comment

"There can be a gulf in professionals' and carers' view of what's best" **DAVID OLIVER**
"Once practices start losing staff, the death spiral is hard to escape" **HELEN SALISBURY**
PLUS Hancock and minimum pricing policy; the long term plan's promise to patients

CUT TO THE CHASE Gabriel Weston

Sing a song of lung health

Just before Christmas I visited an inspiring class at the Royal Brompton Hospital. Set up 10 years ago, Singing for Breathing offers an alternative to usual lung rehabilitation for people with chronic lung disease. Although many conditions are represented, most participants have chronic obstructive pulmonary disease—no great surprise when it's currently ranked by the World Health Organization as the fourth biggest cause of death in the developed world, affecting 3.7 million people in the UK.

In one sense, the suffering associated with respiratory disease is special. Breathlessness is something uniquely terrifying, often likened by patients to suffocation or drowning, as the psychologist Christopher Eccleston writes in *Embodied*, his wonderful book on physical sensation. These patients are also more likely than most others to experience anxiety, depression, and feelings of social isolation.

In another regard, one chronic illness looks much like another. Whatever specialty we've chosen, our patients bear a similar burden: the grind of managing difficult symptoms, the conundrum of negotiating family and working life around hospital appointments, and the deep sense of disappointment from inhabiting a body that doesn't function as it should.

The teacher tunes his guitar as his singers arrive. Some come straight from the ward in wheelchairs, with drip stands attached. Others bring fresh air in on their coats. I see panting, wheezing, coughing, and greetings of old friends. But soon, after a series of breathing exercises, we're filling the room with song: Elton John, Michael Jackson, Perry Como.

A 2016 systematic literature review found that such sessions compare favourably with conventional physiotherapy across a range of outcomes, and more than 70 hospitals nationwide now have them. So, I'm not surprised by patients who stop on their way out to rave about the positive effect this class has had on their life. What does astonish me is how much better I feel at the end of the session myself despite having clear, non-stertorous lungs and a complacent sense of my own physical normality.

Illness doesn't just mirror illness: disease also works as a kind of metaphor for the simple mess of being alive. And the heroic ways in which people manage can reveal plenty to those of us still inhabiting the lofty realms of presumed health.

As I begin 2019 I wonder how I might introduce to my own clinical space some of the human warmth I felt among those brave, breathless singers. Bring biscuits? Offer a choice of music from my phone? Or perhaps just remove my head from my own backside long enough to engage meaningfully for a while with each of my patients, before reaching for the reassuring anonymity of my knife.

Gabriel Weston is an ENT surgeon, Surrey
gabriel.weston@nhs.net
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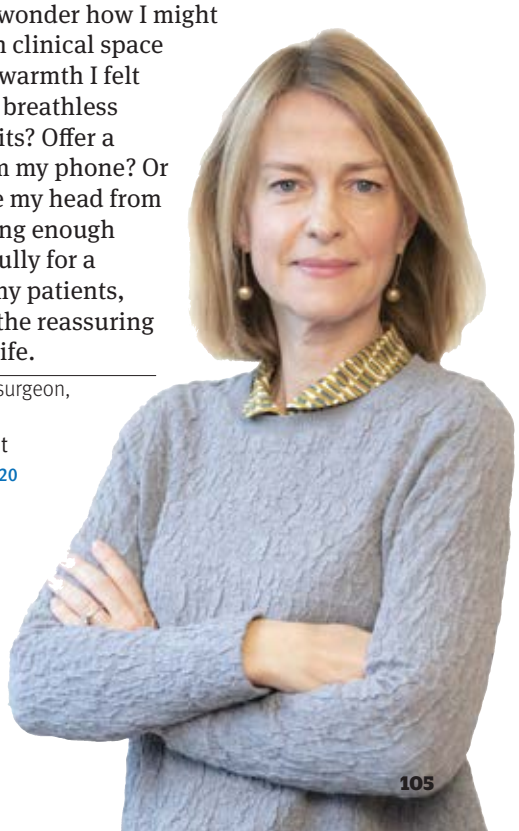
After a series of breathing exercises, we're filling the room with song



PERSONAL VIEW Alison Douglas and Ian Gilmore

Why has Hancock ruled out minimum unit pricing for alcohol?

Research shows that MUP does not "punish" moderate drinkers and is an effective measure to discourage excessive drinking

It was a week of mixed messages from the health secretary, Matt Hancock. In his statement to parliament on the NHS long term plan, he emphasised that at its heart is the principle that prevention is better than cure, and he highlighted the active role that the health service will take in helping people to cut their risk factors, including reducing alcohol intake. Yet in the same week he was widely quoted saying that alcohol is only a problem for a small minority, perpetuating the myth promulgated by the alcohol industry.

While Public Health England (PHE) figures suggest that less than 5% of us drink one third of all alcohol consumed, they also show that "the combination of increasing risk, higher risk, and extreme drinkers accounts for about 25% of the population and consumes over 75% of the total self reported alcohol consumption." That means one in four of us is putting our health at risk, whether in the short term from alcohol related accidents, or over the longer term from liver disease and cancer.

The long term plan recognises alcohol as one of the top five risk factors that cause premature deaths in England—it is not just "extreme drinkers" who are ill or dying.

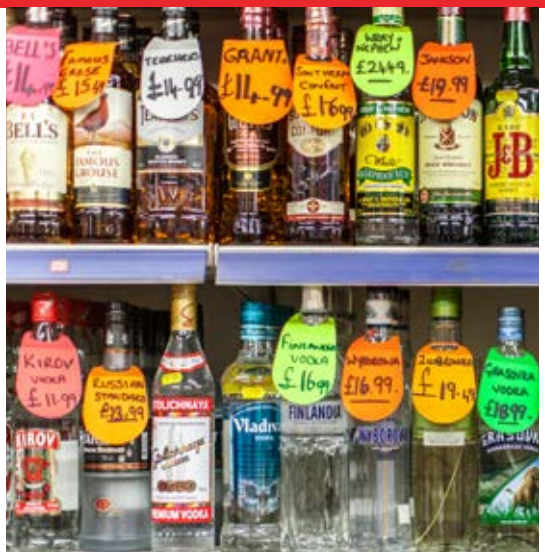
The plan to strengthen alcohol care teams in the worst affected areas is a welcome addition to early intervention in hospitals, but we also need primary prevention measures that will have a broader impact. We drink around a quarter more than we were in the early 1980s and suffering the consequences. This increase is driven by environmental factors. Alcohol is now 60% cheaper in real terms than it was 30 years ago, more readily available, and more heavily marketed.

