this week

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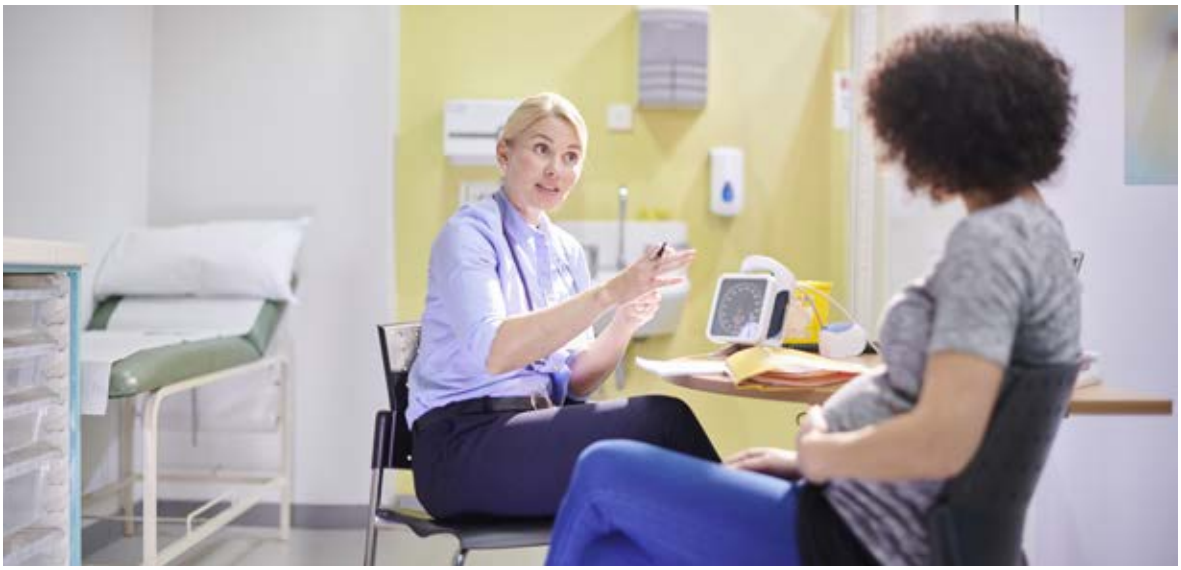


"Leave PPROM pregnancies till 37 weeks"

Pregnant women whose waters break early (from 24 weeks) but don't go into labour should be given the choice to continue with the pregnancy until 37 weeks, as long as there are no signs of infection or complications, say new guidelines.

Preterm prelabour rupture of membranes (PPROM) affects up to 3% of pregnancies and is potentially serious.

The updated recommendation from the Royal College of Obstetricians and Gynaecologists, launched at the college's world congress this week, said that continuing the pregnancy closer to term could reduce the risk of problems linked to premature birth, such as breathing and feeding difficulties and infection.

Previous guidance had advised that delivery be considered at 34 weeks, but the recommendations changed after evidence indicated that waiting longer was associated with better outcomes for the mother and baby.

Around half of women who experience PPROM will go into labour within a week of their waters breaking but often it is possible to continue the pregnancy for weeks or even months.

The new guidance says that the woman and baby should be closely monitored. If there are signs of infection or complications it may be safer for the woman to give birth straight away. All women with PPROM should also be offered antibiotics to reduce the risk of infection, such as sepsis, and to help the pregnancy continue.

Other recommendations in the guidance are that women and their partners should be offered additional emotional support during these pregnancies and after birth and that if they become pregnant again they should be cared for by an obstetrician with expertise in preterm birth.

Andrew Thomson, consultant obstetrician and author of the new guidelines, said, "PPROM is an uncommon but potentially serious condition with significant health risks to a woman and her baby. Evidence shows that waiting for labour to begin may be the best option for a healthier outcome, unless there is a reason for the baby to be born immediately.

"Every pregnancy will be different, and each woman's individual preferences need to be considered. All maternity units across the country are encouraged to follow these guidelines, which should improve health outcomes for both mother and baby."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2019;365:l4266

Women whose waters break early will be given the option to continue with the pregnancy three weeks longer than current guidance

LATEST ONLINE

- Lack of training in eating disorders is contributing to avoidable deaths, finds inquiry
- Consultant who breached tribunal's conditions and failed to remediate is struck off
- Forced organ harvesting in China constitutes crimes against humanity, tribunal finds

SEVEN DAYS IN

Legal advice to GMC in Bawa-Garba case was incorrect, chief executive admits

The GMC's chief executive has acknowledged that the legal advice he received during the Hadiza Bawa-Garba case was incorrect. In an interview for a BBC documentary, Charlie Massey said that if the case arose now he would not appeal the tribunal decision to suspend but not strike off Bawa-Garba after the death of 6 year old Jack Adcock.

Massey (left) was interviewed by Samantha Batt-Rawden, a trainee in emergency and intensive care medicine in Surrey, as part of a Radio 4 documentary looking at why doctors are leaving the NHS. Batt-Rawden, who is also chair of the Doctors' Association UK, asked Massey what led to the decision to appeal the tribunal verdict.

Massey replied, "I felt I had no option but to appeal. The High Court decision upheld that view, and then the Court of Appeal overturned that view. It clarified that the legal advice I had was, with hindsight, not correct. If that case came up now, that appeal judgment would mean that I wouldn't have appealed that case."

Reflecting on Massey's comments in a bmj.com opinion piece Batt-Rawden said, "It seemed that some real learning had taken place. The GMC will have to show it is capable of real change to regain doctors' trust."

Gareth Iacobucci, *The BMJ* Cite this as: *BMJ* 2019;365:l4218

NHS performance

MPs warn on long waiting times

Patient suffering is being overlooked as NHS performance against waiting time targets for cancer and non-urgent care "spirals downwards," MPs warned. The Public Accounts Committee said that national NHS bodies seemed to understand little about how a long wait can harm patients. A committee report on 12 June found that under half of trusts met the 18 week waiting time standard for elective treatment, and only 38% met the 62 day standard from referral to cancer treatment.

Training

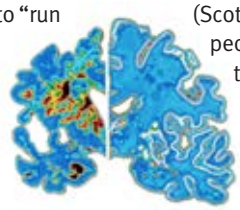
Medical schools "must expand further"

More medical school places will be needed as the NHS expands and more doctors seek opportunities to work flexibly, said NHS England's chief executive. In 2018 medical school places rose from 6000 a year to 7500. Speaking to *The BMJ* at the Health Foundation's annual event last month, Simon Stevens said that a further expansion would be needed to meet future demands. "A 25% expansion in medical undergraduate intake is only the first stage," he said.

Dementia

Diagnoses in England hit record high

Nearly half a million people aged over 65 had a dementia diagnosis in May 2019, the highest monthly number on record, said NHS England. Data show a 7% rise in older people with a diagnosis in the past three years. Alistair Burns, NHS national clinical director for dementia and older people's mental health, said the NHS was having to "run to keep up" as the population aged, which was why it had made early diagnosis and treatment of major health problems a "top priority."



Regulation

Reflective notes have many benefits, say regulators

The GMC joined eight health regulators in stating that healthcare workers will never be asked to provide personal reflective notes as part of an investigation into them. Workers can choose, however, to offer their written reflections as evidence of insight into their practice. In a joint statement promoting the benefits of reflective practice the regulators said that reflection can aid professional development, wellbeing, commitment, and meaningful insight and learning.

