NICE will create standards on obesity, tobacco, and alcohol

Nigel Hawkes BIRMINGHAM

The National Institute for Health and Care Excellence (NICE) is to create new quality standards for public health, the Department of Health for England has announced.

At NICE’s conference in Birmingham, the health minister Earl Howe said that the first three standards would cover tobacco, harmful alcohol use, and obesity—three topics that he admitted had not been difficult to select. He expected that the standards would provide a key tool for Public Health England in tackling the three issues.

A consultation will follow on other public health issues, amounting eventually to a “growing portfolio” of quality standards.

NICE’s growing influence, which also now encompasses social care, was reflected in a huge attendance at the conference. David Haslam, NICE’s chairman, said that the audience, which overflowed the Birmingham International Conference Centre, was a tribute to the success of his predecessor, Michael Rawlins, in establishing the organisation.

The conference’s opening session on 14 May heard from the recently appointed chief executive of the Care Quality Commission, David Behan, who promised that clinicians would in future be involved much more with the CQC’s inspections of hospitals. “We want to move away from generic inspections by people who know about hospitals to those involving specialists who know about services,” he said. He envisaged clinicians being seconded to CQC, perhaps for a two year period, to provide their expertise to improve the process.

Bruce Keogh, national medical director of NHS England, echoed the thesis by claiming that there were now more clinicians involved in running the NHS than ever before—in clinical commissioning groups, clinical senates, clinical networks, and academic health science centres. But, he was asked, would clinicians stand up and be counted when they saw something going wrong, such as at Mid Staffordshire?

“No, not yet,” he admitted, saying that it was the job of NHS England to give people the confidence to make their feelings known.

Cite this as: BMJ/2013;346:f3150

Government welfare cuts are hitting children, says BMA

Jacqui Wise LONDON

Recent cuts to welfare benefits and social care will hit the most vulnerable children and widen social inequalities in the United Kingdom, warns a major new report from the BMA.

Growing up in the UK says that the current high levels of poverty in the UK, including among children, are unacceptable. The report says that intervening early with family support and education was cost effective and essential to reduce inequalities.

It highlights the value of the Sure Start Children’s Centres but adds that with local authority budget cuts and services no longer ringfenced some centres had closed or reduced their services.

The BMA acknowledged that there had been some progress since its last report on children’s health in 1999, as the overall health and mortality of children in the UK was improving. For example, in 2007 a Unicef study of children in 21 wealthy countries put the UK in bottom place, whereas a more recent Unicef study ranked the UK 16th of 29 countries.

But the report said that such studies did not reflect the effects of policies implemented since the 2010 election. It also pointed out that the number of UK children referred to local authority care because of abuse and neglect was the highest ever in 2011-12.

The 247 page report calls for an annual report on the health of children, similar to the chief medical officer’s report on the state of the public health, to monitor children’s health trends.

The BMA emphasised that interventions to improve children’s future health needed to start before birth, such as by improving maternal nutrition, providing parenting classes, raising awareness of the benefits of breast feeding, and targeting families at higher risk of harm.

Its report also makes a number of recommendations to tackle the rising prevalence of obesity. Averil Mansfield, chairwoman of the BMA’s Board of Science, said, “The BMA is particularly concerned that any improvements in tackling child poverty are in danger of being eroded by some government welfare policies.

Children should not pay the price for the economic downturn. Every child in the UK deserves a start in life that will help them achieve their true potential. While there has been some progress, I still find it shocking that for a society that considers itself to be child friendly we consistently underperform in international ratings.”

Vivienne Nathanson, director of professional activities at the BMA, acknowledged that some improvements had occurred since the last report, including the appointment of a children’s commissioner for England.

Cite this as: BMJ/2013;346:f3129
BMA disputes government claim that rollout of NHS 111 was supported by evidence

Gareth Iacobucci [BMJ]
The BMA’s General Practitioners Committee has rejected ministerial claims that the pilot study of the new 111 urgent care telephone hotline provided enough evidence to support the national rollout of the troubled service on 1 April.

