

The report of the committee of inquiry commissioned by the Royal College of Obstetricians and Gynaecologists suggests that further review by the statistical referee might have highlighted a problem but also notes that the paper, as published, has been independently reviewed by a further statistician, who did not think that a significant problem would have been identified on the basis of the data in it. Would the journal's statistical referee have been less credulous about the number of cases recruited in the stated time interval?

Lock alludes disparagingly to "amateurism in journals." But the *British Journal of Obstetrics and Gynaecology* relies on "amateur" editors to uphold its deserved high standing. Amateurism and high standards are not mutually exclusive. Retrospective wisdom should not be allowed to extend blame beyond the real culprit.

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1 Lock S. Lessons from the Pearce affair: handling scientific fraud. *BMJ* 1995;310:1547-8. (17 June.)

BMJ nurtures spoof publication

EDITOR,—I am pleased to read that the time has come for Britain to abandon its lax approach to scientific fraud.¹ Perhaps the *BMJ* could set an example. In the past it has published spoof articles on April fool's day. It was a bit more restrained in the issue published on April fool's day this year, limiting itself to a small spoof letter. Such submissions are actively sought by the *BMJ*. In the past it has published a large article on pig sticking injuries, which was not genuine in terms of scientific validity. Is this fraud somehow more acceptable if done for reasons of humour rather than self advancement?

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1 Lock S. Lessons from the Pearce affair: handling scientific fraud. *BMJ* 1995;310:1547-8. (17 June.)

Clinical fraud is common

EDITOR,—Britain's lax approach to scientific fraud¹ is not an isolated phenomenon but exemplifies its endemic disregard for the veracity of medical discourse generally; this disregard is largely condoned by institutions. Clinical correspondence and case notes commonly display an apparent indifference, sometimes amounting to recklessness, about the accuracy of information represented as fact and the sustainability of expressed opinion.

Fraud is fraud whether it consists of inventing research subjects and data or, for example, garbling a patient's history to conceal a practitioner's incompetence or negligence² or passing off pseudodiagnostic psychiatric colloquialisms as objective professional diagnoses.^{3,4} Britain's track record of policing these types of clinical fraud is poor.⁴ Detection devolves primarily on victims, who until 1991 had no legal right of access to the evidence of their victimisation. The legislation granting access⁵—which, notably, was opposed by the profession—grants patients only limited rights of access to recent records and is user unfriendly, bureaucratic, and difficult to enforce. Correction of factual inaccuracies is at the discretion of the record holder. There is no provision for patients to dispute opinions. Legal aid is not available for libel. Legislation leaves the fox guarding the henhouse.

The General Medical Council's annual report for

1993 tells its own story. Between 1 September 1992 and 31 August 1993, 140 doctors were reported (128 by patients) for "contents of/falsifying/failure to provide records or reports." The preliminary proceedings committee considered only three cases, sending a letter of admonition in one and referring two to the professional conduct committee. The professional conduct committee considered four cases, suspending the doctors concerned in three cases and subjecting one to erasure with immediate suspension. In the remaining 97% of reported cases the doctors seem to have had no action taken against them.

Like the legislative arrangements for patients' access to their records, these performance indicators do not suggest any concerted will to address, much less to solve, the problem of clinical fraud. The profession needs to decide whether it is sufficient to tackle scientific fraud while leaving clinical fraud—undoubtedly more prevalent and no less potentially harmful to patients—untouched. Sooner or later this nettle will need to be grasped. The profession's integrity in the eyes of the public may depend on how promptly and wholeheartedly this decision is taken.

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- 2 Millman M. *The unkindest cut. Life in the backrooms of medicine.* New York: Morrow Quill, 1977.
- 3 Ripperre V. 'Hysteria', 'functional' or 'psychogenic'? *J R Soc Med* 1992;85:59-60.
- 4 Ripperre V. The mental state of dismissed patients—an enquiry into dismissal injury. V. Wider repercussions of psychogenic dismissal. *Newsletter of the Society for Environment Therapy* 1992;12:138-48.
- 5 *Access to Health Records Act 1990.* London: HMSO, 1990.

Prospective registration of health care research would help

EDITOR,—Stephen Lock urges Britain to abandon its lax approach to scientific fraud and to establish national mechanisms to reassure the public that the activities of the research community can, when necessary, be audited.¹ We agree and suggest that a national health register is a fundamental prerequisite for addressing this problem.

Internationally, there has been increasing acknowledgment that controlled trials should be registered at their inception to facilitate participation in them; to prevent unknowing duplication; and to make it easier to identify irregularities in their design, analysis, reporting, and publication or non-publication.² Had prospective registration of trials been accepted as a component of good clinical practice at least one of Malcolm Pearce's two known misdemeanours might have been prevented.

Prospective registration of controlled trials can help to reduce another, probably more widespread form of scientific misconduct—namely, biased underreporting of research. As Pearn notes, failure to publish the results of well designed, well executed research is unethical³; yet this form of scientific misconduct is often ignored by writers on the subject—most recently by Evered and Lazar in a statement published on behalf of the European Medical Research Councils.⁴ Contrary to a widely held assumption, it is investigators and some funders of research, not journal editors, who are the main culprits in this form of misconduct.⁵

Egger and Davey Smith have shown that underreporting research seriously misleads recommendations for clinical practice and new research.⁶ Bodies that fund research, including industry, should audit their own portfolios to assess the extent to which past research remains unreported and take steps to ensure that the results are made publicly accessible. They should also help to establish prospective registration of categories of

research on which judgments about health care are likely to be based.

Research funded by the NHS research and development programme is now on a national research register. Among the other main sources of funds for health research, the Medical Research Council and the medical charities are already well disposed to prospective registration of research, and there are encouraging signs that industry increasingly recognises the importance of making its contribution to these developments. What is required now is an efficient infrastructure to capture the information needed to build and maintain registers of health research. Given their existing responsibilities, research ethics committees seem to provide the obvious foundation for the infrastructure required and for ensuring that standard details about all studies approved are reported to the register.

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- 4 Evered D, Lazar P. Misconduct in medical research. *Lancet* 1995;345:1161-2.
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- 6 Egger E, Davey Smith G. Misleading meta-analysis. *BMJ* 1995;310:752-4.

Serious allegations are hard to believe

EDITOR,—In his editorial on scientific fraud Stephen Lock states, in connection with the frauds of Malcolm Pearce: "In most other medical institutions in Britain nothing would have happened; the affair would have been brushed under the carpet, and the whistleblower would probably have been hounded out or his or her job."¹ This is a serious reflection on the standards of behaviour of British members of our profession. To say that it surprises me would be an understatement. Certainly it does not tally with my experience of our profession. Lock should tell us on what evidence his statement is based.

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1 Lock S. Lessons from the Pearce affair: handling scientific fraud. *BMJ* 1995;310:1547-8. (17 June.)

Author's reply

EDITOR,—I would refer R P Ryan to a survey that I conducted in the late 1980s, which I gave as a reference.¹ My correspondents then knew of 60 cases of scientific fraud, only one of which was in the public domain. I have heard nothing since that leads me to believe that the situation has changed.

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1 Lock S. Misconduct in medical research. *BMJ* 1988;297:1531-5.