

LETTERS

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RESEARCH MISCONDUCT

The emperor is marching around buck naked

Godlee's report of widespread research misconduct is disturbing and, I believe, generalises to the US.^{1,2} It's not just the fact that it is happening, but that it reflects a culture within which new researchers are socialised. Previous research indicates the motivators for dishonesty include a high pressure achievement oriented environment, where “if everybody else is doing it, it must be OK.”³

The problem also underscores how important are reanalysis and replication of reported research, a recent topic on the US Institutional Review Board Forum (www.irbforum.org/forum/). But, get this, “Ginny Barbour, a senior editor with the PLoS group of journals, said one third of authors could not find the original data to back up figures in scientific papers when these were questioned.” I wonder how many journal editors seek to discover and reject such authors. I wonder how meticulous the US Food and Drug Administration is in policing the input it receives in support of marketing approval for new drugs and medical devices.

These behaviours are beyond the reach of surveillance by institutional review boards and research ethics boards, and they indicate the need for a new end product quality control system.⁴ The simplifying assumptions about the efficacy of peer review and professional ethics and responsibility fail miserably when the emperor is discovered marching around buck naked.

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Competing interests: None declared.

- 1 Godlee F. Research misconduct is widespread and harms patients [Editor's Choice]. *BMJ* 2012;344:e14. (5 January)
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The REF and UK academic medicine

In a recent analysis,¹ retracted fraudulent papers were found to be more likely than retracted erroneous ones to be authored by repeat offenders, to be published in higher impact factor journals, and to come from US institutions. Tavare's review summarises responses to misconduct from countries (including the US) where research fraud is mainly regulated by institutions.² Such an approach is less likely to succeed in the UK because, under the Research Excellence Framework (REF), institutions are highly incentivised to publish in high impact journals. Furthermore, the potential financial spin-offs for successful research constitute a conflict of interest at institutional level.

For individual researchers the threat of redundancy can have an effect.³ If your job was at risk might you “tweak” that nearly significant result to make your study publishable?

Government and regulatory bodies need to consider proportionate and targeted rules and processes, keeping in mind that effective research usually takes decades, not years, before results translate to patient outcomes. The development of expertise in individuals and academic units must be supported in this time frame. The huge financial interests that often drive medical research may also promote misconduct and hyperbole. Better declaration of conflicts and financial disclosures help minimise this, but when academics are encouraged to develop spin-off companies before results have even been replicated there is clearly a fundamental problem. That financial outcomes in some medical schools are now more important than teaching tomorrow's doctors is a shift in culture that may promote misconduct. Further research on misconduct should explore the role of institutions, their governance, and mentoring of academics as potential factors that push the susceptible individual to cross the line.

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- 1 Steen RG. Retractions in the scientific literature: do authors deliberately commit research fraud? *J Med Ethics* 2011;37:113-7.
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Reported inaccuracies about the UK Research Integrity Office

We welcome the *BMJ's* focus on research misconduct, but this article contains serious errors about the UK Research Integrity Office (UKRIO).¹

UKRIO is not “hosted by the University of Sussex.” Since December 2010 we have leased premises at the Sussex Innovation Centre on the university's campus, but we remain an independent organisation.² Although the university is one of many institutions that has supported UKRIO since our move to a wider pool of funders in 2011, we have no other affiliation with it. It is regrettable that your article stated, incorrectly, to the contrary.

We are baffled by the claim that UKRIO “exists in a vestigial form.” Neither our relocation or transition to a limited company caused any break in the continuity of UKRIO's services.¹

Had we been contacted before publication, and I am puzzled that we were not, we could have explained that we still provide independent and confidential support on issues of research integrity, responding to more than 60 cases in the past year.

It is not surprising that a confidential service generates little publicity, but this has not prevented use of our services. Researchers, the public, and those who deal with research integrity on behalf of organisations value our guidance, as shown by the continuing rise in the use of our services. We would not be asked for help if we were not needed.

Inaccurate statements about our operations or affiliations can cause confusion and distress to the whistleblowers and others who use UKRIO's services.