Organ donation

Scotland agrees on opt-out system

Scotland will follow Wales and England in introducing an opt-out system of organ and tissue donation. The approval of the Human Tissue (Authorisation) (Scotland) Bill will mean all people over 16 being deemed to be organ donors unless they opt out. People currently have to opt in to be organ donors after death. Scotland has the UK's highest proportion of people on the organ donor register but the lowest rate of family consent.

Tattoos

Royal society calls for revamp of infection control

The rest of the UK should follow Wales and introduce a mandatory licensing scheme for tattoo and piercing shops that requires an infection control qualification, the Royal Society for Public Health recommended. It noted in a report that one in five of the UK population has a tattoo and that 18% of people who have had a tattoo, piercing, acupuncture, or electrolysis in the past five years have reported negative effects.

Indemnity

Government faces action over state backed GP deal

The Medical Defence Union is to take legal action over the govenrment's GP indemnity scheme launched on 1 April, claiming that it does not tackle liabilities arising from incidents before then for most GPs in England. Chief executive Christine Tomkins said, "The fact of legal action should not preclude sensible discussions. Our preferred option remains an agreed solution that makes good on the government's promise to protect GPs from the rising cost of claims."

US opioid maker declares bankruptcy

Insys Therapeutics has declared bankruptcy and is the first drug company to seek protection owing to liabilities from opioid litigation. It agreed to pay $225m (£179m) to settle a Department of Justice inquiry into its business.

MEDICINE

Medical marijuana

Access has not cut opioid overdoses in US

US states that allow access to medical marijuana did not, on average, see fewer deaths from opioid poisoning than the rest of the country, research published in the *Proceedings of the National Academy of Sciences* found. The study replicated findings for 1999-2010 from an earlier study, which found that opioid mortality was lower in US states that allowed medical marijuana. But it found that opioid mortality after 2012 became statistically indistinguishable between states that allowed medical marijuana and those that banned it.

Research suggests legalised cannabis does not cut opioid deaths

Patient care

CQC denies "whitewash" of hospital abuse

There was no cover-up of events at a specialist hospital for people with learning disabilities who were found to have been abused by staff, the Care Quality Commission told MPs and peers. CQC officials appeared before the joint committee on human rights

on 12 June as part of an inquiry into the detention of young people with learning disabilities or autism. The session focused on the CQC's inspection of Whorlton Hall (above), in County Durham, where the BBC's *Panorama* exposed abuse last month.

Mental health trust is fined over teenager's death

An NHS mental health trust was fined £200 000 after admitting it had failed to provide care safely to a teenager in its care who was known to be suicidal. The ruling against Sussex Partnership NHS Trust followed the death of Jamie Osborne, 19, who took his own life in the hospital wing of Lewes Prison in February 2016.

Gender equality

AMA pushes to improve female doctors' status

At its annual meeting the American Medical Association adopted new principles to improve female doctors' status and pay. Women now outnumber men in medical schools but earn less than men and are under-represented in senior medical school faculties. The association calls for equal opportunities in jobs and practice, training and full involvement of women in leadership roles, and pay based on competence and expertise.

Ebola

Congo outbreak is not public health emergency

A WHO committee has decided not to label the Ebola outbreak in the Democratic Republic of Congo (DRC) a public health emergency, concluding it could do more harm than good. When the 2014 west African Ebola epidemic was declared an emergency other countries cancelled visas for visitors and airlines stopped flights, harming economies, said committee chair Preben Aavitsland. The current outbreak is almost entirely confined to the DRC, he added.

Cite this as: *BMJ* 2019;365:l4261

INFANT DEATHS

Infant mortality in England and Wales increased from a record low of 3.6 deaths in every 1000 live births in 2014 to 3.9 deaths in every 1000 in 2017

[Office for National Statistics]

SIXTY SECONDS ON . . . FORTIFIED FLOUR

THE YEAR OF FORTIFICATION?

It would seem so. The government has announced a consultation on mandatory fortification of flour with folic acid to help reduce neural tube defects in babies, by raising women's folate concentrations.

WHAT'S THE RATIONALE?

The UK has 1000 diagnoses of neural tube defects such as spina bifida and anencephaly every year, and evidence from elsewhere in the world indicates mandatory fortification could prevent around half of these cases.

DON'T WE ALREADY FORTIFY FLOUR?

Only on a voluntary basis, but as the government acknowledges, this hasn't worked. Data from the past nine years show that folate intakes of women who could become pregnant have continued to fall and are particularly low in deprived areas.

WHY HAS IT TAKEN SO LONG?

The administrative burden, the potential impact on business, and concerns that fortification risked people consuming harmful levels of folate have all played a part. But with the evidence clearer and the voluntary scheme failing, the government has decided some flour power is required.

IS THE UK AN OUTLIER ON THIS?

Increasingly so. There are now more than 60 nations, including Australia, Canada, and the US, that have mandatory fortification. Such countries have seen falls in rates of neural tube defects of between 16% and 58%, and they have not identified increased risks.

HOW HAVE DOCTORS TAKEN THE NEWS?

Medical organisations have long been calling for the move and are pleased the government seems to be using its loaf. The Royal College of Obstetricians and Gynaecologists said fortification was "simple, safe, and evidence based, and will ensure all women receive adequate folic acid through their diet."

ARE THERE ANY DISSENTERS?

The iIndustry will be keen to ensure that any policy doesn't harm or disrupt its business. To allay such concerns, the government has pledged to develop proposals that are "proportionate, effective, and ultimately enforceable."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;365:l4241

Doctors alleging sexism at BMA welcome appointment of QC to lead review

A leading employment lawyer who specialises in discrimination has been appointed to lead an independent review of sexism in the BMA, which will begin this month and publish recommendations later this year.

Daphne Romney QC will head the review, which follows allegations of sexist remarks made to senior BMA General Practitioners Committee members Zoe Norris and Katie Bramall-Stainer at the local medical committees conference in March. The allegations led to other doctors speaking out about their experiences of sexism, harassment, and inappropriate behaviour during BMA activities.

The appointment was announced ahead of the BMA's annual representative meeting in Belfast next week, where a motion on the investigation will be debated (box).

Romney has represented thousands of women in mass claims against local authorities over equal pay. She won a "substantial settlement" for a former NHS trust chief pharmacist at an employment tribunal in claims of whistleblowing and unfair dismissal, and she successfully defended the pharmacist in a hearing at the General Pharmaceutical Council.

A BMA spokesperson said, "Romney is recognised as a leading expert in employment law, most notably discrimination, equal pay and the gender pay gap, protected disclosures, and victimisation. The investigation will begin in the next few days, and the recommendations will be made public later in the year."

Appointment welcomed

Norris and Bramall-Stainer told *The BMJ* that they were happy that Romney had been appointed.

Norris said, "[Romney] seems to be someone whose background is entirely appropriate to conduct this kind of inquiry. Certainly at this stage she has my confidence, and I hope she'll have the confidence of all the other members to be able to come forward and talk to her confidentially."