A real, lasting difference to health

To make a real, lasting difference to the nation's health we must take action at population level. Minimum unit pricing (MUP) is one such approach, which has the backing of the World Health Organization and the health secretary's advisers at PHE.

That is why it was disappointing to hear Hancock say to Sky News last week: "I'm dead against minimum unit pricing of alcohol." It seems a strange time for such a strong stance on one of the most effective measures available—one which could save thousands of lives and improve tens of thousands more.

It had already become clear that MUP was unlikely to form part of the government's alcohol strategy. It has been suspected that ministers might choose to postpone a decision until the impact of legislation in Scotland—and in due course Wales—becomes clearer.



There would be some logic to the health secretary's delaying stance if it did not mean more lives lost

There would be some logic to that if delay did not mean more lives lost. But to actively rule MUP out now does not make sense. It has been scrutinised and approved by two devolved administrations, as well as our Irish neighbours. The health secretary faces the real possibility of leaving England as an outlier on the British Isles, at significant cost to health and to the NHS.

If the minister is looking for a "nudge" then MUP is the perfect candidate. By creating a price below which alcohol cannot be sold, it principally affects the high strength, low cost drinks favoured by the heaviest drinkers. It is a measure which applies to the whole population, but actually has quite a targeted effect on those who drink the most because they are the most sensitive to price increases.

BMJ OPINION Angela Coulter

What does the NHS long term plan promise for patients?

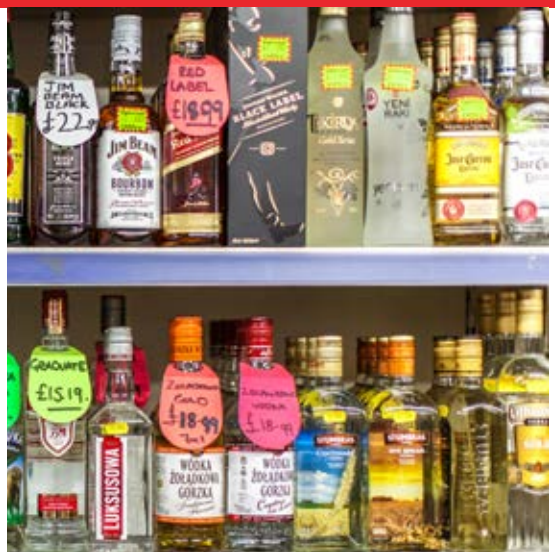
Few patients are likely to wade through all 136 pages of the NHS long term plan, but those brave souls that do will find it contains quite a bit of good news. The promise to make services more joined up, proactive, and personalised will be widely welcomed, as will the commitments to tackle long standing problems such as waits to see a GP, time wasted in badly run outpatient clinics, lack of coordination of community services, and inadequate responses to mental health crises.

People who have to attend outpatient clinics will be interested to know that NHS England plans a major shake-up of these services. The plan suggests that up to a third of the 120 million appointments each year could be avoided altogether or replaced by online consultations. This is excellent news for those of us who spend hours of our valuable time getting to a hospital with inadequate public transport or lack of parking spaces, only to sit around for more hours waiting for a consultation that lasts only a few minutes.

It is strange the plan did not give more prominence to the Comprehensive Model of Personalised Care

The plan's most disappointing omission is the lack of coherent proposals for tackling multimorbidity, arguably the greatest problem facing the health service. A recent study by the Health Foundation reported that more than 14 million people (one in four) live with two or more conditions and these account for over half of hospital admissions and outpatient visits and three quarters of primary care prescriptions. Yet our health system is organised around single diseases and there is alarmingly little research on how best to manage multiple conditions.

It is strange, therefore, that the plan did not give more prominence to the Comprehensive Model of Personalised Care. Published about a month before, the model outlines a strategy for providing better support for people with long term physical and mental health conditions by giving them greater choice and control, with the aim of building their



So what of the Hancock's assertion that MUP would "punish" those of us who drink responsibly? Sheffield University's acclaimed modelling suggests that moderate drinkers would pay an extra £2.25 a year. A PHE evidence review confirms that "implementing MUP is a highly targeted measure which . . . improves the health of the heaviest drinkers. The MUP measure has a negligible impact on moderate drinkers and the on-trade." This contrasts with the £1.3bn that MUP is estimated to save NHS England over the next 20 years.

Why would Hancock take against such a policy now? The alcohol industry was quick to welcome his statement. It would be worrying if the health secretary is listening to the views of those vested interests above those of the health community.

Alison Douglas is chief executive, Alcohol Focus Scotland

Ian Gilmore is director/chair, Alcohol Health Alliance UK
I.Gilmore@liverpool.ac.uk

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knowledge, skills, and confidence to live well. The model was excellent news. So why were only a few short paragraphs devoted to it in the long term plan, lowering its ambition to focus on a few relatively small target groups? And why does the major diseases chapter contain hardly any information on how the delivery of care will change to give more patients a bigger role in decisions and better self management support?

This is just an outline plan and more details on how it will be actioned are due shortly. We must hope the commitment to personalised care will be threaded through all the other commitments, leading to the shift in care delivery many patients have been calling for.

Angela Coulter is a non-executive director of NICE and a member of the *BMJ*'s patient panel

ACUTE PERSPECTIVE David Oliver

Ageing, risk, and public perception

In last week's column I discussed some issues raised by the BBC One drama *Care*. The show highlights different perceptions and attitudes about risk and autonomy in older people who have difficulty managing at home.

Hospital staff were portrayed as desperate to get Jenny's mother, Mary (Alison Steadman), back into her home after being disabled by a stroke and cognitive impairment. They clearly saw this as the right thing for Mary and for a system under pressure. But, in Jenny's view, Mary was clearly no longer safe—and short, episodic visits from home care staff, who didn't know her well, wouldn't make her so. A nursing home seemed the least bad option.

In 2014 a BBC Two documentary series, *Protecting Our Parents*, covered issues facing frail old people who use health and social care services. A recurring theme was health professionals' belief that they were respecting the wishes of older patients with the capacity to make decisions about ongoing support needs, while acting in the best interests of those who lacked capacity. But the families often seemed surprised, concerned, and even horrified that these patients were allowed to remain at home or return there.

The *Times* columnist Janice Turner has written regularly about her mother's repeated hospital admissions. Turner acknowledges that this is often not the best, safest, or most personalised environment and advocates more "halfway house" destinations to allow rest and recuperation before returning home. Yet she sees a repeated race to discharge her mother from hospital as quickly as possible.