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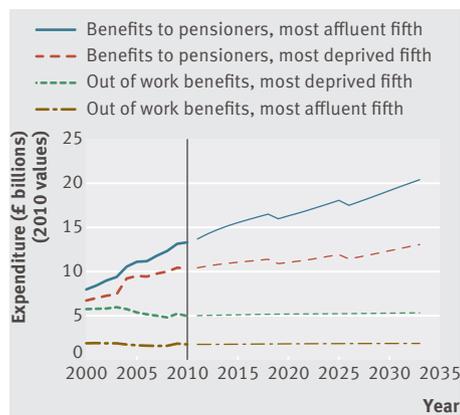
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ASSAULT ON UNIVERSALISM

Stop blaming the unemployed and focus on mutual security

McKee and Stuckler indicate that one strand of the “assault on universalism” is to vilify the “undeserving poor.”¹ Those who wish to reduce welfare support argue that the welfare bill is rising and unsustainable because of the number of people on out of work benefits. To justify the £4bn (€4.8 bn; \$6bn) cut to out of work benefits, the coalition government associated the fact that the “welfare bill has risen by 45% in the past 10 years” with the “5 million people who are on out of work benefits” and suggests this rewards “social failure.”²

The portrayal of the workless poor as the cause of unsustainable welfare spending is disingenuous. Welfare expenditure has escalated because improved life expectancy has increased the proportion of the population above the state pension age and not because of increased public spending on out of work benefits. Expenditure on out of work benefits has actually declined slightly, particularly in more deprived areas. Furthermore, expenditure on benefits to pensioners has increased more in the



Expenditure on benefits to pensioners (basic state pension, pension credits, and winter fuel allowance) and on out of work benefits (job seeker’s allowance, employment support allowance, incapacity benefits, and income support)³ in most affluent and most deprived fifth of local authorities⁴ adjusted for inflation to 2010 prices. Predicted level estimated by applying 2010 expenditure per head to national age specific population projections⁵

most affluent areas. The higher life expectancy in these areas results in an older population and a higher proportion of the population claiming pensions. These trends will continue to diverge if health inequalities persist (figure).

The principle of the universal welfare state is that society as a whole benefits from the redistribution of support between groups and across the life course. Support for each group cannot be seen in isolation. Inequality in educational and employment opportunities means that greater welfare support is needed for those out of work in poorer areas, while the existence of health inequalities means that greater public resources are directed to support elderly people in more affluent areas.

Rather than victim blaming, we need to focus on a universal system of mutual security. The sad truth is that poor people save the state money in benefit payments—by dying earlier.

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BENEFICIAL DRUG REACTIONS

System driven approach needed for discovery

Parle and colleagues highlight some of the many examples of chance findings of beneficial effects of drugs.¹ It is already possible to mine pharmacovigilance databases—for example, that of the Uppsala Monitoring Centre, which contains upwards of 6 million reports of suspected reactions pooled from national databases around the world, including the yellow card database of the UK’s Medicines and Healthcare Products Regulatory Agency (MHRA). Indeed, Hauben and I have defined a signal of suspected causality in pharmacovigilance as “information that . . . suggests a new potentially causal association, or a new aspect of a known association, between an intervention and an event or set of related events, either adverse or beneficial, which would command regulatory, societal or clinical attention”²; this definition was incorporated, in

slightly modified form, into the eighth report of the Council for International Organizations of Medical Sciences (CIOMS).³ One problem in achieving it is that, just as adverse reactions often cannot be predicted at the outset, beneficial reactions are also often unexpected and unpredictable.

Although new indications may be identified through biological or pharmacological plausibility, benefits mediated through other targets are less likely to emerge because new chemical entities are increasingly often intended to affect single targets. If this “targetophilic” approach to drug development were replaced by a systems approach the likelihood of discovering unexpected benefits would be enhanced.⁴

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Competing interests: None declared.

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LESSONS FROM ELSEWHERE FOR NHS

Public and private providers coexist in Singapore

Proposed changes to the NHS to make it financially sustainable for future generations are often lambasted by sceptics as attempts to turn the NHS into a “US style commercial system.”¹ Many models of healthcare delivery work as a partnership between private enterprise and public institutions. Perhaps we should turn our attention away from the US and look instead towards the Far East.

In Singapore, for example, the public healthcare system provides 80% of inpatient beds, through eight public hospitals and five specialty tertiary centres, with the remaining 20% of inpatient beds provided by the private sector.² The primary care system is provided by a network of private GPs (80%) and government polyclinics (20%). Public and private sectors have a symbiotic relationship, with public services subsidised by the government through national insurance-style contributions linked to salaries. Public hospitals also provide a proportion of paid-for premium services to subsidise their public commitments, such as supplements for private rooms.

We have to break away from the mindset that private and public cannot coexist. The NHS is indeed a noble ideal, and Aneurin Bevan’s vision of fair equitable access to healthcare should be

the driving force behind our efforts as healthcare professionals. But for the NHS to survive into the future, some combination of privately financed, publically provided or publically financed, privately provided healthcare is needed. Otherwise, the system that we know today will implode somewhere down the line in the manner of the Greek debt crisis.