The new non-emergency service has faced a litany of problems since its launch last month, with NHS England announcing an inquiry into the rollout after reports of inappropriate delays in treatment, slow response times to calls, and increased pressure on emergency departments.1,2

On 13 May the health minister Lord Howe acknowledged that the service had been unacceptable in some areas but insisted that the report into four 111 pilot areas by the University of Sheffield had provided sufficient evidence to proceed with the national rollout across England.3

But Peter Holden, lead negotiator on 111 for the General Practitioners Committee, said that the report, which found that the new service had “not delivered the expected benefits” in terms of improving patients’ satisfaction or reducing emergency admissions to hospital, did no such thing.

Holden told the BMJ, “The report was heavily caveated. The government published a very polished version of the report that de-emphasised the disadvantages. The bottom line is, no, it was not ready for rollout. Senior civil servants and managers just sold successive sets of emperors’ new clothes to ministers who’d already made a decision.”

He added, “What annoys us is that we warned them. We told them not to roll this out all in one go and at Easter. So they brought it forward a week. We were playing with patients’ lives here.”

His view was echoed by Clare Gerada, chairwoman of the Royal College of General Practitioners, who said, “NHS 111 was rolled out far too early, with unnecessary pressure placed on some sites to go live before they were ready.”

Responding to a question in the House of Lords

NHS regulator is given new powers to shut hospitals whose clinical care is poor

Ingrid Torjesen LONDON
Healthcare regulators in England are to receive tougher powers to act on hospitals that provide poor quality clinical care, including the ability to shut down foundation trusts that fail to improve within a set time period.

The Care Bill,1 published on 10 May, outlines new powers the government is introducing in response to Robert Francis QC’s report into failings at Mid Staffordshire NHS Foundation Trust.2

For the first time the economic regulator of the NHS, Monitor, is to be given authority to shut down foundation trusts that are failing clinically and not just financially. The Francis report found that poor quality care at Mid Staffordshire was related to too much focus on financial and organisational issues rather than on quality of care.

The health minister Norman Lamb told a press briefing, “This for the first time puts quality of care on a par with finances. It is a rather bizarre feature of the old regime that it was only finances that could push an organisation into administration. Now quality of care can achieve that as well.”

The Care Bill outlines a new single failure regime for hospitals, encompassing both finance and quality. There will be a single rating system for hospital trusts, led by the chief inspector of hospitals at the Care Quality Commission (CQC), which will draw on financial information from Monitor and the Trust Development Authority.

When the quality of care at a hospital trust needs significant improvement, the chief inspector

Two cases of coronavirus are confirmed in France as death toll reaches 18

Anne Gulland LONDON
French health authorities have confirmed that a second patient has been infected with a novel coronavirus, as the World Health Organization confirmed that it was increasingly likely that the virus could be spread from human to human.

The French Ministry of Social Affairs and Health informed WHO at the weekend that a second person had been identified as having the virus, after laboratory confirmation of the first case on 7 May. The two patients shared a hospital room between 27 and 29 April.

Three epidemiological investigations are currently under way in France. The first concerns the 124 people who had contact in France with the first patient infected with the virus. Laboratory tests were carried out on five people, four of whom tested negative.

Another investigation is focusing on the 39 people who travelled to the United Arab Emirates with the first patient. And the final investigation is looking at the 38 people in contact with the second patient, who is in an isolation ward in a hospital in Lille.

Since September 2012 a total of 34 laboratory confirmed cases of the novel coronavirus have been reported around the world, 18 of which have resulted in death. Most cases have been in the Middle East, with 25 in Saudi Arabia, two in Jordan, two in Qatar, and one in the United Arab Emirates. There have also been two cases in the UK, one resulting in death.1 Most patients are men (23 of the 29 cases in which sex was reported) and range in age from 24 to 94 years (median 56 years).

