Upholding research integrity: the need for an international collaborative effort

Sir,

China's medical research integrity has recently been called into question in an editorial in the *Lancet* (Anonymous, 2015). A total of 42 papers from Chinese researchers were retracted between March 26 and 31 2015 by Biomed Central as a result of concerns over fabrication and falsification of data (Anonymous, 2015). With rising misconduct, identifying and reflecting on such cases to promote integrity and rigour are welcomed (Khajuria and Agha, 2014a,b). However, research misconduct is a global phenomenon and retraction of papers exclusively from Chinese institutions by BioMed Central must not deter from international collaborative measures.

Fraud detection is challenging. Fanelli's (2009) meta-analysis of self-reported surveys revealed 2% of scientists admitting to misconduct, a likely conservative estimate of the prevalence because of the sensitive survey questions and other limitations. Methodologically, genetic verification and replication of independent experiments present further difficulties. Given these and other challenges (Anonymous, 2015), it is time to implement more robust measures to tackle an expanding global phenomenon.

An international, collaborative effort of researchers, journals, employers and funders, with international policy development, is required to nurture a culture of integrity at the individual and institutional level, targeting each stage of a researcher's development. Medical students lack experience in research methods and applying to research ethics committees (Ologunde et al, 2014). Higher research degrees should be encouraged with effective mentoring, guidance and teaching on research integrity. International grant-giving bodies should incorporate mandatory reports on investigations and integrity – promoting activities as prerequisites for funding (Khajuria and Agha, 2014a). These orchestrated by integrity officers will foster transparency (Khajuria and Agha, 2014a). Crediting publication quality not quantity would facilitate diversion from the 'publish or perish' notion. Moreover, whistle-blowers must be protected with concerns raised in a confidential manner (Khajuria and Agha, 2014b). These measures may facilitate a paradigm shift in research culture that is underpinned by the upmost integrity.

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Quality of life must be the deciding factor for the NHS

Sir,

The NHS must make £22 billion in savings by 2020 if it is to cope with the demands on its resources – an amount topping the 'Nicholson challenge' of the last parliament.

The question is how will those savings be made? Changes to care models, certainly. Inevitably, a review of procurement and purchasing. But there is also the question of whether these savings will affect clinical decision making and patients' access to the medical devices that ensure the best possible quality of life.

This is of concern to patients with chronic and degenerative conditions, including spinal injuries, multiple sclerosis and spina bifida. Many require intermittent catheterization to manage the continence issues they experience as part of their condition. For these patients, access to the right catheter to meet their individual needs is vital.

Standard practice is for these patients to use single-use catheters. But research is currently being undertaken to establish the utility of multiple-use catheters. While this is to be welcomed if it provides patients with more choice, there is a risk that it becomes a cost-cutting vehicle.

Such a study has the potential to fundamentally change clinical practice and which devices are available to patients. Were such a decision to be based on cost, and therefore reduce and limit the choices of patients and their access to devices that best meet their needs, it would be a betrayal of the founding principles of the NHS.

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