Bramall-Stainer said, "I am delighted to hear the news of the

FULL WORDING OF THE BMA's MOTION

That, in light of the allegations, this meeting:

- welcomes the independent investigation into sexism and sexual harassment at the BMA
- calls for the BMA council to consider the outcome of the investigation and report back to members in a timely manner;
- believes implementation of recommendations should not be delayed.

Mental illness: outgoing PM announces prevention plan

NHS staff, teachers, and social workers will be trained to spot the signs of mental health problems, under a new prevention plan announced by the outgoing prime minister, Theresa May.

Domestic legacy

In an attempt to cement her domestic legacy, May announced a package of measures to tackle the "burning injustice" of mental illness. "We should never accept a rise in mental health problems as inevitable," she said. "It's time to rethink how we tackle this issue, which is why I believe the next great revolution in mental health should be in prevention."

May also confirmed that a white paper will be published before the end of the year in response to the review of the Mental Health Act chaired by Simon Wessely, past president of the Royal College of Psychiatrists (RCPsych). She said the act would be overhauled to make it fit for modern society, including a total ban on the use of police cells to detain people experiencing mental illness.

Under May's plan, all NHS staff will be encouraged to take suicide prevention training from the Zero Suicide Alliance. Every new teacher will be taught to spot the signs of mental health problems, and schools will be given extra support to help children who self harm or are at risk of suicide.

Also announced was a public awareness campaign called Every Mind Matters, launching in October, and a £1m grant to the Office for Students, the higher education regulator, for a competition to find new ways to support mental health at universities.

May said that there would be greater transparency in how money is spent on mental health services, with a commitment to independent audits to ensure that funding committed under the *NHS Long Term Plan* reaches the front line.

Stretched to breaking point

Barbara Keeley, the shadow mental health minister, criticised the announcement as just "warm words." She said, "The reality is that mental health services are stretched to breaking point, and people with mental health problems aren't getting the support they need." She added that May's government had cut local authority funding and not protected mental health budgets.

Daphne Romney has extensive experience in discrimination and pay cases

appointment to independently chair the review, and I look forward to engaging with her."

Norris said she was also pleased that BMA council chair Chaand Nagpaul had agreed to widen the scope of the inquiry to include "poor behaviour."

"Behaviour rarely happens in isolation," she said. "Often sexist behaviour is part of a bullying culture. It's important to look at all the issues underlying it."

Norris also hopes the review will look at the process for raising concerns. "That's one of the areas that I have the most worries about, and I think it is one of the areas that really needs to change," she said.

"It's fundamental to the BMA's ability to function as a successful union that it deals with this openly and honestly. We've always said that the whole purpose of this is because we haven't been listened to. I hope now that this will be dealt with and the BMA can move on and become the strong doctors' union the profession needs."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2019;365:l4259

"It's time to rethink how we tackle this issue"
Theresa May

Wendy Burn, RCPsych president, said, "The independent review of the Mental Health Act was an important step in making sure that people get the support and care they need when they are at their most vulnerable. It is good to see the start of the implementation of the reveiw's recommendations."

But she warned, "Success will depend on continued commitment from future prime ministers."

Jacqui Wise, London

Cite this as: *BMJ* 2019;365:l4260

Q&A

Listeria outbreak: Hancock orders review of hospital food after deaths

England's health secretary calls for a "root and branch" review of NHS catering after five patients die from food poisoning. **Nigel Hawkes** reports

Is Hancock's response proportionate?
Almost certainly not. While any deaths from food poisoning merit immediate and careful investigation, these cases do not cast doubt on the whole NHS food chain. Hancock's reaction may have had something to do with his now withdrawn bid for the Tory leadership.

How exceptional are these deaths?
Between 2010 and 2016 an average of 46 people a year died from listeriosis in England and Wales, and an average of 166 cases a year were detected. Many more people would have been infected, but in healthy people the infection is either unnoticed or causes very mild illness.

What caused this outbreak?
Sliced meat from a Salford based company called North Country Cooked Meat has been implicated. The company supplied the meat (reported to be chicken) to the Good Food Chain, who sold sandwiches to NHS trusts.

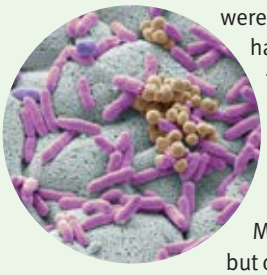
What is the guidance on sandwiches?
In 2016 the Food Standards Agency relaxed previous guidance that vulnerable patients should be given sandwiches only with a doctor's approval. In its place it set out what it called "good practice controls" to manage the risks. The adequacy of these controls is now being questioned, with Jeff Thomas, owner of North Country Cooked Meat, reported as saying it was "an outrage" that vulnerable patients should have eaten pre-packed sandwiches.

Is there evidence of negligence?
It's too soon to say. Salford City Council told the *Sunday Mirror* it had inspected North Country Cooked Meat for many years. It had detected listeria in 2009 and 2010, and the company "acted promptly to deal with it satisfactorily." Inspections last October and February found nothing untoward.

How widespread was the outbreak?
The Good Food Chain supplied 43 trusts. Deaths occurred at two hospitals in the North West and two in the Midlands. Another four hospitals in the South and South East also had cases but no deaths. The products were withdrawn on 25 May, but symptoms can appear up to 70 days after eating contaminated food.

Is there any risk to the general public?
Nick Phin, deputy director of the National Infection Service, says the risk is low. No cases linked to the outbreak have so far been identified outside hospitals.

Can such outbreaks be prevented?
In principle, yes—but in practice, no. If hospitals provided only hot food, listeria infection would be prevented. If food companies were monitored more intensively, or had their own more rigorous checks, the risks might be reduced. But the bacterium is found everywhere in the environment, and the contamination of food production machinery is hard to eliminate. Maintaining a good cold chain cuts but does not stop the bacterium's growth. UK outbreaks are rare, indicating the industry in general does a good job.



So, what's the answer?
Good surveillance is critical in identifying a cluster of cases with a common origin and eliminating the cause as soon as possible. If not, an outbreak can continue undetected for months, as in 2018 in South Africa, when processed meat affected 1061 people. Whole genome sequencing (used by Public Health England in this outbreak) is a powerful tool and has shown that about half the cases detected in Europe are sporadic, the other half forming part of a cluster.

Can conclusions be drawn on hospital food?
Not really. The cause was specific, not general. Hancock said he wants to examine whether all hospital catering should be brought in house. He told MPs that where trusts had done this the result was better quality and better value food. For many trusts this would be a big change with considerable financial implications. Whether it is justified by the listeria outbreak is questionable.

Nigel Hawkes, London Cite this as: *BMJ* 2019;365:l4262

A decade on from Marmot, why are health inequalities still worsening?

Experts give a taste of findings ahead of next year's update of the 2010 review. **Elisabeth Mahase** reports

It is important to stop pouring money into the services that are mopping up problems which are preventable
Tim Elwell-Sutton

Experts in public health have warned that inequalities in health have worsened since Michael Marmot's landmark review was published in 2010, and they call for major policy reforms to tackle growing disparities in life expectancy in the UK.

Figures published in March by the Office for National Statistics show that the gap between rich and poor people in life expectancy and healthy life expectancy is increasing in England.

Against this backdrop, a 10 year update to the Marmot review will report next February on the existence and effectiveness of policies to tackle the social determinants of ill health and to examine what societal trends have affected health inequalities.