Keiji Fukuda, WHO’s assistant director general for health security and the environment, is currently in Saudi Arabia investigating an outbreak.

Cite this as: BMJ 2013;346:f3114
from the Labour peer Philip Hunt on why the government had proceeded with the national rollout after the University of Sheffield report, Howe said, “The . . . report showed 92% were satisfied with the service, and 93% felt the advice given was helpful. Overall, the service was meeting its objective of getting people to the right place first time. On the basis, it was considered safe to go ahead with the rollout.

“Unfortunately, in particular areas, the resources deployed to meet the demand have not been accurately assessed. I stress that was in a minority of locations.”

Howe added that NHS England and clinical commissioning groups were working hard to “stabilise providers who have failed to deliver an acceptable service,” but he insisted that most areas were receiving a good service.

The NHS Alliance, which represents providers in primary care, said in a discussion paper that the failure of NHS 111 was a result of “unprecedented” pressure from the Department of Health to meet the 1 April deadline and a focus on cost over quality.

Cite this as: BMJ 2013;346:f3131

will issue a warning notice requiring the trust’s board to improve within a fixed time period. Currently the CQC is only able to act where a hospital is failing to comply with one of its standards, but the bill will award it wider powers to enable it to act when it spots poor care.

Monitor (for foundation trusts) and the Trust Development Authority (for NHS trusts) will be able to step in to suspend or remove hospital boards. If the improvement demanded is not forthcoming, Monitor will put the foundation trust into special administration to ensure that problems do not become longstanding. Currently Monitor is able to put foundation trusts into special administration only if they become financially unsustainable.

The bill will also make it a criminal offence for secondary care organisations to provide false or misleading information, such as for mortality rates. Organisations found guilty of the offence could face an unlimited fine. The bill allows ministers to expand on the types of information and providers covered by the offence in the future.

Although the bill is being used to implement some of the Francis report’s recommendations, its main focus is to legislate for changes to the funding of long term social care in response to the Dilnot review. These include a £72,000 lifetime cap on the contribution that any individual makes to the costs of social care, to be introduced in 2016, and a £118,000 threshold on assets under which eligible care would be free.

Cite this as: BMJ 2013;346:f3097

Without integrated care we risk another Mid Staffs, warns minister

Gareth Iacobucci BMJ

The UK government has set out ambitious plans to fully integrate health and social care in England within five years, in a new blueprint hailed by ministers as a landmark moment in the future of the NHS.

The coalition government has pledged to establish new integrated care arrangements in every area of the country by 2015, with a view to fully integrating healthcare and social care by 2018.

The plans will be kickstarted by 10 “pioneer” areas around the country, which will be chosen by September 2013 to take the lead in testing “innovative, practical approaches” to integration, with other areas then encouraged to follow.

The government said that the move to accelerate integrated care across England was essential to stop the NHS from “buckling under the pressure” of an ageing population with increasingly complex healthcare needs and ongoing financial pressures.

Launching the plans at the health policy think tank the King’s Fund on 14 May, the care and support minister, Norman Lamb, warned that a failure to deal with the lack of coordination in the current system led to poor care and to resources being wasted and risked a repeat of the Mid Staffordshire scandal.

To mark the launch, the government has published a set of commitments signed by 12 national organisations, which it hopes will ensure that its vision is delivered across the NHS and local authorities.

The commitments include outlining how national resources will support local work; promising to ensure that tools are available to help; detailing how data and information will be used to enable integration; and formulating plans to accelerate learning across the system.

Clinical commissioning groups are also being encouraged to use their annual 2% funding allocated for non-recurrent expenditure to pay for new integrated care projects.

The government’s vision will be supported by the first concrete definition of integrated care and support, developed by the charity National Voices, and the introduction of new ways to measure patients’ experience of integrated care by the end of 2013.

The announcement comes after the UK Labour Party proposed to merge the budgets for health and social care and mental health services in England, when it launched its own flagship integrated care policy in January.

Lamb said that the fragmentation that characterised the current system “has to change.”