Healthwatch England's *Safely Home* report and its research on emergency readmissions contain many stories of patients feeling marooned in hospital by long waits for social care or stepdown intermediate care, echoing official figures on delayed transfers from hospital.

Legal duties and rights, in the form of the mental capacity, human rights, and equality acts and professional codes of conduct, require us as professionals to respect older people's decisions and rights and to consider their best interests. We do so despite concern from families, the media, and wider society about risk. Our professional training emphasises the need to respect patients' choices and not infantilise them. Initiatives such as NHS Improvement's "Red2Green" bed days programme for improving patient flow emphasise that admission carries its own risks and that we should support any patient's right to accept managed risk and return home.

In my view, much managerialist guidance for professionals takes insufficient account of carers' needs and views. It also tends to assume that any sane patient, if asked, would want to go home. Clearing beds by ever faster discharge is a holy grail. Admission does carry risks, but it isn't automatically riskier than leaving.

Guidance also fails to acknowledge what Healthwatch has shown—that patients and their families often don't feel ready. Even if they do, the stepdown health and social care capacity to support timely discharge often isn't there. And, once a patient is back home, it's not the health and care professionals who are living 24/7 with anxiety, isolation, or at best intermittent support, often from relative strangers on low pay.

I'm not saying that any party has got this entirely right or wrong. But there's often a clear gulf in perception between health professionals' and carers' views of what's best for a patient, and mainstream media are throwing an overdue spotlight on this.

David Oliver is a consultant in geriatrics and acute general medicine, Berkshire
davidoliver372@googlemail.com

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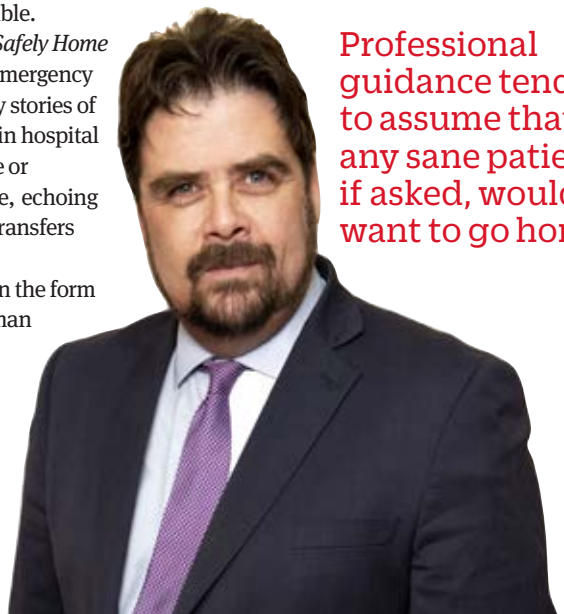

Professional guidance tends to assume that any sane patient, if asked, would want to go home

Patients lose when practices compete

With too few doctors, nurses, and experienced admin staff to go around, general practices are endlessly poaching from each other, and the pool of available talent is shrinking.

When I first became a partner, GPs were encouraged to compete for patients. The idea being that innovative practices that responded to patients' needs would thrive and grow, driving up quality as a result. Most GPs ignored this, and patients are remarkably reluctant to change doctors anyway, even those getting a terrible service.

In terms of patient care the pendulum has swung away from competition: the new rhetoric is all around collaboration and integration. Yet practices really are competing now—for staff. It's a struggle for survival because, once you start losing staff, the death spiral is difficult to escape.

A doctor leaves unexpectedly, and your already tough workload increases. This sparks an early retirement, and any potential recruit looks at how hard the remaining staff are working and decides to go elsewhere. Soon you're handing back your contract or holding your nose as you go into partnership with a corporate medical chain.

In some areas the solution has been to merge into "superpractices": these gain stability, but doctors risk losing autonomy and personal connections. Federations of smaller, traditional practices have banded together to bid jointly for contracts and support each other, but in many places this hasn't stopped practices from going under—either merging reluctantly or closing completely.

There are tiny glimpses of silver linings. Quality of life among workers may improve as practices compete for staff. If you can't compete on price the only chance of retaining your staff is to make your practice a friendly place to work, with coffee and cake, support and education, and almost infinite flexibility around sessions.

But competitions inevitably have losers. Too often, alongside the exhausted and defeated partners of a collapsed practice, those who lose out are the patients. They must now travel further, to an unfamiliar surgery with unknown doctors and nurses.

The struggle doesn't end there. When practices close, patients are often given a list of available surgeries and advised to re-register. Some do so immediately, especially those who are ill or need medicines. But young and fit patients may not get around to it until they're unwell. This is a problem, because funding is based on providing a weighted payment for each patient registered. Calculation of this weighting is far from perfect and, in usual circumstances, income attached to healthy patients helps to pay for the sicker patients' care. This can't work if only sick patients re-register. Instead, these practices see workloads rise without the necessary resources. At this point, in many cases, the domino effect begins: each practice that closes destabilises the one next door, pushing it closer to collapse.

The recognition that competition doesn't help patients in an underfunded and understaffed system is welcome. It's not clear whether the latest NHS long term plan, which links a desperately needed rise in primary care funding to collaboration in new networks of practices, will be a solution to our problems. For many surgeries it may be too little, too late.

Helen Salisbury is a GP, Oxford
helen.salisbury@phc.ox.ac.uk
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In many cases each practice that closes destabilises the one next door, pushing it closer to collapse

NEW BMJ PODCASTS

Clinical coding

Trying to foresee all the potential causes of injury and death is a Herculean task. The World Health Organization originally took this work on and continues to produce the International Classification of Diseases, the bedrock for health statistics. In this podcast, *The BMJ*'s Duncan Jarvies talks to Robert Jakob, head of the classification team at WHO, about everything from who decides what is in the classification to why there's a code for spacecraft collisions.

He describes how the level of detail needs to be "feasible internationally in routine doctor reporting. On the other hand, a statistical classification needs to have categories for everything."

Coca-Cola in China

This week's issue features an investigation (pp 110-12) into the influence of Coca-Cola on obesity policy in China. In a linked podcast we hear from the author Susan Greenhalgh, who describes how she went about doing this work and the anthropological approach she took. She describes how "far from regulating industry," the Chinese government's approach "has been to spur its growth."

"I was stunned to learn that in China the notion of conflict of interest scarcely exists. Of the people I talked to, a tiny handful spoke to me very quietly and off the record acknowledging that corporate funding of health science can bias the results, but that was a minority view. Most of the people insisted that corporate funding of science wasn't even a problem in China. There's little to no government regulation and the practice is extremely common. In fact, the government is constantly encouraging scientists to go out and solicit funding from corporate partners."