Speaking at the Westminster Health Forum on 11 June, Tim Elwell-Sutton of the Health Foundation, who has been working on the Marmot update with the Institute of Health Equity at University College London, gave a preview of some of the trends.

"It's not just that the worst-off groups are not increasing [in life expectancy] as fast as the better-off groups; life expectancy is actually going down in the most deprived groups," he warned. "That's a new phenomenon. In fact, in Scotland and Wales life expectancy has declined. There's something different going on. This is not the norm."

"Shocking" disparity

Elwell-Sutton emphasised it was not just about people living longer but living in good health. He pointed to the latest statistics, which show that healthy life expectancy in the most deprived decile of women and men is now 52 years. "That's shocking. It's shocking for the individuals. It's shocking for the families involved, for the communities involved, but also for us as a society and for our economy."

A joint analysis on 12 June by the Health Foundation and the King's Fund estimated that by 2021 public health budgets will have been slashed by around 25% per head in real terms since 2015-16

He added, "We need to understand that health is one of our most important national assets."

The Marmot update is also looking at new trends and evidence in connections between work and health, Elwell-Sutton said. He said it was no longer obvious that having a job was better than not having one, with some evidence showing that having a poor quality job might not actually be better for a person's health than being unemployed. This was being driven by changes in technology, in the way people were paid, and types of contracts, he said.

He continued, "The other theme that's come through is that the relationship between work and poverty has changed. We used to assume that poverty was largely a function of people not having work, or enough work, but actually a huge amount of poverty now is in working households, and we are seeing an increasing number of children growing up in families that are below the poverty line. It's roughly 30% of children that are in poverty, and the projections are for that to increase."

Drug expert's tweets fail vetting by advisory committee

A drug policy expert has been disallowed from joining the Advisory Council on the Misuse of Drugs because of criticisms she made of the government.

Niamh Eastwood,

executive director at Release, an independent body that provides expertise on drugs and drug law, had been cleared to join the council by the Home Office but was later rejected after her social media activity was vetted.

Eastwood has used Twitter to criticise the government's drug policy, including saying that it had misrepresented the evidence about drug consumption rooms (left), which weren't recommended for rollout in the UK. Because of these comments a minister vetoed Eastwood's appointment, documents obtained by the *Guardian* showed. The documents, obtained by a subject access request, also showed that candidates for public bodies routinely have their social media profiles reviewed, including any comments made in reference to the government, the prime minister, the Windrush scandal, Brexit, and anything related to diversity.

In correspondence discussing Eastwood the advisory council's secretariat said, "Having a different view to the Home Office is not a barrier to appointment, but the

"NEARLY 10000 people have died from heroin related deaths in England, Wales, and Scotland since 2010"

The relationship between work and health is being reassessed

The effect on health equality of public health budget cuts should not be ignored, experts say.

Budget squeeze

Siva Anandaciva, the King's Fund chief analyst, said the cuts were "at odds with the government stated mantra that 'prevention is better than cure.' While local authorities have tried to make do by introducing efficiencies, the budget squeeze is taking its toll," with figures showing rising incidence of some sexually transmitted infections such as syphilis.

Elwell-Sutton told the forum it was important to start "rebalancing public expenditure and public investment" towards things that keep people healthy and "stop pouring money into the services that are mopping up problems which are preventable."

As an example, he pointed to the New Zealand government, which is to use wellbeing instead of GDP to measure success. "That's a model we should consider seriously," he said.

He also highlighted how the Welsh government has made it mandatory for any policy decisions to consider the impact on future generations. He said the NHS had an important role in such a culture shift, as an "anchor institution" and one of the biggest employers in the country. "The way the NHS treats its staff has a direct impact on the wellbeing of a large section of the population, not only in terms of who it employs but the built environment, the green spaces, and other climate effects as well," he said.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2019;365:l4251

language and tone used identifies a concern that the candidate would find it hard to work alongside government and may use the appointment as an inappropriate lobbying opportunity."

But Eastwood stood by her comments and called the blocking "deeply concerning." She said, "I am critical of the government's policy on drug consumption rooms and have aired my frustration on social media. I stand by my comments—even the language used.

"Nearly 10 000 people have died from heroin related deaths in England, Wales, and Scotland since 2010; yet this government continues to prevent interventions that can save lives, including drug consumption rooms." She added that the Home Office had "repeatedly and inaccurately" presented information on the measure.

Eastwood described the routine checking of applicants' comments on Windrush or Brexit as "incredibly worrying" and as "damaging to the development of independent expert advice." She suggested that the Home Office only wanted "yes people."

A Home Office spokesperson said, "Ministers are responsible for appointing members to public bodies in line with governance codes. They are provided with a choice of appointable candidates and will make the appointment objectively and on the basis of expertise."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2019;365:l4214

FIVE MINUTES WITH . . .

Nicole Stott

The former astronaut on the Space for Art Foundation, which provides therapy for children on cancer wards

"It started with the spacesuit art project in the Arts in Medicine programme at the University of Texas MD Anderson Cancer Center. The artist Ian Cion has always worked with kids, helping to incorporate their individual artwork into a bigger community project—and he wanted to do something with space. We actually flew a couple of the spacesuits with the kids' designs up to the International Space Station.

"The simplest way to describe the initiative is space themed art therapy, but that doesn't do it justice. It's much bigger. It's about allowing the children and their families, who are going through what you hope is the worst thing they will have to deal with, to transcend the experience. It's like taking them to space—not just figuratively but literally, with their artwork going to space.

"We've gone from working in just one hospital to more than 30 around the world, from New Zealand to Iran, Ecuador to Tonga. In the UK we have children from Great Ormond Street Hospital participating. We're also expanding to work with kids in refugee situations.

"Children are inspired by the idea of an astronaut, but we may be getting even more out of it, just witnessing their strength. They physically get stronger: they often come in tired, their parents almost dragging them into the room, and they don't want to be there—but you see this transformation as they paint and talk. So many times I've walked away from a session just in awe of what the children were thinking and doing.

"As astronauts, we always talk about this view of looking out of the window to Earth and how stunning that is. But if you flip it around and look out towards blacker-than-black space, you get the same kind of feeling. It's the same with these kids: it's using the inspiration of space flight as a way to imagine themselves in a healthier place and hopefully give them some hope for the future."

To hear the podcast of the conversation visit bmj.com

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2019;365:l4244

I WALK AWAY FROM SESSIONS IN AWE OF WHAT THE CHILDREN WERE THINKING AND DOING


A JOURNEY
FROM DON'T
TO SAVE HIM
When the doctor's WHITE
No more
TOLERANCE
TO
VIOLENCE
SAVE THE
SAVIOUR!!!

DAVID TALUKDAR/SHUTTERSTOCK

THE BIG PICTURE

Doctors in India strike after attacks

Doctors at Guwahati Medical College Hospital in Assam stage a silent protest during a nationwide strike in India last week.

Almost all of the country's 800 000 hospital doctors walked out to demand better working conditions, after years of complaints about violent attacks from patients' families.

The latest strike followed a brutal assault on junior doctors in Kolkata, by the family of a 75 year old man who died at the NRS hospital on 10 June. One of the doctors had a fractured skull and needed a craniotomy.