He said, “Seriously ill people fall between the gaps. Too often patients get poor treatment. Too often the system looks dysfunctional, and the pressure is rising inexorably.”

“Unless we get everyone working effectively together and stop duplicating effort and start keeping people out of hospital, then the NHS will eventually buckle under that pressure. The risk is the NHS will be branded with the perpetual risk, perpetual underachievement, and ultimately failure, and we will see another Mid Staffordshire,” he warned.

Lamb added, “This national commitment to working together is an important moment in ensuring we have a system which is fit for the future.”

“Inside the treasure chest of integration lies the solution to the challenges that will define the future of the NHS.”

Responding to the announcement, Chris Ham, chief executive of the King’s Fund, described integrated care as “the central challenge that defines modern healthcare.”

He said, “To meet the needs of an ageing population and transform services for the growing number of people with long term conditions, it is essential that coordinating care and support becomes the core business of everyone working in the NHS and social care. So today’s announcement is an important statement of intent.”

Cite this as: BMJ 2013;346:f3152

Norman Lamb: “Ill people fall between the gaps”
**IN BRIEF**

**Hospitals had more than 750 “never events” in past four years**

Hundreds of patients have been subject to preventable mistakes in England’s hospitals over the past four years, show figures obtained under a freedom of information request by the BBC. The investigation found more than 750 “never events”—those that should never happen, including 322 cases of foreign objects left inside patients during operations and 214 cases of surgery on the wrong body part.

**H7N9 flu has killed 32**

The outbreak of H7N9 avian flu in China had killed 32 people and infected 131 as at 8 May, the World Health Organization has said. It said that so far there had been no evidence of sustained human to human transmission. With the source of infection yet to be identified and controlled, WHO said that it expected further cases of infection of humans.

**New technique of virus genetic sequencing is announced**

Scientists from the National Chiao Tung University in Taiwan claim to have developed a new technique for carrying out virus genetic sequencing that could cut the cost of developing vaccines and antiviral drugs. The new technique, which unlike current methods uses no external aids such as fluorescence to read polymerase synthesis, produces results in one hour instead of one day.

**Six per cent of patients with cancer are given wrong drugs in hospital**

Macmillan Cancer Support has released figures indicating that around 10000 of the estimated 170000 patients with cancer admitted to hospital each year in England receive the wrong drugs. The YouGov survey of 2142 adults with cancer also showed that a third of people admitted to hospital who needed extra food never received it and that 7% (around 12000 of the total number) wished to drop out of treatment early because of the way hospital staff dealt with them.

**Pregnant women could be tested for carbon monoxide**

Pregnant women could be offered a breath test for carbon monoxide at an antenatal appointment and throughout their pregnancy, to assess their exposure to tobacco smoke, under a proposal by the National Institute for Health and Care Excellence. The proposal, aimed at highlighting the harms of smoking and passive smoking, is included in a quality standard on smoking cessation that is out for consultation.

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**Study proposes antibiotics as possible treatment for back pain**

**Jacqui Wise LONDON**

Patients with chronic low back due to disc herniation that could benefit from surgery have been treated with antibiotics in two randomised controlled trials.

The first of two studies in the *European Spine Journal* found *Propionibacterium acnes*, an anaerobic bacteria, in 43% of patients undergoing primary surgery for lumbar disc herniation. Hanne Albert and colleagues at the University of Southern Denmark also found that new bone oedema (Modic type 1 changes) developed in adjacent vertebrae of 80% of discs infected with the anaerobic bacteria.

Previous studies had shown that Modic changes were six times as common in people with low back pain as in the general population. This was mostly thought to be the result of mechanical reasons, but it was known that under some circumstances infections played a role. Conventional treatments for back pain such as exercises, injections, and manipulation were ineffective in patients with Modic changes.

The study of 61 patients found a highly significant association between presence of the anaerobic bacteria in nuclear tissue of discs and Modic change ($P=0.0038$), with an odds ratio of 5.6 (95% confidence interval 1.5 to 22). The researchers said that this discovery merited the establishment of a new disease category: Modic related low back pain.

