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Publishing research supported by the tobacco industry

Journals should reverse ban on industry sponsored research

The tobacco industry's behaviour is as noxious as its products. During the past year, tobacco executives have denied that nicotine is addictive, spent heavily to stop antismoking laws in the American Congress and states, prosecuted their own former executives who have tried to speak out, and even threatened the media's attempts at investigations.[1] So it is not surprising that the American Thoracic Society, the scientific arm of the American Lung Association, decided last month that it would no longer accept any medical research that is funded by the tobacco industry in its two peer reviewed journals (6 January, p 11.)[2] The decision was a step further in the medical society's laudable fight against tobacco, but it was a misguided one.

Tobacco accounts for a third of deaths in the developed world[3] and about 10% of medical costs in the United States result directly from tobacco use. More perniciously tobacco advertising has been shown to be aimed successfully at young people.[4] In Washington, the industry spends millions to maintain its own livelihood by being, according to one congressman, "the most pervasive lobbyist in politics today."[5] The tobacco industry also promotes itself through research grants. In 1994 in the United States it distributed $19·5 million for research, which resulted in 375 scientific papers. Nearly 1100 investigators at more than 300 institutions, including medical schools, have accepted grants since funding began in 1954.[6]

We praise the American Lung Association and the American Thoracic Society for their firm stand against tobacco. Indeed, the society's directive that its members should not accept funding from the tobacco industry is a good step, although enforcement will be difficult. But the extension of the rule into the pages of its scientific journals, the *American Journal of Respiratory and Critical Care Medicine* and the *American Journal of Respiratory Cell and Molecular Biology*, is a threat to medical science, to journalism, and ultimately to a free society.

The editors' decision was made after much thought, and the leaders of the American Thoracic Society said it was essentially a moral decision. Before the decision was made the issue was debated by two medical ethicists in the *American Journal of Respiratory and Critical Care Medicine*. Arthur Caplan of the University of Pennsylvania wrote: "Any organisation committed to the goal of preventing respiratory illness and disability and to working with government agencies who seek to do everything in their power to reduce the use of tobacco products among children and adults cannot remain credible if it permits research sponsored by the tobacco industry in its publications."[7] But H Tristram Engelhardt Jr of Baylor University used the "slippery slope" moral argument. "If receiving tobacco money is unacceptable, why is it acceptable to take governmental money if acquired through unjust taxation policies? Or if the party in power does not support health reform in accord with ATS and ALA views? . . . Or if the funds come from corporations that sell tobacco products?"[8]

But the issue is more than a moral one, as Engelhardt implies. Scientific inquiry rests on investigation that is presented to other scientists for their review and judgement. Every sponsor of every study has an agenda to promote, but all studies undertaken must be made available in some form: if some studies are systematically suppressed then we will reach false and biased conclusions when reviewing a body of research. The peer review system is designed to try and ensure that the conclusions of studies are supported by the evidence they contain, but peer review cannot guarantee the validity of studies. Studies must be published so that other researchers can make up their own minds on their quality. Because peer review cannot guarantee the validity of a study and because bias operates very subtly, many journals, including this one, print authors' funding sources alongside papers. By doing so, the journals ensure that the ultimate peer reviewers, practising doctors, can use that information to make up their own minds on the validity and usefulness of a piece of research. (Some readers may consider drug company sponsored research to be suspect, never mind the tobacco industry.) By impeding the process of scientific publishing the American Thoracic Society is being antiscientific.

The leadership of the society says that taking tobacco money represents a conflict of interest for researchers. Engelhardt wonders where it will all end: Will smokers be banned from the pages of the journals? He also raises an issue that is too seldom discussed: the conflicts of interests beyond money. They can be personal, political, academic, and religious,[9] and Engelhardt adds personal habits. Conflicts of interest cannot be eradicated from medical journals, and the American Thoracic Society is deceiving itself to think it can.

Most journals subscribe to the International Committee of Medical Journal Editors' (Vancouver Group) position on conflict of interests by requiring authors to disclose their own perceived conflicts.[10] Journals have more to do in this difficult area, because what authors perceive and what readers might perceive as conflicts of interest can be very different. But for

the time being, many journals, including the *BMJ*, tell readers the conflicts that authors feel they have.