Catch up on all of *The BMJ*'s latest podcasts at bmj.com/podcasts

Curated by Kelly Brendel, assistant web editor, *The BMJ*

TESTS IN UK PRIMARY CARE

Primary care includes more than just GPs

O'Sullivan and colleagues report a rise in test use in UK primary care (Research, 1 December), but they focus almost exclusively on GPs.

While GP numbers have stagnated, the number of non-GP clinicians in primary care (including nurses, pharmacists, emergency care practitioners, and physician associates) has continued to rise. The distinction is important, as some evidence shows that novel roles for non-GPs in primary care can lead to increased use of tests

Considering the time it takes GPs to review the results of tests requested by others, we must find the right staffing mix that optimises the great value that non-GPs bring to primary care without adding to GP workload.

The explanations put forward by the authors for their findings may operate in different ways across different categories of primary care clinicians. The rapidly diversifying workforce has major benefits for patient care and system resilience, but it means that observations made about primary care need careful attribution.

Linus U Onah, GP, Biggleswade

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Clinical implications of increased testing

Despite increasing test use in primary care, we are not seeing a concomitant rise in disease incidence. Presumably testing is shifting into populations at lower risk of disease.

But tests work in a bayesian fashion, meaning that interpretation depends on two things—the performance characteristics of the test and the subgroup of people it is performed on (the prior odds or pretest probability of disease).

This can have counter intuitive implications; we have shown that people with normal test results have an increased risk of cancer. This is because merely conducting a test predicts cancer, and this additional risk is only partly eliminated by a negative result.

As we increase testing in lower risk populations, people with positive test results may have a lower incidence of disease. This will lead to a reduction in the signal-to-noise ratio, lower positive predictive values, and more false positives.

The more tests we do, the less we can trust the results.

We need better evidence, not only on the diagnostic accuracy of tests,but on whom to test in the first place and, perhaps just as importantly, whom not to test.

Jessica Watson, GP and research fellow, Fergus Hamilton, specialist registrar in microbiology, Bristol; Sarah Bailey, research fellow, Luke Mounce, research fellow, Willie Hamilton, professor of primary care diagnostics, Exeter

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LETTER OF THE WEEK

Hearing loss and depression

Depression is common among older people, for many reasons (Editorial, 1 December). As Wilkinson and colleagues remind us, medical treatment of this group is particularly prone to cause side effects. Treating hearing loss has fewer ill effects and greater benefits; I think it should be the first intervention to try.

Research shows that hearing loss doubles the risk of developing depression and increases the risk of other mental health conditions. Using hearing aids can reduce the risks and is cost effective.

NICE guidance on adult hearing loss lists several papers that investigate the experiences of older people with hearing loss and depression. The NHS action plan on hearing loss reminds us that it often occurs alongside impaired vision in older age groups. Dual sensory impairment has a major effect on communication and wellbeing and can cause social isolation, depression, reduced independence, mortality, and cognitive impairment.

The benefits of treating hearing loss also extend to carers, family, and friends. Depression in older adults needs a higher profile; hearing loss likewise, and their conjunction in particular.

Ted Leverton, retired GP, Bere Alston

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SHIFT WORK AND DIABETES

Should late chronotype be considered a risk factor?

Shan and colleagues show that night shift work and unhealthy lifestyle are associated with a higher risk of type 2 diabetes in nurses (Research, 24 November). Among the possible determinants of an unhealthy lifestyle, however, they don't mention disruption of circadian rhythms and chronotype (individual circadian preference).

Horne and Ostberg have published a self assessment questionnaire that categorises people as evening (E-type), morning (M-type), or intermediate (I-type). We have found that E-type is associated with unhealthy dietary habits, smoking, and alcohol drinking (in younger people) and with diabetes and metabolic syndrome (in adults).

Shift workers are more likely to have unhealthy habits and sleep deprivation, and eating behaviour was associated with a more unbalanced diet and abnormal eating patterns in female nurses. A recent systematic review showed that E-type female nurses were more prone to having sleep disorders and insomnia than were male and M-type nurses.

Assessment of chronotype and sleep attitude by means of validated questionnaires could provide an easy, inexpensive way to identify people at potential higher risk of developing metabolic diseases.

Roberto Manfredini, professor of internal medicine; Rosaria Cappadona, director of teaching activities; Fabio Fabbian, associate professor, Ferrara, Italy

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CHEST DRAINS

Non-specialist doctors lack experience

Millar and Hillman's review on the management of chest drains on medical wards is clear, practical, and timely (Essentials, 24 November). In many hospitals, chest drains for non-trauma patients are inserted by local specialist teams—often a combination of respiratory specialists, thoracic surgeons, and radiologists.

This undoubtedly improves success rates and reduces complications, but has the unintended outcome of reducing general medical trainees' experience in both inserting and managing drains. As the authors point out, these non-specialist doctors are often still the first to be called to the ward when something goes wrong.

Inexperienced doctors called to see a sick patient with a malfunctioning chest drain should find Miller and Hillman's guidance helpful, but if it doesn't resolve remember your local respiratory team is only a phone call away.

James H Campbell, retired respiratory physician, Grantham

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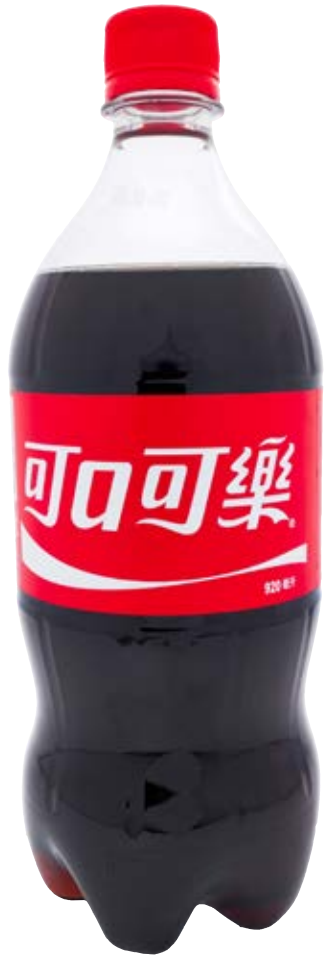
INVESTIGATION

How Coca-Cola shaped China's response to rising levels of obesity

Susan Greenhalgh reports on how, faced with falling sales in the west, the soft drink giant turned to the Chinese

