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Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers a wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment. Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Bias in awarding research grants

Sir,—Dr Brian Martin makes serious allegations against the National Health and Medical Research Council (NHMRC) of Australia (30 August, p 550). In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

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The case can be summarised as follows. From 1976 to 1982 project grants were rated from 1 (poor) to 6 (excellent) by two anonymous external assessors and the applicant interviewed by a multidisciplinary regional committee, which scored each project from 1 to 6 on the basis of application and interview. Dr Wertheim applied for project grants in 1976, 1979, and 1982. When the 1976 application was not funded she requested— as is her right—a commentary from the NHMRC on her application and interview. She was happy with neither the verdict nor the NHMRC response. In 1979 her application succeeded, in 1982 it was unsuccessful, as was her application for an NHMRC fellowship. Under the newly introduced Freedom of Information Act she sought documentation of her rejected grants. Among the documents was one in which an assessor’s rating had been incorrectly entered on a committee member’s report form.

Dr Martin says, “Although it seems certain that an injustice was perpetrated [in Dr Wertheim’s case], there is no way to prove bias.” The qualifier is unsustainable and the main clause misleading. Dr Wertheim, appropriately in my opinion, not satisfied with the replies she received from the NHMRC, took her case to the ombudsman. He found that various NHMRC procedures were suboptimal (and that they may not have been much improved)—he criticised aspects of the way complaints had been handled but found no evidence of injustice. There are ways in which bias can be strongly suspected on a population basis, if not proved in an individual case. If proposals written by women are much less successful than those written by men, those written by people with Central European names less (or more) successful than those written by Smith or Jones, those written by PhDs less successful than those written by medical graduates, then various sorts of bias—gender, ethnic, or clinical—may be entertained. The possibility of such biases can be examined in the NHMRC system; and until such an examination is made, and dispassionately reported, the statement that bias exists is nothing more than prejudice or speculation. In fact Dr Wertheim was successful in one out of three applications, which is almost exactly the average success rate for project grant applications in 1976-82.

Dr Martin claims, “It seems reasonable to infer that the spokesman [of the committee considering Dr Wertheim’s application] misinterpreted the assessors’ reports to the committee.” The inference here is that only the spokesman saw the external assessors’ report. This is not the case; applicants for grants are interviewed by a committee, all members of which can make their own judgments on the assessors’ reports. Clearly, the spokesman did not agree with one assessor who rated the project as 56 “very good”); equally clearly, his opinion was shared by every other member of the interviewing committee.

Dr Martin says, “One assessor’s rating was altered from 5 to 1.” This refers to an error made by the spokesman, who entered 1 rather than 5 in the box reserved for the assessor’s mark. To alter a rating from 5 to 1 would have entailed tampering with every copy of the assessor’s report, in which the box marked 5 had been ticked; proof that the assessor’s rating was not altered is that the copy on the spokesman’s report could be shown to be wrong. The spokesman makes clear that the erroneous entry had no bearing on the fate of the application.

Dr Martin argues that as a member of the Department of Health, has no corporate voice; as an individual I have tried to point out the groundlessness of Dr Martin’s charges. I have never been a member of NHMRC, I have served on interviewing committees and have had grants approved and rejected over the period in question. I share with Dr Wertheim the feeling of dismay and disbelief when an application fails. I do not, however, share with Dr Martin the feeling that this reflects injustice, bias, and falsification by those responsible for the negative decision, in a system where on average only one application in three is funded.

In his discussion Dr Martin puts the specific charges into the wider context of peer review performed in Australia by anonymous elites with unspecified (but five times reiterated) vested interests. Open institutions—like democratic government and peer review—are fertile ground for conspiracy theories; in closed societies the enemy is obvious, and there is no need to postulate any hidden forces to explain lack of success. The NHMRC system of peer review and awarding research grants is imperfect, like any human institution. The system was substantially refined between 1976 and 1982 and recently has become even more “user friendly.” It still has some (little) way to go—for example, by providing the assessors’ reports to applicants before interview. All this aside, it has emerged as a democratic and externally accountable method of ranking competing project grants in a situation where funding has been scarce and competition for limited funds fierce.

Dr Martin asks that “The discussion should encompass not only administrators and scientists but also members of the general public, all of whom have a stake in fairness and the promotion of scholarship in service to the community.” Quite so; but the promotion of scholarship is not served by innuendo and insupportable allegations of injustice—all of which have been examined and dismissed by the office of the ombudsman.