A third strand of this argument is one that is most critical to Americans: freedom of the press through prohibition on prior restraint of information. It is a centrepiece of the US Constitution. This fundamental freedom, which dates to the Enlightenment, is based on the idea that a free and open marketplace of ideas fosters truth. "That the best test of truth is the power of the thought to get itself accepted in the competition of the market . . . . That, at any rate, is the theory of our Constitution," wrote the jurist son of the great American physician, Oliver Wendell Holmes. To ban scientists who take tobacco money is to restrict the freedom—and so the effectiveness—of the press.

The ban of tobacco funded research by the two American journals turns two respected scientific journals into publications with political agendas. In the end, this will make them little more than house organs for one group. And no matter how praiseworthy the goals of that group, it and its publications will be diminished. In the nasty debate over tobacco, the industry may well welcome the journals' censorship. It may try to say, "See, you are no better than we are." We urge the American Thoracic Society and its journals to reverse their decision and fight the tobacco industry not with censorship but with the abundant evidence on the serious harm that its product inflicts.

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Nursing shortages

A reality, and likely to get worse without national and local intervention

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Nursing shortages are back in the headlines, and Britain's government ministers, briefly reassured that local pay had rid them of the troublesome profession, are back on the defensive. Concern about staffing shortages was last on the NHS agenda in the 1980s, with increasing demand for health care and reduced supply of recruits due to the "demographic timebomb"; but by the early 1990s, NHS reforms and general economic recession had reduced job mobility and vacancies, and concern over staff shortages largely disappeared. This year has seen its return to the front pages of the tabloids, if not to the top of the ministerial agenda. Is there any truth behind the "nursing shortage" headlines?

Any analysis of nursing labour markets has to acknowledge three fundamental points. Firstly, nursing shortages are inextricably linked in the minds of the profession and of politicians with nurses' pay. The nursing unions are adept at playing the shortage card to argue for pay increases; the government and NHS Executive are equally keen to downplay any problems with the labour market to keep pressure off the pay bill. The history of pay determination for NHS nurses is littered with examples of official denial of staffing difficulties followed by hastily implemented "catch up" pay awards when these difficulties could no longer be ignored.[1]

Secondly, information on the nature and extent of any staff shortages is fragmented and eroding. The NHS reforms have made detailed standardised aggregation of local workforce data more difficult. This allows official denials of any difficulties to be justified on lack of evidence. It also allows anecdotes about local staffing shortages to receive undue prominence.

Thirdly, workforce planning in nursing tends to focus narrowly on headcounts and whole time equivalents, rather than taking into account what motivates people to enter and continue in nursing or what skills they need for different nursing specialties. Playing the numbers game is a flawed approach to planning: it does not recognise that there may be other options open to employees (including not to work); it does not take account of incentives other than pay; and it considers only pairs of hands rather than skill requirements.

Against this background of politicised debate and flawed data, the "hard" information does point to an actual or potential increase in difficulties in recruitment. We may be some way from a national nursing shortage, but most indicators point towards increasing local difficulties. This begs the question of how many local difficulties are required to cause a national problem. An assessment of the current state of Britain's nursing labour market has to take account of developments in both the demand for staff and the supply.

On the demand side, the number of nurses employed within the NHS has remained largely static since the late 1980s, after four decades of employment growth. This has happened despite a continued increase in NHS activity between the mid-1980s and mid-1990s. But this increase—much of which has been achieved through more rapid patient throughput, reduced length of stay, and increased bed occupancy—has had its own effect on nursing supply. Coupled with advances in health care, it has made patient care more "intense," with higher dependency patients requiring more care in a shorter time period. The effects are reflected in feelings of increased workload and stress among the nurses surveyed by the Institute of Employment Studies.[2] The institute's annual surveys show an increase in job mobility among nurses in the past two years and, for the first time in three years, a rise in the number of nurses leaving the NHS. The "feel bad" factor for NHS nurses has been exacerbated by organisational change, the uncertainties of local pay, and job insecurity from the increased use of temporary staff and short term fixed contracts. The supernumerary status of nursing students since the implementation of the new system for nurse education, Project 2000, has heightened the sense of a staffing shortfall by reducing their contribution on the wards.[3] Many NHS nurses have left to work in the private sector: the number of nurses working in private hospitals and nursing homes almost doubled between 1998 and 1993-4.[4]