protective effect that, based on epidemiological and experimental data, is restricted to the lung [2]. However, it should be noted that exposure to endotoxin-containing dust commonly results in severe respiratory diseases [7].

Critics who observed lower than expected rates of lung cancer have suggested that this is a result of reduced smoking rates. However, a recent study [5] of controlled smoking found a significantly lower mortality rate for lung cancer.

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Reply to Hocking and Lange et al.

One of the hypotheses of our study [1] during the planning stage was that work in the textile manufacturing industry would decrease the risk of lung cancer as suggested by Lange and colleagues [2]. Unfortunately, there were only three deaths from lung cancer identified in our cohort and we did not have the power to test this hypothesis.

Hocking [3] highlights the limits of our exposure information. About 2000 of our cohort members were sewing machine operators, but we had no further electromagnetic field (EMF) information on these subjects. Most of the cohort (88%) were exposed to EMF and, as stated in the discussion, misclassification in exposure allocation could have occurred, resulting in us being less likely to detect an effect if one were there.

One explanation for the low number of lung cancers in our cohort is the endotoxin hypothesis. Similarly, one explanation for the possible increase in lymphohaematopoietic cancers is the EMF exposure within the cohort [3]. However, we caution that the limitations of the selection and matching processes in our study, the small number of deaths from these subtypes of cancer and the restricted information on exposure mean it is unwise to extrapolate too far from our results.

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Training in occupational medicine

Dear Sir,

The editorial [1] on the training in occupational medicine is very timely. However, it does raise a more important issue: ‘there is need, perhaps, to redefine Occupational Medicine in light of the many changes in the world of work and the new public health agenda’.
Obviously, ‘the effect of work on the worker and the effect of the worker on work’ has changed considerably in the last 40 years and the doctor is no longer regarded as the be all and the end all of wisdom on occupational health matters.

As in all other branches of medicine, we now have to be part of a team whose job is to safeguard the worker. The doctor, with his or her medical skills, may be regarded as the human engineer who needs to work along with the other members of the production and management team. While there is a need for facilities for clinical examination and confidentiality, the majority of problems are to be found in the factory, in the shop or in the office, and these areas need to be visited and observed.

The editorial highlights the views of the trainees, but this is like asking a learner driver their views on motor cars!

If we are to get a clear idea of the future we should ask the doctors presently practising occupational medicine, at all levels, the GP with a little involvement, the full time consultant and the head of an academic department, what is their workload in occupational medicine?

With all the developments in health and safety and the extended NHS interest in healthy living, we may discover that the role of the doctor, in occupational medicine, is now very different, and will continue to change.

It is also worth noting the apparent demise of EMAS. Any future training regime will need to take these changes into account.

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    R. A. Cooke