and environmental health problems, problems which ensure that there is a great deal of work to be done in the years ahead. What are the resources available to deal with these problems in Canada? Most importantly, we have good

people at work in universities, in governments, in unions and in industry. I have the impression that insofar as occupational medicine is concerned, the corporate component is decreasing and that OHS programs are being reduced. That is not necessarily a bad thing and a case can be made that such services should be provided outside of the aegis of corporate interest. As an occupational physician, however, I am concerned by what I see as a trend to locate physicians away from the workplace. It is a trend that makes it more difficult for a physician to have that detailed knowledge of the work environment that is one of the major factors in the development of occupational medicine as a specialty. I make the comment as a cautionary note—a caution which says that while “walk-in” clinics provide a service appreciated by the general public, only rarely can such a clinic provide appropriate occupational health services. There are problems, but there are also resources, and many of them are very good resources. What then?

Some of you may know of the Beveridge Report on Health Services, published in Britain in 1942 during the Second World War. For many, implementation of the recommendations of that report became a War Aim—one of the war aims that was achieved. When William Beveridge set out on the task of preparing his report he was confronted with what has been described as the balkanization of health services in Britain and when he finished, he had set out a proposal for the national organization of health services in that country. The proposal became law under that Minister of Health to whom I have referred, Aneurin Bevan, and for all its faults the service that emerged did ensure that essential healthcare became available to all. I will suggest to you that we in Canada are confronted by a situation in which the available occupational and environmental health and safety resources in this country are, to a large extent, balkanized; that is to say, split up into small packages which achieve less than maximal effect. If we are really clever, we should be able to coordinate these resources in such a way that for no increase in overall cost, maximum effect is achieved. “Fine words” I hear you say, but let us keep plugging doggedly away at the problem.

The Canadian Medical Association had a sub-committee on Environmental and Occupational Health—a lively group that achieved some repute during the years of its existence. This committee had considering the OEHS resources in Canada and prepared a recommendation that will

go to General Council of CMA this year. Briefly, the recommendation asks General Council to resolve that Federal and Provincial Governments be requested to convene a Task Force to consider the provision of occupational and environmental health and safety services in Canada and to make recommendations for their improvement. The Task Force should include representatives from all the community who are providing the services (and here I include research as an essential service) as well as those who use the services. If all goes very well, if the recommendation is approved by General Council and acted upon by governments, it will be a year or two before the Task Force is brought together and this is no bad thing for it gives each one of you time to gather your thoughts and come to some conclusion as to what the outcome should be. I ask all of you to go back to your provincial divisions, to your unions and professional organizations and to stimulate discussion of the question: “How should occupational and environmental health and safety services be provided in Canada?” Then, having discussed, make sure that your views are heard and acted upon, both in your organizations and at the political level. The question is a wide-open one and all of the pieces of a complex jigsaw puzzle should be thrown on the table to see how they can best be fitted together.

Whatever message you may take away from this talk, please think about and get others to think about the future of occupational and environmental health and safety in Canada and in the world, for many of the problems that beset us are world problems. It depends upon you how the future looks. Should more OEHS work be covered by walk-in clinics? Is the present system of dispersed activity good enough, or should we be looking to an integrated nationwide OEHS program that among other things will provide a consistent and effective way of reporting occupational diseases across the whole of Canada as recommended by Dr. Ross? Then, having thought about the problem, think about some solutions. If you conclude that we should be planning an integrated OEHS program—how should it look, how should all interested be represented? “The way ahead is always clear and open for those who know where they are going”—it doesn’t always work out that way but it is a very good philosophical starting point. But beware, for if the proposed Task Force is convened and if it produces the finest report anyone could wish for, the fate of reports is to gather dust unless there is a hard push for the implementation of the recommendations contained in them. You

in the OEHS community, you and your constituents will be the ones who have to push. The task will not be easy but the effort will be worthwhile.

Let me then summarize four main points I have made:

- We must ensure that working people are not treated as commodities;
- We must ensure that there is effective international control to prevent the export of occupational hazards;
- We must ensure that effective records of occupational disease mortality and morbidity are maintained in Canada;
- And above all in the context of this meeting, we must plan for the future of OEHS in this country.

Ladies and gentlemen, it would be a dull life if there were no problems and perhaps I have been able to show you that we have some interesting problems before us. Happily, this is a commemorative lecture and Ernie Mastromatteo is going to be around for a long time to take part in our efforts.

Thank you for listening to me.

## Occupational Health and Safety Publications from Alberta Labour

Physicians should be aware of the series of pamphlets and bulletins published by Occupational Health and Safety. These publications are concise and well written, and provide information in the context of Alberta industry and legislation:

### BREATHING APPARATUS

- Medical Assessment of Fitness to Wear Respirators
- Use of Resuscitators in Industry
- Use of Inhalators in Industry
- Infectious Disease Issues in Resuscitation Training and Respirator Use

### CHEMICAL HAZARDS

- Health Effects of Lead Exposure
- Health Effects of Styrene Exposure
- Health Effects of Solvent Exposure
- Health Effects of Organic (Alkyl) Mercury Compounds
- Health Effects of Pesticide Exposure

### GENERAL HEALTH AND SAFETY

- Health Effects of "Active and "Passive Smoke
- Prevention of Brucellosis in Meat Packing Plant Workers
- Occupational Cancer
- Occupational Health and Video Display Terminals (VDTs)
- Guidelines for Occupational Health Services
- Stress and the Worker
- Health Effects of Fingernail Sculpting with Methyl Methacrylates
- The Impaired Worker
- Health Problems from Your Work
- What Your Doctor Needs to Know About Your Job
- First Aid Training

### MEDICAL GUIDELINES

- Monitoring of Workers Exposed to Isocyanates
- Monitoring of Workers Exposed to Inorganic Lead
- Monitoring of Workers Exposed to Asbestos
- Monitoring of Workers Exposed to Mercury (other than alkyl)
- Monitoring of Workers Exposed to Alkyl Mercury
- Workers Exposed to Cold Environments
- Workers Exposed to Heat
- Monitoring of Workers Exposed to Polychlorinated Biphenols (PCBs)
- Monitoring of Workers Exposed to Coal Dust
- Monitoring of Workers Exposed to Silica
- Monitoring of Workers Exposed to Sewage Medical Guidelines (continued)
- Monitoring of Workers Exposed to Organophosphate Pesticides
- Monitoring of Workers Exposed to Pentachlorophenol
- Monitoring of Workers Exposed to Ethylene Oxide
- Monitoring of Workers Exposed to Styrene
- Monitoring of Workers Exposed to Carbon Monoxide
- Monitoring of Workers Exposed to Benzene
- Monitoring of Workers Exposed to Tetrachloroethylene (Perchloroethylene)
- Medical Assessment of Workers for Fitness to do Strenuous Work
- Medical Assessment to Pregnant Workers
- Workplace Hazards Affecting Fertility

Medical and health information is also available on a variety of other topics, including AIDS and the Workplace, Back Care and Lifting, Ergonomics, Chemical Hazards, and General Health and Safety. To obtain copies or a complete listing of these publications, contact your nearest regional office:

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