

# New year resolutions

Andrew Bush,<sup>1</sup> Ian Pavord<sup>2</sup>

We have deliberately not published these in January, so they will be intact beyond the first week of the New Year. This is in essence a six month report of where we are, and where we hope to go. It is also a formal invitation to the readership to be pro-active with suggestions for improvement.

## THE JOURNAL

We received 1839 submissions in 2010. Outright rejections were 41% and eventual acceptance rate was 16%. Time from submission to first decision was 26 days (54 days for reviewed papers). We received submissions from all round the world, reflecting our International standing, and the main areas were UK 27%, USA 10%, Italy 6%, Netherlands 5%, China 5% and Japan 4%. We are particularly grateful to the Associate and Deputy Editors and the reviewers, without whom the Journal would not function. A particular thanks to our statistical team, Drs Gibson, McKeever and Tata from Nottingham. They have provided superb and prompt reviews, and majorly contributed to keeping the manuscript quality high. Thanks also to Dr Jenny Quint who has done such an excellent job with 'lung alerts' and Mark Fitzgerald who has kept the flow of fascinating Images, Case reports and Pulmonary puzzles going. We have appointed an entirely new Editorial Board and have had two excellent editorial meetings in Barcelona, with lots of energy and ideas. We want to take these forward in 2011. Our aim is to keep getting the content right, and see that reflected in a rising impact factor. We are also grateful to our Journal support staff, in particular Claire Weinberg and Sarah Szatkowski, who are unfailingly patient with our foibles.

We are aware we are still too slow, however, and that this is not fair in particular to junior authors. This will be helped by our switch to ScholarOne from Benchpress early in 2011. The new

system is infinitely preferred by virtually everyone who has used both. We also are aware of production difficulties—the abstract book for the winter meeting arrived after we had set out for the final day! We aim to get manuscripts online much quicker, with e-alerts when a new paper goes online. We have had really helpful talks with Allison Lang from the publishing side, and we hope we will make progress on this too.

## NEW DEVELOPMENTS

We are aware that with ever-increasing specialisation, no-one can possibly be master of the whole field, and some manuscripts may be difficult to understand. So we will have a box at the start of each article, in which authors will give a single sentence reply to the questions: What is the key question? What is the bottom line? Why read on? By this means, we hope to challenge ourselves and everyone to read articles not in the mainstream of our interest.

We also plan to introduce our new clinically orientated section 'Chest Clinic' in early 2011. This section will include a new recent advances review series, clinical cases for discussion, short reviews dealing with the clinical impact of new basic research findings, a short section highlighting key audit findings and updates to guidelines and a section for opinion and other lighter pieces addressing aspects of clinical practice of relevance to the practising respiratory physician. We are happy to consider uncommissioned articles, particularly from our colleagues who are retiring or nearing retirement who might have more time, wisdom and inclination to contribute to this section. We hope Chest Clinics will increase the readability of the journal and help to address educational needs by linking articles to self assessment MCQ questions. For more information on the format and structure of the new content please visit our instructions for authors online.

course we attended in November. For those who understand such things, *Thorax* is on Facebook and Twitter—we wonder how many readers know about this. This is an exciting new development to help keep us posted! The BMJ is trialling an i-phone app, and we hope to have that too in 2011. The number of visits to the *Thorax* web site from mobile devices has increased month on month recently, and in general mobile access to our content will continue to be a key objective for the journal. How should we make the most of these new media, together with blogs, podcasts and others that are a closed book to elderly editors? We would welcome ideas, enthusiasm and input—only those young enough to be our children need apply!

## WIDENING ACCESS

We believe that *Thorax* is an outstanding journal, despite the best efforts of the Editors in Chief. We are keen to increase access in 2011. So anyone who wants can have a free Table of Contents, Airwaves and the editors' choice manuscript emailed to them. We would welcome collaboration with sister societies to widen the access to *Thorax* of the International readership. Please contact us if you have ideas how we can achieve this. A new Spanish language edition will come into being, and we are working on a Chinese edition as well.

## ENDPIECE: RESOLUTIONS FOR OTHERS

For Mr Lansley, our Minister of Health: we note you have devolved public health to local authorities, and control of the obesity epidemic to MacDonalds, but please try not to let Rothmans take charge of Tobacco control, or allocate cardiac surgery to the Foreign Office. Reflect also that it is better to build river defences than try to 'nudge' the flood waters back; legislation can work (seat-belts, the smoking ban) and the record of voluntary restraint by the tobacco industry does not bear thinking about.