"The events in Kolkata were just a flashpoint. This has gone on for too long. We have a right to security as ordinary citizens. This violence against doctors is not acceptable in any civilised society," said Rajan Sharma, president elect of the Indian Medical Association.

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2019;365:l4268

EDITORIAL

New preprint server for medical research

Announcing the launch of medRxiv for faster access to better evidence

Preprints—preliminary versions of research articles—have been circulated among researchers for decades. Initially, hard copies of manuscripts would be sent to collaborators and peers around the world for comments before formal journal submission. With the advent of the internet, physicists, in particular, embraced electronic circulation of preprints, primarily on the arXiv (https://arxiv.org/) server. Life science researchers have followed suit,[1] particularly using the bioRxiv preprint server (https://biorxiv.org). But clinical researchers have been slower to embrace electronic preprints for fear of the potential to cause harm.

The main arguments for sharing work in its preliminary form are, first, that science works faster if work is made available sooner after it is completed and, second, that articles are improved by feedback from a wider group of readers, alongside formal peer review by a few experts. Simple estimates suggest that halving the delay to sharing a result can double the speed at which research progresses.[2] Ambitious funders are embracing preprints and other measures that aim to accelerate the pace of research.[3]

Public access

But there have been concerns about providing public access to preliminary clinical research.[4,5,6] Might it result in more health scares or harm to patients? There is some evidence that preprints can accelerate progress in handling infectious disease outbreaks,[7] but what about less obviously urgent medical research? Can the need for speed be balanced with suitable safeguards to protect the public?

This debate is not new for *The BMJ*: more than 20 years ago deputy editor Tony Delamothe asked readers what we should do about electronic preprints,[8] and the responses[9] were similar to discussions now. The headline conclusion reached was that clear labelling of preprints might allow them to be used safely.[8] As a result, BMJ (publisher of *The BMJ*) launched the first clinical preprint server, ClinMedNetPrints.org, in 1999. The server operated until 2008 and received around 80 submissions before it was closed because of lack of use.

We believe the community will be served best by a preprint server specific to clinical research

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But times have changed, and we believe the need for an independent clinical preprint server remains. Clinical research can be found scattered on various preprint servers, ranging from bioRxiv and arXiv to servers established by publishers to link to their journals.[10] We believe the community will be served best by a preprint server that is specific to clinical research so that suitable safeguards can operate and by one that is not linked to specific journals or publishers but provides a central, freely accessible archive.

BMJ is therefore announcing its partnership with Yale University and Cold Spring Harbor Laboratory to launch medRxiv. Harlan Krumholz and Joseph Ross, clinician-researchers at Yale, have long been advocates of preprints,[4] while Cold Spring Harbor Laboratory operates the bioRxiv life sciences preprint server. BMJ brings its long experience of publishing and review of clinical research, researching the effects of changes in publishing,[11] and publication ethics.[12]

Light touch processes

In working to launch medRxiv we have focused on light touch processes and workflows that we believe will reduce the potential for harm while retaining the advantages of speed and openness. A first step will be for authors to make various declarations about the work: how it has been conducted and reported, any conflicts of interest, and details of ethical approval. Then, all manuscripts will undergo several rapid rounds of screening before they are posted. The first will ensure a manuscript is a research article (medRxiv will not accept case reports or opinion pieces, for example) and will cover obvious legal problems such as plagiarism and defamation. Then, a researcher in a relevant field will check the article's basic content and organisation—but medRxiv does not endorse a manuscript's methods, assumptions, conclusions, or scientific quality. And finally, a key screening question will be whether a preprint has the potential to do harm to individual patients or the public. If in doubt medRxiv will not post the preprint and the authors will be encouraged to publish only after peer review.

By posting preprints, authors can help promote openness and transparency and reduce research waste from duplicated efforts and non-reporting. By helping ensure a balance of safety and speed, we believe medRxiv can provide a valuable service to the clinical research community. We will regularly report on any research on the effect of preprints, and we encourage third parties to contact us for research opportunities. We also urge all readers of *The BMJ* and its sibling journals to read and deposit preprints in medRxiv. We look forward to reporting on its progress.

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WELLBEING

New cash for junior doctors' messes: how would you spend it?

After last month's announcement that hospitals were to receive at least £30 000 government funding to improve rest and social facilities, **Abi Rimmer** asks several doctors nationwide how the money would be best used

Jeeves Wijesuriya, chair of the BMA Junior Doctors Committee and GP trainee in London. "The BMA's Fatigue and Facilities charter outlines the steps needed to improve facilities and enable doctors to get proper rest. So I hope the funding will contribute to dedicated rest facilities, dedicated communal spaces, and safe storage, as well as other improvements that junior doctors at each trust help decide.

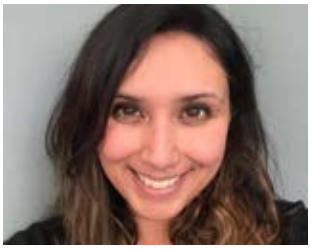
"Lack of access to rest not only risks the quality of patient care but also causes abysmal morale. The BMA will monitor the implementation of provisions, but hopefully this is the start of much needed cultural change."

Samantha Batt-Rawden, emergency and intensive care medicine trainee, Surrey, and chair of the Doctors' Association UK. "Additional rest hubs could be considered for areas such as the labour ward; neonatal, paediatric, and adult intensive care units; and emergency departments, where doctors may not be able to get away. Providing expressing facilities for breastfeeding mothers is an important but often neglected consideration.

"None of this is revolutionary, but getting the basics right is important if we are to start treating doctors as human beings, not just numbers on the rota."

Danielle Eddy (pictured) and **Sarah Arthur**, paediatric trainees, recently transformed the mess at the Bristol Royal Hospital for Children. "Junior doctors are not superhuman: we need space to rest, eat, and relax. We recently renovated our mess with limited time and money. We focused on what junior doctors prioritise most: a clean and tidy space with a kitchen, computers, phones, comfy sofas, and a TV for those rare down time moments. Lack of cleanliness is a common complaint, though.

"Regular restocking of hot food supplies, on weekends as well as weekdays, can boost morale. Popular facilities provided by other messes include book swaps and outdoor break areas."



Roopa McCrossan, vice chair of the Association of Anaethetists trainee committee. "If there is a doctor's mess or on-call rooms already on site, it makes sense to refurbish them.

"Many areas in hospitals aren't used overnight, such as outpatient clinics, day surgery units, and offices. Sleep pods [soundproofed capsules] are one solution, but a cheaper more practical alternative is to consider if sofa beds would work in these areas.

"Different specialties will have different requirements: the trust's junior doctor forum, or any local junior doctor social networks, are a good place to find out what people want and need."

Samantha Cockburn (pictured), trust doctor, **Emily Gray**, foundation trainee, and **Peter Rogers**, anaesthetic trainee, worked with Northern Devon Healthcare NHS Trust to improve its facilities. "We recently moved our mess into our main building and have doubled our membership.

"The renovation included finishing touches such as plants and board games. In an ideal world we would expand and include an outdoor area to allow staff to enjoy fresh air. Within the grounds is a tennis court that hasn't been used for years. We could rejuvenate this and give doctors sporting facilities to promote wellbeing and a balanced life."

