or her loss of health. At the second level the occurrence of an asbestos-related illness is approached as a failure of control measures, and one seeks to identify the point of failure so that appropriate action can be taken to protect the health of the new generation of workers (the children and younger colleagues of today's victims), who may be currently entering the industry.

Nowhere is this more evident than with the finding of a patient with malignant mesothelioma whose only possible contact with asbestos is indirect, through neighborhood and/or domestic exposure. Given a history of neighborhood exposure, should one advise the family to move for the sake of its other members? Probably not, because the long time lag of this tumor makes it most likely that they have already received any exposure relevant to the future development of mesothelioma. Should new families moving into the district be advised against this, unless there has been appropriate action for environmental control over the previous years? An unanswerable question. Given a history of domestic exposure, the clinician should at least be able to assure the new families that work practice codes now insist that dusty work clothes are not taken home to be cleaned.

Faced with a person with a known exposure risk, what medical measures can be taken to protect his or her health? Sadly, it must be admitted that there are none, because effective health protection lies in effective environmental control, and medical surveillance is, probably correctly, considered a form of biologic monitoring supplementary to environmental monitoring (231). Thus, good work practices and quitting or refraining from smoking are the best "medical measures" for the individual worker; however, the examination implied by medical surveillance can provide other services, including case detection and other forms of health care. As knowledge improves, it is possible that medical surveillance will be able to fulfill its hoped-for role, namely, the detection of health effects in a person at a stage when some action (for instance, removal from exposure) might prevent eventual disablement.

Given the "imperfect" state of the art, it is, at present, believed that medical surveillance should include a clinical examination (emphasis on basal crepitations), an annual chest radiograph, and a measurement of lung function, probably the most useful being the forced expiratory volume test, and possibly the diffusing capacity. At what point in time changes in one or more of these methods of examination call for action remains to be established.

For the currently exposed worker, research in this area certainly has the most relevance, in particular, methods of identifying the persons in whom the disease will progress, whether or not exposure continues. Animal work suggests that withdrawal from exposure may slow progression (62), and in the absence of definitive data, this must also be assumed to occur in man. With regard to the future worker, it remains to be determined whether the person at high risk can be identified before entry into the industry. Meanwhile, there seems to be merit in deploying energy into maintaining currently proposed standards. Three times in the twentieth century, levels have been set, because the asbestos worker's health became a matter of public concern. Had the standards been more systematically adhered to, it is likely that the asbestos-related diseases would not have re-emerged as the "occupational illness of the 60s," a testimony to the working conditions of the previous decade. It is to be hoped that current concern is translated into effective action for the workforce currently entering the industry.

Acknowledgment

The writer wishes to express her very sincere appreciation to Dr. S. Hurwitz of the University of the Witwatersrand, Johannesburg, South Africa, for able help in the literature search behind this review; to Dr. J. C. McDonald, director, and all members of the McGill University group engaged in research into the health effects of asbestos exposure since 1964, in recognition of their stimulating collaboration during this period, experience that forms the basis of the present review; to Dr. R. Oseasohn, Chairman, and Prof. F. D. K. Liddell, Dr. G. Gibbs, and Dr. M. Arhirii of the Department of Epidemiology and Health, McGill University, and Dr. M. Newhouse of the London School of Tropical Medicine and Hygiene for valuable editorial comment; to Dr. M. Pelnar, of the Institute of Occupational and Environmental Health, Quebec Asbestos Mining Association, for access to the Institute's extensive library of reprints and for his editorial comment; and to Diane L. Cloutier, Jane Ross, Arlette Maurus, and Thea Hopkinson for their willing help in preparation of the manuscript.

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