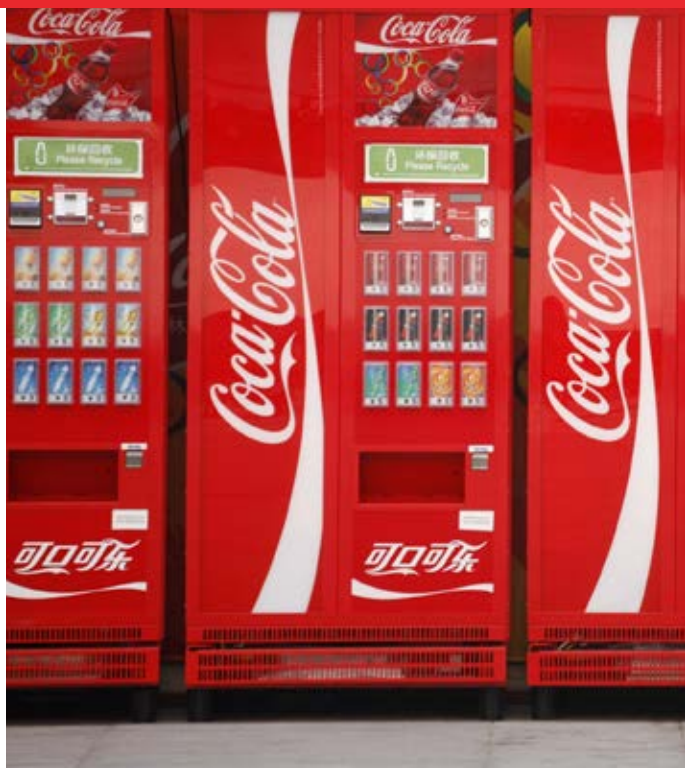


Since 2001, when the US surgeon general called on Americans to fight the newly named epidemic of obesity, the soft drink industry has had a target on its back. Recent investigations have shown how it is responding. From blocking New York City's ban on supersize drinks to lobbying against fizzy drink restrictions and funding specialists to promote physical activity as the best solution to obesity, "Big Soda" has been defending its interests.[1-4] Yet with US sales plummeting, the industry is losing the battle.[5]

As the American market shrinks, the industry has set its eyes elsewhere, especially rapidly developing countries such as China, with its vast undeveloped market for products associated with "modernity."[5 6] Until recently, China's hypermarketised political economy and pro-Western culture have enabled some multinational firms, especially politically well connected ones, to prosper.

This is particularly true for Big Soda's largest and most famous brand, Coca-Cola. China is now Coke's third largest market by volume.[7] And its vast population and potential makes it "critically important to the future growth of our business," according to Muhtar Kent, former chief executive.[7]

But Coke's recipe for success in China relies on more than cultivating political relationships and strategic placing of products and marketing. Through a complex web of institutional, financial, and personal links, Coke has been able to influence China's health policies. The company has manoeuvered itself into a position that ensures that government policy to fight the growing obesity epidemic does not undermine its interests. It has done this by leveraging the Chinese branch of an organisation it created to advance its interests around the world. The International Life Sciences Institute (ILSI), set up by a Coke executive 40 years ago in the US, is housed within the Chinese Centre for Disease Control and Prevention (CDC), a unit of the health ministry. The staff of ILSI-China have unparalleled access to government officials, and the organisation established itself as a premiere scientific body capable of providing access to the best that Western science has to offer.



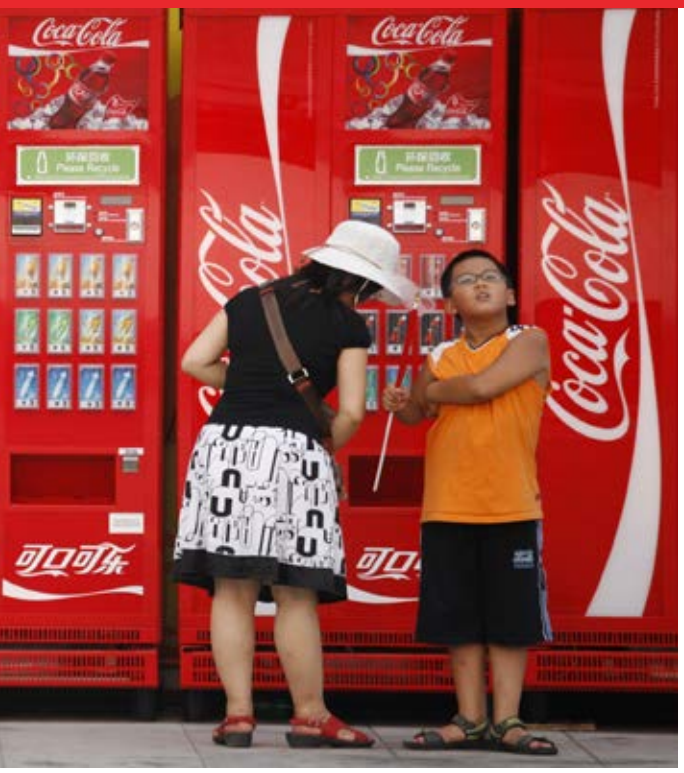
Coke has manoeuvered itself into a position that ensures that government policy to fight obesity does not undermine its interests

Critics call ILSI a front for the food industry, yet little is known about how it works.[8] As a China specialist and anthropologist with longstanding interests in opening up the "black box" of Chinese policy making, I conducted dozens of interviews in late 2013 with Beijing based obesity researchers to try to understand the rapidly growing Chinese epidemic. In 2011, 42.3% of Chinese adults were overweight or obese, up from 20.5% in 1991.[9] What started out as interviews expanded into a four year research project—just published in the *Journal of Public Health Policy*—and involved poring over hundreds of archival newsletters, annual and sustainability reports, tax filings, and websites.[10] A clear pattern emerged—one that explains how Chinese obesity science and policy came to emphasise physical fitness over dietary restrictions, matching strategies advocated by Big Soda.