Hannah McKee, specialty doctor in emergency medicine at the University Hospitals North Midlands NHS Trust. "Tackle accessibility. I have never set foot in the mess at my hospital as it is too far away for me to use. Set up satellite rest spaces for staff from high acuity areas such as the emergency department and the intensive care unit.

"Ensure reliable provision of the basics such as a fridge and toaster and access to drinks and snacks. Provide sockets for charging phones and other electricals: these are especially important if you need to stay in contact with home."

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Grassroots calls for a blame-free NHS

In the wake of the Bawa-Garba case a campaign by the Doctors' Association UK to end blame culture in the health service has received high profile support. **Francesca Robinson** reports

"Your campaign is crucial. It will change minds. It will change approaches and lead to far greater success than outmoded ways of thinking. Your title tells the story: 'Learn Not Blame.'"

This was how, by video message, the safety expert Don Berwick endorsed a campaign that says that blaming professionals when healthcare goes wrong poisons efforts to learn from what happened. The UK government's former patient safety adviser, Berwick is president emeritus and senior fellow of the Institute for Healthcare Improvement in Boston, Massachusetts.

The Doctors' Association UK launched its Learn Not Blame campaign six months ago in the wake of the Hadiza Bawa-Garba case. It calls for a change in the culture of the NHS to improve patients' safety and healthcare professionals' wellbeing, and it is already having an impact.

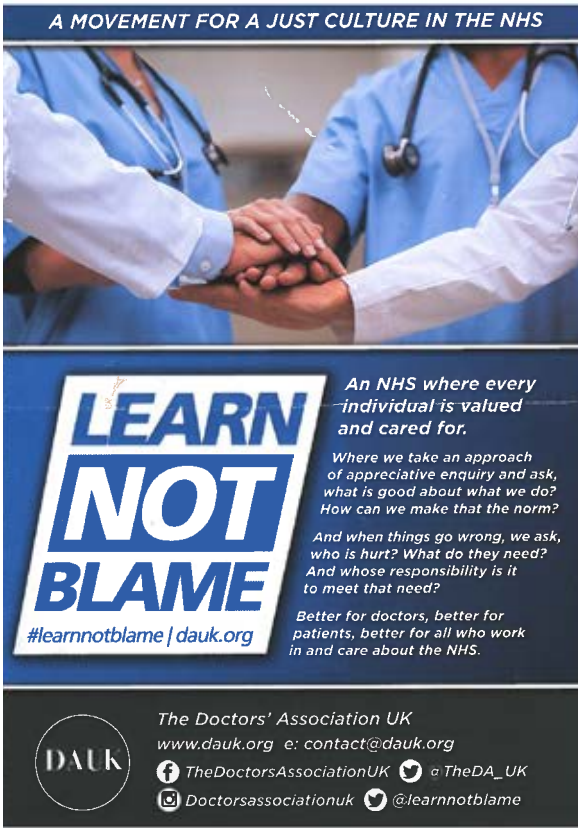
In 2015 the trainee paediatrician Bawa-Garba was found guilty of gross negligence manslaughter after a boy in her care, Jack Adcock, died. She received a suspended prison sentence (bmj.com/bawa-garba).

The Doctors' Association UK was formed in 2018 by doctors outraged when the GMC won a High Court appeal to erase Bawa-Garba from the medical register despite a ruling by a medical practitioner tribunal that she was safe to practise. She successfully appealed.

A cake iced with the phrase "Learn Not Blame" was subsequently delivered to the GMC, warning it of what was to come.

Climate of fear

The Learn Not Blame campaign wants an end to the threat of imprisonment for doctors who make mistakes, to reduce what it describes as a climate of fear in the NHS.



Workplaces should be scrutinised by the CQC to the same degree as the individual professional
Jenny Vaughan, Doctors' Association

The campaign's lead, Cicely Cunningham, a clinical oncology trainee in Glasgow, says that Learn Not Blame reflects the profession's anger. She was so emotionally affected by Bawa-Garba's case that she couldn't sleep the night after the GMC won its appeal to erase her from the register, she told *The BMJ*. At 1 am she phoned a number on the website of BBC Radio 4's *Today* news programme, and someone picked up.

She told the bemused producer who answered that the case needed to be discussed. Coincidentally, the then health secretary for England, Jeremy Hunt, was being interviewed on the show that morning, and thanks to Cunningham's intervention the matter was raised with him on air.

The campaign launched at an event at parliament in November 2018, attended by MPs, patients who had experienced medical harm and their families, whistleblowers, policy makers, and the current health and social care secretary for England, Matt Hancock. The next day in the House of Commons Hancock raised the issue of the need for a more compassionate culture in the NHS. He repeated these concerns a week later in a speech calling for NHS leaders to encourage whistleblowing, listening to patients, and shared learning.

The campaign has attracted thousands of followers on social media, gained national media coverage—including in the *Guardian*, the *Times*, and *The BMJ* and on BBC radio—and has been endorsed by healthcare leaders, including Hancock. It has also contributed to a House of Lords meeting on harassment in the NHS, and the campaign group has joined an anti-bullying alliance that includes the Royal College of Obstetricians and Gynaecologists.

Hamilton and Williams reviews

Learn Not Blame contributed to the cardiac surgeon Leslie Hamilton's independent review for the GMC of the use of gross negligence manslaughter and culpable homicide laws in medicine, published earlier this month. Full implementation of Hamilton's recommendations, the campaign says, should mean far fewer prosecutions of healthcare workers in future.

One of the campaign's founders, Jenny Vaughan, the lead on law and policy for the Doctors' Association UK and a consultant neurologist, opposes criminalisation of healthcare workers for errors. She says that one of the most important recommendations of the Hamilton review is that workplaces should be scrutinised

WHAT IS THE DOCTORS' ASSOCIATION UK?

The association originated in early 2018 in a Facebook group for doctors called "The Political Mess." It became a focus for doctors who wanted to express anger after the High Court judgment that Hadiza Bawa-Garba should be erased from the medical register.

The founders were also angry about former health secretary Jeremy Hunt imposing the junior doctor contract and thought that ordinary doctors' voices weren't being heard.

The association is now a private company, and its constitution guarantees it to be non-profit and volunteer led. It told *The BMJ* that it is developing democratic processes. It says it advertises its leadership vacancies on social media and tries to include anyone who wants to be involved.

Any UK GMC registered doctor can join for £25 and will have voting rights when it moves to elections, but it could not say when that would be. Other healthcare professionals and members of the public can join as associate members.

It has relatively few members but declined to say how many, pointing to its presence on social media. Its public Facebook site has a reach of 200 000. On Twitter it has more than 3000 followers and a reach of 800 000.

It says it aims to speak out on issues that matter to UK doctors and the NHS as a whole and to represent the whole profession, not just its members. It takes direction from social media, including the private Facebook groups "The Consulting Room" and "Learn Not Blame."

Besides Learn Not Blame its campaigns include:

NHS Me Too—Against bullying and harassment in the NHS

Compassionate Culture—For doctors to share positive experiences to encourage a kinder NHS culture

Scrap the Cap—It successfully petitioned Theresa May to exempt foreign doctors in the NHS from visa caps, as did *The BMJ*.

Patient safety is key to its campaigns, the association says, and it works with Action Against Medical Accidents, the Patients Association, and the coalition of health and social care charities National Voices. It also advocates for people whose family members died because of NHS care.