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- 1 Torjesen I. NHS hospitals will be able to raise up to half their income from private patients. *BMJ* 2011;343:d8338. (29 December.)
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US doctors want to use private providers as levers for change

I was dismayed by Spence's recent column "Lessons from America."¹

Personal Medical Services (PMS)/General Medical Services (GMS) GPs should be classed as private providers of healthcare contracting with the NHS (arguably as a monopoly) and not differentiated from other "private" providers. It seems a convenient mistruth to use.

As a private provider of NHS primary care services our practice is subject to intense scrutiny around performance, efficiency, and the quality and safety of care. Having been a PMS partner for many years, I know that this is not the case for most GP practices in NHS England. Similarly, we can demonstrate by our key performance indicators that we operate more efficiently and, arguably, more effectively than NHS general practices. I believe that introducing private primary care providers into NHS primary care is a strong lever for change that will be missed if this artificial separation is used to protect the status quo.

Most disappointingly for me as a believer in continual improvement and learning from others, Spence says that he will be speaking to American doctors about their problems. Although we can all learn from others' mistakes, this is a negative and blinkered approach and unlikely to help our current needs. Many US clinicians are aware of their system's problems, but I disagree that they are trying to disentangle themselves from private providers; rather, they want to use them as levers for change, as was highlighted at the recent King's Fund integrated care programme with Dana Safran and others. That can teach us something useful.

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- 1 Spence D. Lessons from America. *BMJ* 2012;344:d8352. (4 January.)

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RECORD DISCRIMINATION AWARD

Independence in disciplinary proceedings against doctors

Dr Eva Michalak's employers were found to have discriminated against her on grounds of race and sex, victimised her for protected disclosures, and unfairly dismissed her.¹ The campaign of harassment made her so ill that the tribunal deemed she would not work as a doctor again. This "career loss" resulted in record damages. How was this possible?

After negotiation with the BMA, the NHS adopted Maintaining High Professional Standards in the Modern NHS (MHPS), which replaced HC(90)9 (Disciplinary Procedures for Hospital and Community Dental Staff). The professional panels that were independent of the employer were abolished, as were rights to a legally qualified independent chairman and independent appeal to the secretary of state. Independence was erased in favour of local panels with no appeal outside the employer.

Michalak's case resulted from clinicians and managers acting unlawfully while making extraordinary efforts to avoid external oversight. The tribunal found that oversight was circumvented and senior clinicians and managers abused their authority. Their conduct was condemned as "dishonest, disreputable, and fraudulent." The BMA negotiated away rights of independence in proceedings that allowed this to happen then declined to support Michalak's discrimination claims at the tribunal. Michalak was represented by her husband, who secured her exoneration and exposed the motivation behind the campaign.

The employment tribunal was the only independent forum available to Michalak. The tribunal found the reasons for dismissal were not based on real events and was astonished by those who dismissed her. The potential for dishonesty among people engineering such events exposes the flaw in MHPS. Had the rights in HC(90)9 not been surrendered, independent review could have stopped what was happening. The removal of independence makes doctors vulnerable to abuses of power. The medical profession must regain independence in disciplinary proceedings to prevent similar cases happening again, with devastating consequences for all parties.

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HUNTERIAN MUSEUM, RCS OF ENGLAND

SKELETON OF "THE IRISH GIANT"

Byrne's body should disappear beneath the waves

John Hunter was a brilliant thinker who pushed forward the boundaries of medicine in all fields. By his own admission, he dissected "some thousands" of bodies, most of them stolen. Yet he did more than any other medical professional of his time to promote the idea of voluntary postmortems and donated bodies and organs. By encouraging many of his friends to agree to postmortems—including the naturalist Daniel Solander, the prime minister the Marquis of Rockingham, the Archbishop of Canterbury, and even his own father in law Robert Home—he helped make the donation of bodies socially acceptable. He left instructions that his own body should be dissected after death and his heart displayed in his museum. The day after his death, his former medical students watched as his brother in law, Everard Home, duly performed the postmortem.

Yet Hunter overstepped the mark when he hunted down and obtained the body of Charles Byrne, the self named "Irish giant,"¹ who

stated clearly and forcefully his abhorrence and objection to being dissected after death. The time has come for the Royal College of Surgeons to remove Byrne's skeleton from display and carry out his final wish to be buried at sea. The Hunterian Society and other bodies devoted to John Hunter's memory should be invited to the ceremony. As Hunter's last biographer, I would be delighted to honour his memory and watch Byrne's body disappear beneath the waves.