One key question was whether the bacteria found in the nuclear material is indicative of an infection or possibly a result of intraoperative contamination. In an accompanying editorial Max Aebi, editor in chief of the *European Spine Journal*, said that the authors give a plausible answer that contamination was highly improbable. “Nevertheless, the evidence shows that standard packaging helps smokers quit and prevents young people taking up the habit and facing a lifetime of addiction. I am bitterly disappointed that the government has bowed to pressure from the tobacco industry, whose only objective is to increase profits by encouraging more people to smoke and become addicted to their products.”

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**Government has lost “credibility on public health” for inaction on cigarettes and alcohol**

**Matthew Limb LONDON**

Health campaigners have criticised the UK government for failing to include plans on legislating for plain cigarette packaging and a minimum price for a unit of alcohol in the next parliament.

Lindsey Davies, president of the UK Faculty of Public Health, said evidence existed that both measures could have saved lives, and failure to enact them was “profoundly disappointing.”

She urged the government to think again, saying, “When it comes to policy decisions that affect everyone’s health, it’s actions, not words, that make a difference.”

The BMA’s chairman of council, Mark Porter, questioned the government’s commitment to protecting the nation’s health.

He said, “The evidence shows that standardised packaging helps smokers quit and prevents young people taking up the habit and facing a lifetime of addiction. I am bitterly disappointed that the government has bowed to pressure from the tobacco industry, whose only objective is to increase profits by encouraging more people to smoke and become addicted to their products.”

Porter said that a minimum unit price for alcohol would lead to thousands fewer alcohol related deaths.

Health campaigners had hoped that the UK government would follow Australia’s lead by announcing plain packaging in its new legislative programme for the 2013-14 parliamentary session unveiled on 8 May. They said that the government had now lost “credibility on public health.”

Ahead of the Queen’s speech on 8 May, the health secretary for England, Jeremy Hunt, told the BBC Radio 4 *Today* news programme that even if the measure wasn’t in the Queen’s speech, a law could still be brought forward at a later date.

The government has yet to publish the outcome of a consultation on standardised packaging, which was launched in April 2012 and closed last August.

The Smokefree Action Coalition has sent a written appeal to Hunt and the prime minister and called for the issue to be decided on a free vote in parliament.

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Cite this as: BMJ 2013;346:f3096

Cite this as: BMJ 2013;346:f3024

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**European Spine Journal**

**Modic changes**

**European Spine Journal**

**European Spine Journal**

**European Spine Journal**
further research is necessary to show what exactly happens in patients with disc herniation who develop Modic change 1 and low back pain and who have not been operated on,” he added.  

In the second study, also in the *European Spine Journal* and led by Albert, the researchers found that a long course of antibiotic treatment was more effective than placebo in patients with chronic low back pain associated with vertebral bone oedema. The double blind, randomised controlled trial involved 162 patients who had chronic back pain of longer than six months after a previous disc herniation and who had Modic type 1 changes in the vertebrae that could be seen on magnetic resonance imaging. The patients were randomised to receive either 100 days of antibiotic treatment with amoxicillin with clavulanic acid or placebo.

The study, funded by Danish foundations and the Danish Rheumatism Association, found that 80% of patients who received the antibiotic were significantly better able to function after one year.  

Cite this as: BMJ 2013;346:f2988

**Antibiotics for back pain: hope or hype**

**Matthew Limb** LONDON  

NHS England has announced steps to tackle rising pressure on hospitals’ accident and emergency departments that has sparked anxiety among regulators and ministers.

It has set up a national support plan with Monitor, the economic regulator of the NHS, and the NHS Trust Development Authority, which provides support and leadership to NHS trusts. The plan requires local urgent care boards to be formed to ensure that “recovery and improvement plans” are in place for each hospital accident and emergency department by 31 May.