Alex Malaspina, Coke executive and architect of the International Life Sciences Institute

Laying the groundwork

ILSI was the brainchild of Alex Malaspina, a Massachusetts Institute of Technology trained food technology specialist and Coke's senior vice president from 1969 to around 2001. Malaspina founded ILSI in 1978 as a Washington based, corporate funded, global non-profit organisation "where scientists from



Coca-Cola was the first international company to re-enter China after Mao

industry, government, and academia . . . collaborate . . . to provide science that improves human health . . . and safeguards the environment," according to its website.[11]

That same year, Coca-Cola became the first international company allowed to re-enter China after 30 years of isolation under Mao. Malaspina visited in 1978 to scout for local scientist partners. He soon identified Chen Chunming, a powerful nutritionist reputed to have connections high up in the central government. In 1983, Chen became the founding president of the Chinese Academy of Preventive Medicine,[12] a division of the Ministry of Health and a forerunner of the CDC. In 1993 she left to lead ILSI's new "Focal Point in China" (ILSI-China), which she headed until 2004. (She then became senior adviser until her death last year.)

In interviews with me in 2013, Chen and her deputy explained the appeal of ILSI-China during the early years. Government management of health research had become burdensome. Money for public health work was in short supply. Establishing a non-governmental research organisation would allow them to seek funding from a wide range of sources outside China and overcome its scientific backwardness by bringing in the advanced ideas of Western science. "Malaspina was very helpful," Chen told me. "He brought new international knowledge that China lacked."

In Chen's eyes, it was a win-win prospect: a chance to gain global connection and use that to shape state policy, advancing public health in an environment in which the state had virtually abandoned the field.

ILSI-China is widely seen as a bridge builder between government, academia, and industry, providing the latest scientific information for policy decisions on nutrition (especially obesity and early childhood development), food safety, and chronic disease prevention and control.[13]

The organisation is funded by dozens of companies—including Coke, Nestlé, McDonalds, and PepsiCo. Companies decide how much to give and sometimes provide more for specific events, but the organisation does not disclose details about funding or even its operating budget. Permitted by ILSI in Washington to "do its own thing," as Suzanne Harris, ILSI executive director, put it to me, ILSI-China had no board of directors, allowing Chen and her deputy to run it as they thought best. "We have lots of freedom; we can do anything we like," Chen told me.

By rigorously enforcing ILSI's rule of no advertising and no product endorsements in all activities, ILSI-China exuded genuine confidence it was protected from influence. "Companies know there won't be any commercial benefit," Chen said.

Over the years, Malaspina and Chen developed a close working relationship. In an open letter celebrating ILSI-China's 20th anniversary, Malaspina wrote that ILSI-China "has had a special place in my heart."[12]

How nutrition lost out

In 1999, ILSI asked its branches to put obesity on their agendas, and ILSI-China soon established itself as the country's leading authority on obesity. Between 1999 and 2003, ILSI-China assembled a cadre of specialists, defined obesity as a Chinese disease, and created guidelines for the prevention and management of obesity and overweight in adults.[14,15] Those guidelines were issued in the name of the Ministry of Health. ILSI-China's involvement was not mentioned. At least until the early 2010s, ILSI-China was the leading sponsor of obesity research and policy making. Though not openly recognised, its substantive role was arguably greater than the government's.

As China was defining obesity as a major health problem, Coke was showing strong interest in the condition and its belief that physical activity was key. Investigative reports show how, within three years of the 2001 US surgeon general's call to action, Coke launched a multipronged strategy to avoid blame and protect its profits.[1] Presenting itself as an advocate of "healthy active lifestyles," Coke promoted the message that all food and drink are part of a healthy diet; to avoid obesity, what matters is how much you move. And it maintained that there were health benefits to the ingredients in sugar sweetened carbonated beverages.

Public health in China: the Coke connection

Exercise is Medicine
This global initiative to encourage healthcare providers to prescribe exercise as medical treatment was launched in China in 2012. Coca-Cola is the founding corporate partner

Happy 10 Minutes
A campaign which introduced 10 minute exercise breaks into the school day. Extended nationwide at a 2006 ceremony supported by Coke China, the campaign was a Chinese adaptation of Take 10!, one of Coke executive Alex Malaspina's pet projects.[19]

Healthy Lifestyles for All
The centrepiece of the Ministry of Health's interventions on obesity and other chronic diseases. Although a government activity, Coca-Cola and other companies used it to showcase their favoured obesity programmes. One year Coke pledged to donate a dollar for every 10 000 steps walked

Under Chen Chunming's leadership, China's obesity policies aligned well with Coke's position that exercise, rather than nutrition, was key to fighting obesity

In 2004, a major WHO report called for public-private collaboration to fight the growing obesity epidemic.[16] But ILSI-China helped China bring corporate involvement in health affairs to a different level altogether.

"Healthy lifestyles"

Chen was a tireless promoter of industry's role in public health. By stressing the theme in meeting after meeting, she helped normalise industry's role in fighting chronic disease by promoting "healthy lifestyles," making it the only approach that was thinkable. And by encouraging and enabling industry participation in conferences, research, and interventions, Chen helped insert it into the nation's core strategy to combat obesity and chronic disease.

The ILSI tripartite model of academia-government-industry was now the official approach for fighting chronic disease, with ILSI at the centre. In an environment in which the government had little interest in and few resources to focus on chronic disease, ILSI-China's industry members were able to take on enlarged roles in anti-obesity work. Few companies had more interest than Coke. And the company had another advantage: in 2009, ILSI-China created a nine member scientific advisory committee including representatives from Coke and three other companies. On paper at least, this made them key decision makers, empowered not only to set research topics but to monitor and essentially police the quality of ILSI-China's science.

ILSI-China's focus on physical activity began to overshadow nutrition. Between 2004 and 2009, a third of its sponsored or co-sponsored obesity activities focused on physical activity. Between 2010 and 2015, the proportion rose to almost two thirds while nutrition focused activities sank to around one in five. Nutritional approaches—such as promoting healthy foods and dietary guidelines—remained on the books, mapped out in national plans for chronic disease prevention, but despite some corporate funding, they lacked visibility and active government support.

"When I went to China I had no idea that this is what I would find". Listen to the author Susan Greenhalgh at bmj.com/podcasts

Susan Greenhalgh, John King and Wilma Cannon Fairbank research professor of Chinese society, Harvard University, Cambridge, Massachusetts
greenhalgh@fas.harvard.edu

"Educating" the Chinese

Clinicians and researchers expect scientific conferences to be places where they can hear debates between leading points of view. But rather than a melting pot of ideas, obesity meetings sponsored by ILSI-China were packed with presentations by experts with financial ties to Coke or ILSI. Although Coke was sometimes listed as a conference funder on the programmes, its myriad ties to experts and ILSI-China remained hidden.

Most of the experts (13 out of 18) were from the US, and Steven N Blair of the University of South Carolina and James O Hill of the University of Colorado received repeat invitations.