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Competing interests: WM is author of *The Knife Man, Blood, Body-snatching and the Birth of Modern Surgery*.

1 Doyal L, Muinzer T. Should the skeleton of "the Irish giant" be buried at sea? *BMJ* 2011;343:d7597. (20 December.)

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Don't forget those who were murdered to order

The Charles Byrne debate has wider implications.¹ Two recent papers demonstrated that subjects depicted in the 18th century anatomical atlases of William Smellie and William Hunter were procured by order to murder pregnant women.^{2 3} The Hunter Collection probably includes preparations from these women. Concentration camp inmates are now known to have been murdered for Eduard Pernkopf's anatomical atlas,⁴ and preparations held by Austrian universities have been buried, although some universities refused.

Contemporary sources indicate that some 200 000 bodies were procured in Britain and Ireland in 1745-1832.⁵ The evidence of Smellie and Hunter, together with contemporary references and the criminal value of a body, suggest a proportion were murdered to order. Many preparations in medical collections must be derived from such subjects, and the Byrne debate should also include them. Whether they should be buried, I leave others to decide.

However, the victims should not be forgotten. After the Pernkopf debate some libraries withdrew his atlas. I do not propose that for Smellie and Hunter, but I do believe these atlases should represent a memorial to the involuntary sacrifice of these people's lives, rather than being used to laud Smellie and Hunter as "founding fathers" of obstetrics. Don Shelton retired chief financial officer, Auckland, New Zealand donshelton@actrix.co.nz

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We cannot change the past, but we can learn from it

We do not share Doyal and Muinzer's views on Charles Byrne.¹ Most early pathology museum displays are grave robbed specimens, executed criminals, or the unclaimed dead from workhouses.^{2 3} Reburial cannot change this. Rather, museum displays highlight the fact that such things no longer occur because of changes in societal attitudes. Anatomical preparations formed the basis of modern medicine. There is no adequate substitute—replica or virtual—for studying actual bodily remains, especially unusual ones. If Byrne's bones had been buried after Cushing's study,⁴ Byrne's DNA would never have recently been analysed.⁵ Moreover, Byrne's relatives support continued display of his skeleton.

Charles Byrne wished to be buried at sea to avoid the fate of dissection, a practice that was stigmatised at the time. That stigma has, thankfully, dissipated, and reburial of Byrne's remains would simply reflect a system of beliefs that do not accord with current views on the human body.

We disagree with the notion that display of remains is intrinsically disrespectful. Having visited the Hunterian Museum we cannot think of a more dignified repository for this important skeleton, or greater respect than can come from serving humankind by aiding advances in medical science. Modern medical ethics exist to protect living people. Applying such values retrospectively to people who died centuries ago is often inappropriate. Hunter's actions were immoral by modern standards, but apologising for the deeds of others long dead just salves the consciences of the living and has no effect on the deceased. We cannot change the past, but we can learn from it. Dropping Charles Byrne's bones into the sea will help no one—not even him.

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Authors' reply

We are glad that Moore, Hunter's contemporary biographer, agrees with our argument.

Smith and colleagues accept that Byrne wanted to be buried intact. Hunter knew his wishes yet boiled him down to create a skeleton. Many people at the time were morally outraged (and still are) by body snatching. The authors claim that modern medical ethics exist to protect living people, and that no moral or legal issues are posed by decedents having been opposed to the use of their bodies for medical purposes. This is not so.¹

They then suggest that respecting Byrne's wishes would deny the importance of studying actual bodily remains for medical progress and would threaten their continued preservation for this purpose. No so. Ordinarily, such exhibits are anonymous, with no knowledge of the explicit burial preferences of decedents. With Byrne we know both. The moral problem is the disrespect for Byrne's memory by continuing to ignore his known wishes. The fact that one or two individuals who share his genetic mutation who have no moral or legal status as "relatives" may now think otherwise is irrelevant.²

The authors argue that Byrne's skeleton should be kept and displayed just in case it leads to further medical discoveries. This is an example of an "anything is possible argument," and we leave readers to contemplate the moral absurdity of this reasoning and the impracticality of its implications (warehouses full of bodies, body parts, and skeletons?). The Human Tissue Act 2004 was created partly to counter just such thinking.

We now have Byrne's DNA, and willing volunteers can participate in further acromegaly research. His skeleton has done enough for medicine. Finally show his memory some respect. Bury what is left of Byrne at sea as he originally wanted.

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Competing interests: None declared.

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