JOHN W FUNDER
Medical Research Centre, Prince Henry’s Hospital, Melbourne, Australia 3084

Sir,—I read with interest and concern the paper by Dr Brian Martin (30 August, p 550). He makes
Relapse of duodenal ulcer

Sir,—Dr J Paul Miller and Mr E Brian Faragher concluded their leading article (1 November, p 1117) with the recommendation that the reported observations (and inferences therefrom) "should probably influence prescribing." Right, but how? There are clearly two problems associated with current ulcer healing therapy. Firstly, most ulcers relapse if treatment is stopped. Even if the ulcers healed by 

H2 blockers relapse more rapidly (and no generalization is possible from currently available data), nearly two-thirds of patients treated with tripotassium di-citrato bismuthate (De-Nol) relapse within one year of healing. As we have pointed out,2 all (and any) ulcer relapse may present with a complication, and in one recent study the rate of complication during ulcer relapse was over 15% in six years and 30% if patients had previously suffered from a complication.2 Since any complication may be lethal, we have concluded that it is not permissible to allow any ulcer to relapse, since it is not possible to predict which relapse is going to be dangerous.

Secondly, all relapses have to be retreated, time after time. Cimetidine and ranitidine have been used for repeated, or continuous, treatment for 10 and five years respectively in animal experiments, but in animal experiments containing preparations is not available either in man or in experiment, while with earlier bismuth containing antulcer drugs was unsatisfactory since some patients developed encephalopathy or arthropathy. It is not valuable to state that a drug "is recommended for four to eight week courses" when it has been stated that at least 59% of treated patients relapse within one year and will therefore require retreatment within a year. With which drug? And what about next year? And what about that? How much bismuth is going to have accumulated after a few years of repeated treatment? We do not know and I am not prepared to risk the matter in my patients with ulcers.

K G Wormsley

Ninewells Hospital,
Dundee DD1 5SY


AUTHOR'S REPLY—The conclusion from Dr Wormsley's statement that "It is not permissible to allow any ulcer to relapse" is that every patient with duodenal ulcer should at the time of diagnosis be put on to lifelong maintenance treatment or undergo surgery. This may be reasonable in certain high-risk patients, but this policy has not been generally adopted among gastroenterologists.

The 

H2 antagonists currently in widespread use are both excellent drugs with very good safety records, but we do not yet know what the risk-benefit ratio would be from their universal continuous use over decades.1 For these reasons I prefer to reserve permanent maintenance for the patient who has proved that he rapidly relapses and for high risk patients—diabetes, the elderly with other medical problems. Most patients are not possible with any available treatment to prevent all relapses. On long term 

H2 blockade the annual relapse rates are between 10 and 47%, though I would accept that such relapses are rarely accompanied by complications.

Bismuth encephalopathy was associated with the prolonged use of high doses of insoluble bismuth salts.3 It is apparently reversible and has never been described with a daily ingestion of less than 1.5 g bismuth metal. It has never been described with tripotassium di-citrato bismuthate (De-Nol) in recommended doses, and more than 1.5 million treatments have been dispensed. The recommended daily dosage of tripotassium di-citrato bismuthate contains 480 mg bismuth. It has been proposed that bismuth preparations should be discontinued if blood concentrations exceed 100 µg/l, with 50-100 µg/l being considered an "alerting zone."4 Patients with encephalopathy have generally had levels of several hundred or several thousand µg/l, while in nearly 500 patients given therapeutic doses of tripotassium di-citrato bismuthate the mean level was 7.0 µg/l with only two values in the alerting zone (Bader JP, De-Nol Symposium, Sao Paulo, 1986). A simple way of estimating tissue bismuth concentrations is, however, clearly desirable.

Tripotassium di-citrato bismuthate is not recommended for long term maintenance, but a maintenance trial is in progress to assess its safety from this viewpoint (Porto Internista, De-Nol Symposium, Sao Paulo, 1986). It takes about two months for urinary bismuth values to return to pretreatment levels after a course of tripotassium di-citrato bismuthate, leading to the suggestion that there should be a two month period between successive courses (Bader JP, De-Nol Symposium, Sao Paulo, 1986).4

How, asks Dr Wormsley, should the data summarised in our leading article influence prescribing? I suggest that the logical use of tripotassium di-citrato bismuthate for the initial treatment of newly diagnosed duodenal ulcer. Until more information is available I would adopt a cautionary approach to its use, but even if two to four eight week courses of tripotassium di-citrato bismuthate a year were used the trials analysed in the leading article suggest that about 60% of patients could be kept under control.

J P AUL MILLER

University Hospital of South Manchester, Manchester M6 8LR


5 R BATEY

Drug and Alcohol Unit,
Werribee Hospital,
Werribee, Westmead, NSW 2145,
Australia.