early 2001 when his role in the affair will presumably be examined.[3] Finally, and perhaps most important of all, it must be determined what happened following the internal enquiry of the Banerjee case at King's College Hospital Medical School in 1991. If Banerjee's work—as it is alleged—was found to be questionable at that time, why did the Dean of the day not refer the case to the GMC immediately? Why was the *Gut* paper not retracted in 1991, and why did Banerjee's supervisor remain associated with the work when other collaborators withdrew their names from the paper? It is likely that answers to all or some of these questions will come out of Professor Peters's GMC hearing; perhaps the GMC will have more work to do as the story evolves even further.

There is yet another matter still to be resolved. Data included in the retracted *Gut* paper allegedly form part of Banerjee's Master of Surgery thesis awarded by the University of London in 1991.[2] I tried to obtain a copy of the thesis from the University to verify whether this was indeed the case, but it was missing from the shelves, apparently out on an "inter-library loan". I was advised to try the library at St Thomas's. Another whistle blower (not Wilmshurst) apparently advised the University of London at the time, in writing, alleging falsification of the thesis, but was subsequently instructed to withdraw the letter with warnings that this might damage future career prospects. This story is almost too difficult to believe; it is perhaps surprising that this additional problem was not dealt with at the recent GMC hearing.

The Banerjee case illustrates a number of important deficiencies in the way in which we handle alleged cases of research misconduct in the UK. Firstly, it is evident that it is relatively simple to fabricate data and get it published in a reputable medical journal. In the majority of cases it will be virtually impossible for reviewers and editors to identify fraudulent material. Detection in this case, and in many others will almost always depend on the willingness of a vigilant whistle blower to speak out. There is little to gain for whistle blowers, particularly when their comments fall on deaf ears, or they are threatened with professional extinction. Secondly, the case demonstrates the potential weakness of the *internal inquiry*. Although it is unclear as to the location of the final resting place of the King's Banerjee Report, it is alleged that its findings were not in Banerjee's favour.[1] It then took almost a decade and the persistent efforts of an external whistle blower, who had no conflicting interests, to bring the case to the GMC. This cannot be regarded as a satisfactory state of affairs and will do nothing to reassure the public that the medical profession is still fit to self regulate. The case also shows the importance of the role of the research supervisor as a custodian of research quality. When it was clear in 1991 that Banerjee's work was suspect, why did he not withdraw his support and insist on an external review by the GMC?

This case, and indeed many others considered by the Committee for Publication Ethics (COPE)[4 5] and probably others still in the GMC pipeline, convinces me that the procedures currently in place in the UK are inadequate to deal with many of the alleged cases of research misconduct. COPE has campaigned for more than three years for an independent body to consider such cases.[6] Although many Universities and Medical Schools have written guidance as to how to pursue an internal review, I have concerns that a lack of independence may inhibit action of the naturally reluctant whistle blower and not provide appropriate protection when required. In October 1999 a consensus conference was held at the Royal College of Physicians in Edinburgh on Misconduct in Biomedical Research. The consensus panel recommended that a National Panel should be established which would develop and promote models of good practise for local implementation, provide assistance with the investigation of alleged research misconduct, and collect, collate, and publish information on the incidence of research misconduct. Although discussions have taken place and a report is said to be in preparation, no clear action has at yet become apparent to those of us on the outside.[7] Even if such an advisory panel is established will it really have the teeth to ensure that we do not have a re-run of the Banerjee case? I have my doubts.[8] What COPE is proposing is not new. The USA, Nordic countries, and others have had external agencies in place to deal with alleged cases of research misconduct for almost 10 years[9]; why is the UK lagging behind? One is reminded of the fact that it took 20 years longer to establish Research Ethics Committees in Britain than it did in the USA![10]

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Retraction

Gut is retracting the paper by AK Banerjee and TJ Peters, "Experimental non-steroidal anti-inflammatory drug induced enteropathy in the rat—similarities to inflammatory bowel disease and effect of thromboxane synthetase inhibitors" (*Gut* 1990;**31**:1358–64) and the abstract AK Banerjee, R Sherwood, JA Rennie and TJ Peters, "Sulphasalazine reduces indomethacin induced changes in small intestinal permeability in man" (*Gut* 1990;**31**:A593) at the request of Dr Banerjee. At the end of November 2000, the General Medical Council found Dr Banerjee guilty of serious professional misconduct and suspended him for 12 months. Both articles were deemed to contain information which was deliberately falsified.