For those who think they have a secret to keep: think Wikileaks. So many secrets, how many really matter, and can secrets be kept anyway? 'Openness is conducive to better government' (Geoffrey Robertson, QC), and it is also conducive to a whole lot of other better things too. It is long since that all clinic letters have been copied to patients, and the world continues to revolve on its axis. Where else can we be more open? Doctors with our relationships with Pharma—yes,

<sup>1</sup>Imperial College and Royal Brompton Hospital, London, UK; <sup>2</sup>Glenfield Hospital, London, UK

**Correspondence to** Andrew Bush, National Heart and Lung Institute, Imperial College, London, UK; a.bush@imperial.ac.uk

we have conflict of interest statements, which can hide a multitude of sins. Should we apply the News of the World test—if what we are NOW doing was on the front page of that newspaper, how would we feel? Big Pharma—let's have all data on all patients readily available on line, and make sure recent lawsuits over concealed data never happen again. Hospital Trusts—be open if there are problems such as surgical mortality, and be open about how they will be dealt with. The other side of the coin—let us all be adults, accept that human beings are human and make mistakes despite everything, and not

degenerate into a flood tide of frothing indignation if something has gone wrong (certain sections of the media take note). 'The man who has never made a mistake has never made anything' GK Chesterton. Can we have done with 'spin' except from Graeme Swann on the cricket pitch!

For our administrators and regulators: back off. Have the confidence to allow people to develop their own ideas and run their own show. Be less risk averse and focus more on articulating risk more clearly (patients and public can and will understand this). Make targets clear,

patient relevant and important; resist the urge to tell us how to do it and focus instead on what should be achieved. Do all you can to encourage innovation and invention.

For innovators and inventors: send your best work to Thorax!

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## Who bears the costs of occupational asthma?

P Sherwood Burge

Most workers with occupational asthma who remain exposed to the causative agent have accelerated loss of FEV<sub>1</sub><sup>1</sup> and recover less when eventually removed from exposure than those removed within the first year of occupational asthma symptoms.<sup>2</sup> The reasons for this are not obvious, as most childhood onset asthmatics remain exposed to the causative allergens and infrequently develop severe airflow obstruction later in life. It is possible that the timing of exposure related to the maturity of the immune system is critical, and the development of a degree of tolerance is more common in childhood than later in life. Whatever the reasons, the recommendation for removal from exposure within a year of first occupational asthma symptoms is based on good evidence.<sup>2</sup>

There is an established societal view that those disabled by their work through no fault of theirs are entitled to some form of compensation. How this is achieved varies widely between countries. Most countries rely on an insurance-based system, sometimes with support from the government.<sup>3</sup> In the UK there is a dual system with a no-fault compensation system without employer contribution funded by the

central government and a common law system which requires the establishment of negligence on the part of the employer. Neither work well in the context of occupational asthma. Central to compensation is the assessment of disability. Most disability systems work better when the disability is fixed (such as loss of a limb or irreversible airflow obstruction) than when the disability is very variable, as in asthma. Many occupational asthmatics are not really disabled in daily life, but are completely disabled from doing the job which caused their disease. There is therefore a strong case for directing compensation to re-entry into the job market. For a young person early in their career retraining with different exposures is often the best option, and some compensation schemes, such as in Finland and Quebec, facilitate this. Surveillance schemes mostly based on specialist clinic reports show the occupational asthma peaks later in life.<sup>4</sup> Retraining in a different trade/profession then places the worker at the bottom of another career pathway with loss of income and promotion prospects. Many such workers would be better moved sideways/upwards where their exposures can be removed and their skills and knowledge retained. This should be more easily managed in large organisations (such as healthcare) but difficult for small employers, such as bakeries where occupational asthma developing later in life is fairly common.

There are therefore costs generated by the development of occupational asthma.

The employer loses a worker and perhaps production, has costs involved in replacement and retraining, and may have an increase in insurance contributions. The worker loses income, particularly in the third of workers in whom relocation fails and unemployment results.<sup>2</sup> Finding a new job often results in a lower income. Finally, the state usually provides financial assistance for those without work and income. Costs may be direct (such as healthcare, retraining and drugs) and indirect (such as loss of income and loss of productivity). These costs have been modelled in a paper by Ayres *et al* for typical UK male and female workers with occupational asthma due to isocyanates, flour or grain and latex or glutaraldehyde (*see page 128*).<sup>5</sup> The methodology used the number of new notifications of occupational asthma to the SWORD surveillance scheme in 2003,<sup>6</sup> a voluntary reporting scheme for respiratory physicians incorporating data from the occupational physicians reporting scheme OPRA, and estimated costs incurred over the lifetime of the disease from the point of first diagnosis (an incidence-based approach). The total lifetime costs for Great Britain in 2003 were then distributed between those incurred by the individual, the employers and the government. The costs were based on estimates from the literature rather than directly measured data, and included data from several European countries including the UK as well as USA and Canada. The average worker with occupational asthma was estimated to take about 4 days extra sick leave per year, with a quarter staying in the same job, a quarter being relocated with the same employer, 15% finding a job with a new employer and 35% remaining unemployed or retiring. Total lifetime costs were estimated

**Correspondence to** P Sherwood Burge, Occupational Lung Disease Unit, Birmingham Heartlands Hospital, Birmingham B95SS, UK; sherwood.burge@doctors.org.uk