The boards, led by NHS England area teams, will work with clinical commissioning groups, hospitals, and local authorities to meet demand, fix problems, and improve performance against national targets. They will also examine the quality of ambulance services, the NHS 111 urgent helpline service, and out of hours services and the effectiveness of primary and community care services.

NHS England said on 9 May that the performance of hospital emergency departments had “deteriorated significantly” over the past six months.

In the final quarter of 2011-12 a total of 47 of 152 providers (31%) failed to meet the 95% target for patients arriving at emergency departments to be seen and discharged or admitted within four hours. In the final quarter of 2012-13 this proportion had doubled to 94 of 148 (64%).

NHS England said that long waiting times in emergency departments not only delivered poor quality in terms of patient experience but also “compromised patient safety and reduced clinical effectiveness.” It said that increased numbers of acute admissions were putting pressure on beds.

Several factors were at work.

There was a “general consensus,” NHS England said, that patients were “presenting more ill and hence more likely to need admission and have longer stays.”

The College of Emergency Medicine welcomed the announcement of a support plan but said it needed to study the proposals. A college spokesperson said, “The concept of creating urgent care boards which oversee the whole care pathway is welcomed as this is a whole system problem. Our fellows and members will look forward to being involved in this.”

The plan emerged a day after David Prior, the newly installed chairman of England’s hospital and care services watchdog the Care Quality Commission, disclosed his worries to a conference on integrated care held by the health think tank King’s Fund in London on 8 May. He said that emergency department admissions were “out of control” in large parts of the country.

Cite this as: BMJ 2013;346:f3065

**Rescue boards will be set up in England to deal with deterioration in A&E departments**

**GP leaders raise concerns about government plans to restrict access to NHS**

**Gareth Iacobucci** BMJ

New restrictions on migrants’ access to NHS services and changes to social care funding are among key policies outlined in the Queen’s speech.

A new Immigration Bill, the centrepiece of the speech to parliament outlining the government’s intended legislation during the next parliament, will set out plans to restrict migrants’ access to the NHS and make temporary visitors contribute to their healthcare costs.

The speech also announced a Care Bill to take forward the government’s commitment to reorganise the funding of social care and offer greater support to carers.

The speech also outlined plans to enable people with mesothelioma to claim compensation more easily, including where “no liable employer or insurer can be traced.”

But the speech didn’t include key public health initiatives—plain packaging of tobacco products and the introduction of a minimum price on a unit of alcohol.

The government’s move to tighten migrants’ access to the NHS and other welfare services comes after a surge in support for the UK Independence Party, which advocates reductions in net immigration to the UK.

The Royal College of General Practitioners has expressed concern that the plans could require GPs to scrutinise patients’ passports before agreeing to treat them and would force them into becoming “a form of immigration control.”

In the speech the Queen said, “My government will bring forward a bill that further reforms Britain’s immigration system. The bill will ensure that this country attracts people who will contribute and deter those who will not.”

The Care Bill will trigger the introduction of a £7 2000 (€85 000; $112 000) cap on the amount that people would have to pay towards the costs of social care in England, which will now be introduced in 2016.

Cite this as: BMJ 2013;346:f3020

**Mark Porter (left) welcomed the reorganisation of social care, but Clare Gerada (right) said GPs should not become the new border agency for immigration**
Save the Children and GSK agree to develop drugs for children

Susan Mayor LONDON

The charity Save the Children and the drug company GlaxoSmithKline have established a partnership to work together to develop drugs to treat some of the leading causes of deaths in children in developing countries.

The two organisations are working together to prioritise areas for research, plan projects, and share expertise and resources to accelerate the development and availability of drugs and technologies to improve the health of children.

“GSK is really engaging with us, focusing on the areas of greatest need and working jointly on projects in the world’s poorest countries,” explained Simon Wright, head of child survival at Save the Children. He said that the partnership also opened up new advocacy channels for putting pressure on governments and other organisations to act to reduce child mortality.