Hadiza Bawa-Garba's conviction sparked the campaign

It partners with NMC Watch, which seeks justice for nurses referred to the Nursing and Midwifery Council. It insists that it is not in competition with the BMA. "We work with the BMA, which is important, given its resources and membership reach," says Vaughan.

by the Care Quality Commission to the same degree as the individual professional. Investigations should take into account the working environment and the pressure the doctor was under, Vaughan says, and the whole system should operate more consistently.

Learn Not Blame also backs the recommendations of last year's Norman Williams's review of gross negligence manslaughter in healthcare, commissioned by the health secretary, which proposed improvements to the expert witness system. The campaign says that everyone working in the NHS should be empowered to do what they can in their own sphere of influence to ensure safer patient care and a better workplace. It is prompting conversations about how the NHS can engender accountability and swap blame for learning, Cunningham says.

To blame is human

Blaming workers is a natural response, Cunningham says, especially if people fear being blamed themselves. But evidence shows that witnessing a colleague blaming someone else can be socially contagious. Such behaviour can spread through a workplace, and the campaign's message is that people can stop that chain. Although the campaign's ambitions are big, Cunningham says that they can be realised through many people doing small things. For example, she has launched an initiative in her hospital for staff to report examples of excellence in healthcare to use for learning and to improve staff morale.

"We want everyone working in the health service thinking about these issues and doing what they feel are the most important and appropriate things that they can do," she says. "It's about empowering people to have these conversations and to be an advocate for a just culture and a learning culture in their workplace."

It's about empowering people to have these conversations and to be an advocate for a just culture
Cicely Cummingham, Learn Not Blame

Such discussions may concern patients and families who have experienced avoidable tragedy, she adds. Most want to know the truth and reassurance that it will never happen again. But many have described believing that they had no choice but to pursue adversarial processes such as complaints and litigation.

Question the system

"On an individual level more of us accept we must question the system if we perceive something is unsafe. In the past we often had to keep our heads down," Cunningham thinks.

Vaughan, as an educational supervisor at her hospital trust, thinks that since the Bawa-Garba case trainees have become more willing to raise concerns with managers about staff shortages and potentially unsafe situations. For example, her trust is considering changes to its specialist drugs prescribing system after one of Vaughan's trainees raised concerns, citing the Bawa-Garba case.

"Bawa-Garba was working in unsafe conditions that day and was wholly blamed, along with nurse [Isabel] Amaro, when things went wrong on a busy shift. Jack Adcock should certainly have received better care, but the hospital has escaped any responsibility. Criminalising these kinds of errors is simply wrong and risks setting the patient safety agenda back by 30 years," Vaughan says.

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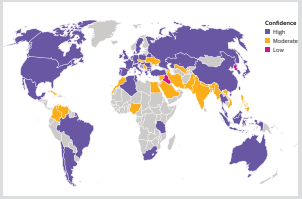
Editorial: Who should own tobacco companies? p 436

Research: WHO framework and reduced smoking p 437



Research: How cigarette smoking has changed since the 1970s p 438

Research: Vaping among young people p 439

Commentary: Necessity of global investment in tobacco control p 440

When states own big tobacco how do they limit cigarette consumption?

China and Japan have controlling interests in giant tobacco companies. They're also signatories to global treaties to control cigarette sales. **Flynn Murphy** and **Gabriel Crossley** report

The governments of China and Japan are in similar, awkward, positions. Both—despite being signatories to the Framework Convention for Tobacco Control, sponsored by the World Health Organization—own or control large tobacco companies.

The framework calls for signatories to protect tobacco control policy from vested interests, but both governments are themselves heavily invested in tobacco industries for the jobs and revenue they provide. The factories fuel vast ecosystems of stakeholders, including growers, advertisers, retailers, and officials. China has by far the biggest tobacco company in the world by market share (China National Tobacco Corp; CNTC), and Japan's ranks fourth (Japan Tobacco; JT).

In Japan, the Finance Ministry retains by law a minimum one third stake in JT, the successor company to the nation's former tobacco monopoly, which was ostensibly privatised in 1985. JT contributed more than ¥864bn (£6.2bn) in tobacco taxes in the fiscal year ending May 2018. *The BMJ* calculates that the Japanese government's stake will have yielded about ¥100bn in additional dividend payments in 2018.

China's state owned tobacco company is a near monopoly that produces a third of the world's cigarettes. It shares staff and offices with its regulator, the State Tobacco Monopoly Administration. Both sit under the muscular Ministry for Industry and Information Technology. CNTC reports that the domestic tobacco industry poured ¥1trn (£1.3bn) in tax and profits into government coffers in 2018 and employed 550 000 people.

Meanwhile, the most recent available tobacco control expenditure figures available from WHO are from 2008 and amount to ¥20m; that's less than one penny per smoker. In 2016 Japan had just two full time positions for tobacco control.

Public health advocates fight back . . . quietly

Despite the immense wealth and clout of these industries the tobacco control advocates are slowly being heard: in Japan, mostly outside the government; in China, after long term inertia, within the vast bureaucracy. Their successes have largely depended on the political winds of the day.

In China, where one in three of the world's cigarettes is smoked and tobacco related disease kills 1.1 million people a year, a landmark 2013 report on tobacco control from the powerful Communist Party School, seen by *The BMJ*, is said by tobacco control advocates to have quietly lit a fire under government efforts to curb smoking.

Symbolic responses followed: rules to discourage officials from smoking in public, laws banning tobacco advertising and increasing cigarette taxes, health warnings on packs, a ban on vending machine sales, and various citywide bans on smoking in public spaces. These policies were implemented with mixed success.

But in 2016, when tobacco sales dropped for the first time in 15 years, the industry mobilised: CNTC's sales actually rose in 2017, as well as in the first quarter of 2018. Industry lobbying is almost all behind closed doors, says Judith Mackay, a Hong Kong based senior adviser at a US non-profit public health advocacy group, Vital Strategies, who has advised top Chinese officials on tobacco control.

"Probably 99% of that lobbying we will never know about," she says, "because it's somebody from the tobacco industry, or somebody from the MIIT [Ministry for Industry and Information Technology], just talking to the finance minister."

Japan Tobacco continues to challenge passive smoking's link to lung cancer, heart disease, emphysema, and chronic bronchitis

The Chinese state industry's strategy convinced smokers to trade up to more expensive brands on the false grounds that they were less harmful

Only last year did health bureaucrats wrestle jurisdiction over tobacco control policy away from the MIIT. Until then it was "like putting the fox in charge of the hen house," says Mackay, because the department that oversaw the tobacco industry was also responsible for warnings, advising on tax rates, and even implementing the Framework Convention for Tobacco Control—one reason, she says, that China still lacks picture warnings on packs.

An even harder fight in Japan

Across the East China Sea in Japan, four decades of grassroots movements and work by non-governmental organisations have seen smoking rates decline despite government actions rather than because of them. Observers say that the Finance Ministry's controlling stake in JT, alongside its control of government purse strings, have hobbled health officials. A landmark national indoor smoking ban, passed last year ahead of the 2020 Summer Olympics in Tokyo, was watered down to exclude over half of Japan's restaurants after lawmakers bowed to pressure.