Hill has had Coke funding and has close ties to ILSI. Blair, who has received Coke funding for years, much through unrestricted educational grants, is well known for his controversial view that lack of fitness—not fatness—is the problem.

Of the other 11 US based speakers at the conferences, eight were exercise scientists, including "father of aerobics," Kenneth H Cooper. Five have or had known ties to Coke, ILSI, or both, and two more were employees of Coca-Cola or its Beverage Institute. Only two were nutrition specialists.

As in most ILSI events, industry presentations were on the agenda. Rhona Applebaum, Coke Global's chief science and health officer (and future ILSI president), presented in 2013, outlining Coke's commitments to preventing obesity, rationalised in the language of energy balance.[17] "We collaborate with folks who are fact based and credible," she declared. "It's not our science, it's theirs."

Coke influence was felt not only in conferences emphasising physical activity, but also in a wide array of public health programmes to combat obesity and in conferences emphasising nutrition.

Condemn it or embrace it?

Though the effect on obesity policy cannot be precisely measured, China's policies aligned well with Coke's position as transmitted through ILSI-China. Dietary policies recommended by WHO—taxing sugary drinks and restricting food advertising to children—were missing, and national plans and targets emphasised physical fitness. Consistent with ILSI's and Coke's "energy balance" perspective, policy documents urge citizens to achieve healthy lifestyles and weight by "balancing eating and activity."[20 21]

Global nutrition expert Barry Popkin, who has worked in China for decades, lamented this policy direction. "There is now no immediate possibility the government will regulate food, beverage, or sugar in the way countries globally are beginning to work. I believe ILSI's influence in promoting the physical activity agenda was extremely detrimental and put China decades behind in efforts to create a healthier diet for its citizens."

But many Chinese scholars welcome industry's public health involvement. A scientist from CDC told me, "They've built schools. Provided equipment for school cafeterias. It's a kind of return to society. There is no profit, but it is good for their reputation."

Coca-Cola, ILSI-China, and the Chinese health ministry did not respond to requests for comment.

Unlike the US and Europe, which have well established institutions of journalism and civil society, China has no watchdogs. Its scientists can hardly bite the hand that feeds them. Since 2016, the state has finally begun to seriously tackle chronic disease, but its approach emphasises education and market development, not industry regulation. With no one to complain about—or even see—this corporate biasing of science and policy, the size and impact of China's obesity epidemic are only likely to worsen.

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Krishna Murari Goel

Consultant paediatrician Royal Hospital for Sick Children, Glasgow (b 1936; q Lucknow 1960; MD, DCH FRCP Ed, FRCP Glas, FRCP Lond, FRCPCH (Hon)), died on 12 August 2018

Krishna Murari Goel came to Glasgow from his native India in 1964. Krishna's Christian faith was the backbone of his life and achievements. In 1967 he met Joyce McMillan; they married in 1992. They shared a love for sick children and their families; for creation and, in particular, gardens; and for God in everyday life. Krishna was crucial to the setting up of Scotland's children's hospices and helped create a domiciliary home visiting team. Joyce and Krishna later volunteered at two medical colleges in India before moving to their final retirement home in Helensburgh. While on holiday in Oban, Krishna collapsed and was taken to Lorn and Islands Hospital, where he died peacefully, with Joyce by his side.

Robert Carachi, Forrester Cockburn, Robert Logan John Stephenson, Joyce Goel

Cite this as: *BMJ* 2018;363:k4587

James Bernard Bourke

Consultant surgeon Queen's Medical Centre, Nottingham (b 1940; q London 1964; FRCS Lond, FRCS Ed), died from old age on 18 August 2018

James Bernard Bourke ("Jim") started as a consultant surgeon and reader in surgery at the Nottingham General Hospital on 1 January 1972. He was part of the team that established the Queen's Medical Centre and founded the new medical school. For the following 30 years he worked tirelessly at both the hospital and the university. He was the rugby club's doctor and chairman in Nottingham in the 80s and 90s. His experiences of seeing too many young men injured while playing led him to believe that scrums should be uncontested, a view published in *The BMJ* in 2006 that attracted national media attention. Dementia afflicted him in recent years. He leaves his wife, Ann; three children; and six grandchildren.

Emad George

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Alan Edward Andrew Ridgway

Ophthalmologist (b 1940; q Cambridge/London, 1965; MA, DO, FRCS, FRCOphth), died from carcinoma of the pancreas on 26 October 2018

Alan Edward Andrew Ridgway started his consultant career at Manchester Royal Eye Hospital in April 1974. He introduced capsule preserving surgery and other groundbreaking new procedures to the hospital and became involved in developing the Manchester Eye Bank—now part of the UK Corneal Transplant Service. Alan also carried out many national duties and published widely. He retired from Manchester Royal Eye Hospital in 2001. Christmas parties held at his home for staff and their families were legendary, and he generously invited colleagues and junior staff to visit the family property in the south west of France. Predeceased by his first wife, Sue, Alan leaves his second wife, Kathleen; three children; and six grandchildren.

Ian Christopher Lloyd

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Rosemary Helen MacNaughton Adams

Consultant in accident and emergency medicine Norfolk and Norwich Hospital (b 1926; q Edinburgh 1948; FRCS Ed), died from Alzheimer's disease on 16 October 2018

Rosemary Helen MacNaughton Davie was brought up in Beverley, east Yorkshire. After qualifying she trained in ear, nose, and throat surgery. In 1954 she married John Adams, later consultant geriatrician at West Norwich Hospital, and after having a family she switched to the emerging specialty of accident and emergency medicine. She helped found the Norfolk branch of what became the British Association of Immediate Care Schemes. She served as a magistrate for 29 years and was a fine pianist. She retired to Beverley, where she pursued her interests in art and music. Predeceased by John in 1995 she leaves three children and three grandchildren.

Elspeth Adams

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Christopher Arthur Rodrigues

Consultant gastroenterologist Kingston Hospital (b 1952; q Armed Forces Medical College, Poona, India, 1975; PhD, FRCP), died from pancreatic cancer on 6 October 2018

Christopher Arthur Rodrigues ("Chris") moved to the UK from India to pursue his medical career. His first consultant appointment took him to Doncaster Royal Infirmary before he moved to Kingston Hospital in 1995. His posts were initially in geriatric medicine but always focused on his specialist interest, gastroenterology. After taking a sabbatical in 1999, he eventually moved into full time gastroenterology at Kingston. He took a keen interest in ethical issues and chaired a multidisciplinary group regarding patient feeding. He pursued this subject nationally as a member of the RCP's Committee on Ethical Issues in Medicine. Chris retired at the age of 60 to spend six years travelling with his wife, Gillian. He leaves Gillian and two sisters.