The partnership has a five year target to develop drugs and improve access to healthcare to save the lives of a million children, but the organisations aim to continue the collaboration in the long term.

Andrew Witty, GSK’s chief executive, said he hoped that the partnership would set a new standard for how companies and non-governmental organisations could work together.

The partnership will initially work on two major projects in sub-Saharan Africa.

The first project is to reformulate the antiseptic chlorhexidine, found in a GSK mouthwash, for cleansing the umbilical stumps of newborns to prevent infections that are currently a major cause of neonatal death in developing countries.

Half of the seven million deaths of children in 2011 were in the neonatal period, and many of these deaths were due to umbilical infections, said Allan Pamba, director of public engagement and access initiatives with GSK in Kenya. “Research indicates that chlorhexidine can be repurposed into a gel that can be mass produced and used to help reduce these neonatal infections,” he said.

The second project will develop a child friendly antibiotic to treat pneumonia. The partnership is planning to reformulate amoxicillin as a powder that will be distributed in dose packs suitable for small babies and infants. They will also look for an alternative formulation to use where access to water or milk is limited.

“Nearly 100 million children in the world had pneumonia last year, and 80 million of these did not get even a whiff of an antibiotic, let alone the right antibiotic,” Pamba said.

Cite this as: BMJ 2013;346:f3103

Researchers thrash out guidelines for joint working

Clare Dyer BMJ

Researchers from around the world gathered in Montreal this week to try to agree a statement to ensure the integrity of scientific research in cross boundary collaborations.

The draft Montreal statement, which was keenly debated at the Third World Conference on Research Integrity that took place between 5 and 8 May, is intended to tackle the challenges arising in the growing number of collaborations across institutions and national borders. It builds on the Singapore statement on research integrity, which set out 14 professional responsibilities for individual researchers, including reporting irresponsible practices.

Tony Mayer, of Nanyang Technological University in Singapore, said that 75% of papers now came from multiple institutions and that 35% of papers were international.

The draft statement requires researchers to adhere to the Singapore statement and the extra responsibilities specific to cross boundary collaborations.

Cite this as: BMJ 2013;346:f2992

“Research passports” could reduce misconduct, conference hears

Clare Dyer BMJ

The UK’s elite universities draw half of their income from research, yet nobody checks the integrity of the work, Michael Farthing, vice chancellor of Sussex University, told delegates at the World Conference on Research Integrity in Montreal on 5 to 8 May.

Farthing, professor of medicine at Sussex and vice chairman of the UK Research Integrity Office, told the conference, “Every five years the research is audited for quality. But nobody asks the question, ‘Is this high quality research also research of high integrity?’”

A report of the recent investigation into suspected research misconduct at Cardiff University’s medical school, which found that a former researcher was to blame for image manipulation in four of 43 papers investigated,2 made the case for enhanced monitoring, he said. “It established that they were not properly monitoring and supervising what was going on.”

The allegations in that case had come anonymously. “My view is that we neglect concerns from any source at our peril, but we need balance,” said Farthing.

He called for more communication among institutions to stop researchers who were guilty of misconduct at one university simply moving to another. He cited the case of Jatinder Ahluwalia, who was dismissed from a PhD programme at Cambridge, obtained a PhD at Imperial College London, and moved to University College London and then to the University of East London, in a 15 year history of misconduct.2

Farthing added that he was “quite interested” in requiring researchers to declare previous research misconduct when they moved to a new institution. Another suggestion was that there should be a registry of researchers, with “research passports” issued.

“My view is we must have a much clearer view of the whole research misconduct landscape,” he said. More research was needed, including into motivation and possible ways of picking up misconduct earlier. Institutions and journals should share information more.

Nicholas Steneck, director of the research ethics and integrity programme of the Michigan Institute for Clinical and Health Research, said that research misconduct was known to be more common than was first thought. What was not known was whether its prevalence was increasing and whether it could be prevented or deterred. “We hope it can,” he said.

Cite this as: BMJ 2013;346:f2971