Mark Levin, a law professor who focuses on tobacco regulation in Japan, says, "Even on a formal basis the government's conflict [of interest] is profound, but on an informal basis, when someone owns a third of a business, they're true insiders."

JT's controlling shareholder also regulates tobacco marketing and sets prices. Then there are tobacco leaf growers, convenience store associations, and the marketing complex the industry supports.

A spokesperson for JT told *The BMJ* that it was the Japanese government's responsibility to implement the Framework Convention for Tobacco Control and that JT supports the framework's call to protect policy from commercial and other vested interests.

In a statement to *The BMJ*, the company said, "We regularly express our views and positions in Japan and in other countries, and we abide by laws and regulations while maintaining our right to question, and if necessary challenge, policies that we believe are flawed, unreasonable, disproportionate, or not based on evidence."

Questionable claims

One thing JT continues to challenge is passive smoking's link to lung cancer, heart disease, emphysema, and chronic bronchitis, almost 40 years after a major study in Japan found that the wives of heavy smokers had as much as twice the risk of developing lung cancer as women married to non-smokers—and in the face of other, overwhelming evidence.

CNTC has made its own questionable health claims. Front and centre is its "premiumisation strategy," which began in 2009 and successfully convinced many smokers to trade up to more expensive brands on the false grounds that they were less harmful. Aggressive marketing techniques linked such "premium brands" with power and business acumen, capitalising on the central role of cigarette giving, mostly among men. Such social practices have been found to drive cigarette consumption, increase initiation, and frustrate attempts to quit.

Mackay recounts that, before the then Communist Party general secretary Jiang Zemin opened the World Conference on Tobacco or Health in Beijing in 1997, he received a letter from China's tobacco industry. Mackay remembers: "They said, 'Yes, China should look after the health of its people but, economically, remember how many people are employed by it, how many people are dependent on tobacco farming and tobacco manufacturing; think of the amount of tax.'" This emphasis on economic arguments has changed little since.

Political and economic realities

"Tobacco growers and retail unions are always pushing the government not to develop tobacco control laws," says Kyoichi Miyazaki, secretary general of the Japan Society for Tobacco Control. With the state unwilling to act, people such as Miyazaki—alongside taxi drivers, teachers, and doctors—have stepped up to the plate. Since the 1970s, when three quarters of men in Japan smoked, grassroots movements have carved out nooks of resistance, organising smoking moratoriums in restaurants, taxis, and railway stations.

Mackay has compiled some figures over the years: in 1985, 65% of men and 14% of women smoked in Japan; by 2016 these figures had fallen to 27.9% and 9.7%. But there's much more to be done, says Miyazaki, who's been pushing for tobacco regulation to be stripped from the Finance Ministry and given to the Ministry of Health, Welfare and Labour. His ultimate goal is for Japan's tobacco industry to be closed down.

Pilot schemes

A pilot programme in 2012 in the town of Yuxi, –Yunnan—home of Hongta Tobacco Group, owned by CNTC—encouraged farmers to learn new skills and substitute their tobacco crops for food crops.

Noting that the state monopoly keeps tobacco prices artificially low, the researchers reported that farmers' yearly incomes increased by 21-110% per acre as a result.

Virginia C Li, of UCLA Fielding School of Public Health in California, led the project. She told *The BMJ* that locals outside the pilot scheme had also been quick to see its advantages. "Neighbouring farmers simply took it upon themselves in turning their cooperatives into business enterprises because they can earn a better income than tobacco," she said. The pilot is now over and the lessons learnt, says Li: "It is up to the government and related organisations to chart its course."

Mackay says that for public health professionals to advance the cause of tobacco control in places such as China and Japan, making the health case isn't enough. She highlights "political and economic realities that we all have to master."

As tobacco use slows at home, JT now focuses on international business, which it describes as its "growth engine." Foreign tobacco sales contributed 59.2% of the company's revenue last year, compared with 28% from local sales. JT has factories in every continent except Australia and Antarctica.

Meanwhile, China's tobacco monolith, CNTC, has been ramping up efforts to go global as part of the nation's international development strategy, the Belt and Road Initiative. Last year China exported $722m worth of cigarettes, nearly a threefold increase from a decade earlier.

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EDITORIAL

Who should own tobacco companies?

Strict regulation that prioritises public health is essential

CHARLY TRIBALLEAU/AFP/GETTY IMAGES

Murphy and Crossley's feature article highlights the economic, political, and cultural challenges that China and Japan face in reducing the immense toll of disease and death caused by tobacco p434.[1] They argue that one of the biggest challenges is that the China National Tobacco Corporation (CNTC) is a fully state owned entity, while the Japanese Finance Ministry retains a minimum one third stake in Japan Tobacco.

Although these governments benefit immensely from the vast sales and tax revenues pouring in from the sale of cigarettes, they must contend with the even greater economic and social costs when substantial proportions of their citizens get sick and die prematurely from this state sanctioned addiction. Shifting the balance between these two divergent sets of interests towards public health is not simple. But full privatisation of these companies is not necessarily the answer.

China and Japan are far from being the only countries grappling with state ownership of tobacco companies. In 2015, 15 other countries had state owned tobacco companies as their principal cigarette manufacturer.[2] There used to be many more.

The right motivation

The debate between state and private ownership in national economies is a seminal one. In centrally planned economies, state owned enterprises produce goods and services. In China, the Communist Party's nationalisation of the tobacco industry in 1949 was about the consolidation of political power and central control of an economic cash cow.[5]

In market economies, state ownership is reserved for those goods and services deemed essential to national interests (energy, transportation, communications, etc). Private ownership, where incentives to innovate and contain costs are strong, is generally preferred to public ownership. Japan Tobacco began as the Japan Tobacco and Salt Company, formed as a state owned monopoly in 1898 to control two products considered necessities in a country with limited food production capacity. The shrinking over time of the proportion of Japan Tobacco owned by the state reflects shifting attitudes towards both state ownership and tobacco.

However, a key assumption is that the commodity is desirable for society. Tobacco is an anomaly. It is not an essential commodity but the world's deadliest consumer product. As such, the rationale for state ownership must change.

The previous goal of ensuring a plentiful supply for the masses is, as Murphy and Crossley describe, contrary to public interests. But so is privatisation, which invites competition and innovation to reign. Public health is hardly served by market forces seeking to produce a deadly product with greater efficiency, competitively sold through lower prices, product innovation, or attractive packaging and widely accessible through worldwide distribution networks.

One alternative is the renationalisation of tobacco companies, alongside strict regulation to control supply

This is indeed what has transpired where state owned tobacco companies were privatised in the 1980s and 1990s.[4] As Gilmore and colleagues argue, "Further tobacco industry privatisation is likely to increase smoking and ... instead of transferring assets from state to private ownership, alternative models of supply should be explored."[4]

One alternative is the renationalisation of tobacco companies, alongside strict regulation to control supply.[7] This, along with efforts to require tobacco companies to reduce use of their products, eventually leading to the companies' obsolescence,[2 8] should be explored as a potential endgame strategy.[9]

Whether tobacco companies are state or privately owned is thus the wrong question. The real challenge is how best to strictly control the production and consumption of a highly addictive and deadly product. The answer is comprehensive regulation that makes public health and not economic interests the top priority—something that many countries, regardless of ownership, have yet to do.

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