Whitehead, in socioeconomic deprivation and health.

As a short report our article must be regarded as preliminary; we now have further data accepted for publication regarding metabolic control of diabetes and deprivation, and we are extending our study to consider those diabetic patients whom we do not usually see, to allow for possible referral bias. We agree that geographically defined disease registers are desirable,⁴ and we would be happy to share ideas with other research workers.

We were not shown the critical letter before publication⁵; this would have been courteous and would have given us the right of concurrent reply. Finally, we agree with Douglas Altman that we should all strive for high standards in research work.⁵

WILLIAM KELLY
MIRANDA KELLY
RASHAD MAHMOOD

Diabetes Care Centre,
Middlesbrough General Hospital,
Middlesbrough TS5 5AZ

STEVE TURNER
KEITH ELLIOTT

Cleveland County Council Research and Intelligence Unit,
Middlesbrough TS1 2YW

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Journals are full of unoriginal and unimportant research

EDITOR,—I read Douglas G Altman's editorial with a profound sense of déjà vu.¹ Publications that have documented the scandal of bogus scientific research stretch back to, and possibly beyond, *Gulliver's Travels*.² Swift's allegorical account of scientific research, depicted in Gulliver's visit to the grand Academy of Lagado in the land of Balnibarbi, was based on a visit in 1710 to the Royal Society in London.

Errors in the design of studies and the analysis of data, misinterpretation of results, selective reporting, and selective citation of the literature in contemporary published research are the tip of the iceberg. One of the main problems confronting clinicians and researchers today is the enormous volume of published material. This has increased almost exponentially in my specialty (anaesthesia), which I suspect is representative of many others: in 1991, 53 anaesthetic journals were published worldwide, compared with two in 1923.³ Although anaesthesia has expanded enormously over this time, each journal seems to be publishing research that is increasingly unoriginal, unimportant, and invalid. Greene pointed out that many journals launched recently are sponsored by publishing houses rather than professional societies.³ This trend has resulted in different goals and perspectives for some journals; profit making publications are inevitably under pressure, however subtle, to continue publishing enough articles to stay in business.

I have two suggestions to improve morale and reduce the number of publications. Firstly, reputable biomedical journals should publish information on the number and quality of rejected papers. In addition, a selected number of papers that would otherwise be rejected should be published, without modification, accompanied by an educational and critical review. Secondly, authors should remain anonymous until their article has

been accepted or rejected for publication. This approach might dispel the notion that the inclusion of a well known person in the list of authors favourably influences the acceptability of submitted research.

There is little more depressing for a young researcher than to see unoriginal, unimportant, and invalid material being presented or published. Altman concludes that we need less research, better research, and research done for the right reasons. The impetus for these changes has to come from the top or we will discourage a whole generation of doctors from undertaking research.

IAN H LEWIS

Shackleton Department of Anaesthetics,
Southampton University Hospitals,
Southampton SO9 4XY

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Metal implants and cremation

EDITOR,—Matthew Barry reports the metal residues after cremation.¹ The guidance notes for the Environmental Protection Act 1990 (PG5(91)) define the cremation process, and all crematoriums in the United Kingdom must comply by 1 April 1998. The guidance notes refer to a minimum temperature of 850°C in the secondary chamber, but do not give any guidance on temperatures in the primary chamber, where any metal residues would remain throughout the cremation process.

Modern cremators that comply with the Environmental Protection Act are computer controlled, and it would be impossible for temperatures to reach 1600°C in either the primary or the secondary chamber. The refractory brickwork would not be stable above 1500°C. It would be extremely unusual for temperatures to approach 1200°C in the primary chamber, and I have never experienced a case of implants reaching their melting point.

I have regular contact with the Department of the Environment, and there is no suggestion that the minimum temperature in any of the cremation chambers will be increased. For these reasons I cannot see the need for implants to be removed before cremation in the future.

JON P LUBY

Federation of British Cremation Authorities,
Carshalton,
Surrey SM5 3HA

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Collecting data on cancer

EDITOR,—Few people would disagree with S J Karp's plea for improving the collection of data on patients with cancer.¹ The case Karp makes for the clinical oncology information network, however, is unconvincing. One justification claimed for the network is that three studies came to erroneous conclusions in auditing the outcomes of care because they used data for cancer registries.^{2,4} This is incorrect; Karp has misunderstood the studies' design.

All three studies were based on review of case notes; the cancer registry was used as all or part of the sampling frame. The third paper Karp quotes, by Chouillet *et al*, did not examine outcomes at all. The two others (which did) interpreted the differences in survival and disease free interval with care. Moreover, these and other studies that have used data from cancer registries augmented

by case notes have made important observations about the treatment of cancer.^{5,6} Data from cancer registries should not be used uncritically but will continue to be valuable for health services research.

A new information system is not a magic solution to the problems of inaccurate and poor data. Most errors in data result from a lack of, or poor quality, information in the case notes. The clinical oncology information network would be just as dependent as Körner and cancer registries on returns of clinical data.

Most worryingly, Karp suggests that the network would "belong to the Royal College of Radiologists," which would own the summary data and control access to them. That is unlikely to be the best way of improving services. Although peer review may be important, the evidence that it produces a sustained improvement in health services in the absence of other incentives is mixed.⁷ The lack of improvement in care noted in the recent confidential inquiry into maternal mortality emphasises this.

The reforms of the health service have resulted in health authorities being required to commission quality health care on behalf of their residents, which necessitates an informed dialogue between purchasers and providers. For that to happen, health authorities must have adequate information about needs, effectiveness, and the outcome of services. Health authorities, general practitioners, and patients need greater openness about information. Improving our current systems (including cancer registries) is a better investment than duplicating them.

IAN BASNETT

Camden and Islington Health Authority,
London NW1 2LJ

ALLYSON M POLLOCK

Department of Public Health Sciences,
St George's Hospital Medical School,
London SW17 0RE

MIKE GILL

Brent and Harrow Health Authority,
Harrow,
Middlesex HA1 3UJ

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Collapse of the health service in Georgia

EDITOR,—Like its neighbours Armenia and Azerbaijan, Georgia struggles with the political and economic backlash of the disintegration of the Soviet Union. Planning for most sectors of society was previously done in Moscow, and the economy was based on imports from Russia, including tourists and vaccines. Relations with Russia are strained at present, and trade is much reduced. Last year the violent secession of Abkhazia and South Ossetia forced 300 000 Georgians to flee and seek refuge in Georgia, which is an additional burden for the government.

The state run health system is grinding to a halt. During winter there is a lack of energy for heating hospitals and clinics. Patients rarely visit health institutions anyway owing to lack of transport,