Mark Spring

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John Lloyd Burton

Professor of dermatology Bristol (b 1938; q Manchester 1964; BSC, MD, FRCP), died from heart failure on 10 November 2018

John Lloyd Burton was appointed to the first academic post in dermatology in Bristol as senior lecturer and consultant dermatologist in 1973. John had influential roles in the British Association of Dermatologists and was adviser in dermatology to the chief medical officer. A sometime editor of the *British Journal of Dermatology* and co-editor and author on *Rook's Textbook of Dermatology*, he wrote review articles and editorials and was known for his humorous after dinner speeches and guest lectures. John retired from his clinical and university positions in Bristol in 1996 but worked as consultant dermatologist at Dorchester Hospital for a further two years. Predeceased by Pat, his wife of 54 years, in February 2018, John leaves three children and nine grandchildren.

Cameron Kennedy

Cite this as: *BMJ* 2018;363:k5226

Tim Evans

Advised the Department of Health on clinical productivity

Timothy Evans (b 1954; q Manchester, 1979; PhD, FRCP Lond, DSc Sheff, FMedSci, FRCA) died from glioblastoma 9 November 2018

Tim Evans made his first contribution as a respiratory intensive care consultant at the Royal Brompton and Harefield NHS Foundation Trust (RBHFT). His administrative career took flight in 2010 when as academic vice president of the Royal College of Physicians (RCP) he was involved in writing *Hospitals on the Edge? The Time for Action*, published in September 2012. The report set out the magnitude of challenges facing acute hospital services after the Mid Staffs scandal.

Next, Evans conceived the idea for the RCP's future hospital commission, resulting in publication of *Future Hospitals: Caring for Medical Patients* in 2013, setting out the RCP's vision for hospital services to be structured around patients' needs to provide "safe, effective, and compassionate care." The report was acclaimed by the *Lancet* as "the most important statement about the future of British medicine for a generation."

"Getting it right first time"

Evans was invited to provide the clinical voice on Patrick Carter's report on unwarranted variations in clinical and operational performance in NHS acute trusts, published in 2016. A major outcome of the report was the Getting It Right First Time (GIRFT) programme, designed to improve clinical quality and efficiency in the NHS by reducing unwarranted variation.

In November 2016, GIRFT was awarded £62m from the Department of Health, allowing it to employ 57 national clinical leads. From this point, Evans focused on job planning, aligning the clinical workforce (doctors, nurses, allied professionals, and pharmacists) with the needs of patients. His last report, *Getting it Right in Emergency Care*, published in August 2018, explored how trusts could avoid failing over the coming winter.

Together with Julian Bion, Evans is credited with establishing the Faculty of Intensive Care Medicine at the Royal College of Anaesthetists in 2010, securing vital support from the RCP for the initiative. The creation of the faculty led to intensive care being recognised as a primary specialty by the General Medical Council.

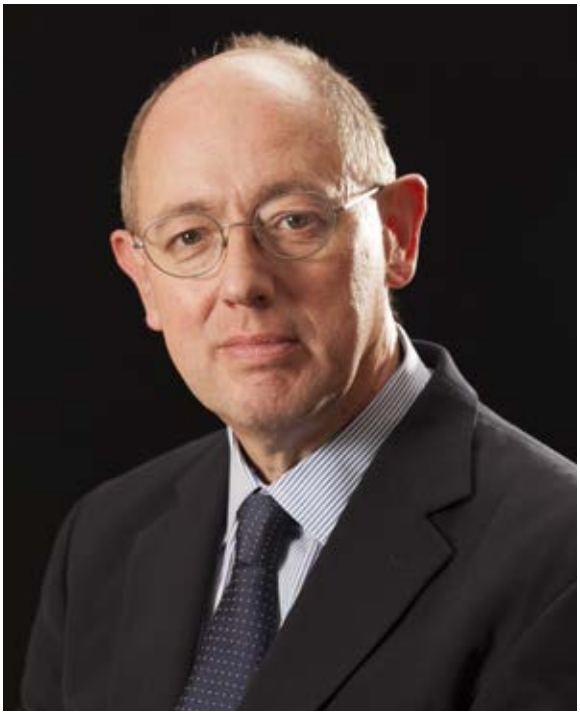
Early life and career

Timothy William Evans was the son of Philip Charles Evans, an architect, and Mary Else, a primary school teacher. He was the middle of three children. Having secured a place to read economics at the London School of Economics, he had a sudden change of heart after working as a hospital porter. Through clearing, he secured a place at Manchester University for a conversion course. In his final medical exams in 1979 he came second out of a year of 270.

Evans was awarded a Medical Research Council travelling fellowship to the Cardiovascular Research Institute at the University of California, San Francisco, where he was first exposed to the role of pneumology in intensive care. He became a consultant in intensive care and thoracic medicine at the Brompton Hospital in 1990 and professor of intensive care medicine in 1996.

In his research, Evans formed many collaborative, translational partnerships. He published more than 300 peer reviewed papers and eight textbooks. His research drove the introduction of ECMO (where an artificial membrane oxygenates blood outside the body, allowing the lung to rest), which ultimately led to the RBHFT becoming one of five commissioned centres in the UK offering it.

Evans's professional enthusiasms included encouraging resuscitation training, and from 1998 he was honorary consultant in intensive care to the British armed forces.



Evans was instrumental in establishing Getting It Right First Time, designed to improve clinical quality and efficiency in the NHS

In December 1987 Evans married Emer MacSweeney, a neuroradiologist, whom he had met at the Brompton. They had four children.

The first inkling that something was wrong came in November 2016 when Evans experienced an auditory hallucination of music during a King's Fund meeting. Emer arranged for an immediate scan, and he knew in an instant from the expression on her face, as she sat in the control room, that his fears of glioblastoma were well founded. After a period of remission the tumour returned, and by the summer 2018 Evans was in a wheelchair. He spent the autumn enjoying precious time with family and friends, with his usual positive approach to life. In the last two weeks of his life he received a gold medal from the Faculty of Intensive Care Medicine of the Royal College of the Anaesthetists on the Wednesday, an honorary fellowship from the Faculty of Pharmaceutical Medicine on the Thursday, and celebrated his son's birthday on the Saturday, before losing consciousness and being admitted to the hospice on the Sunday. He died the following Friday, surrounded by his family.

Janet Fricker, Hemel Hempstead
janet.fricker1@btinternet.com

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