failing hospitals have so far proved almost irresistible.

The guidelines offer a set of procedures to follow when a provider is in financial difficulty. Prominent among these are procedures for establishing that it is genuinely in financial difficulty. This is not as easy as it might seem, given the variety of possible indicators. The procedures for action once the lack of financial viability has been established all seem sensible enough and would greatly ease the necessary adjustments—if the political will were there to implement them. The problem, of course, is that the political will is often lacking, and here there is little that any NHS Executive guidance or other activity can offer.

Collusion or cooperation?

With respect to the problem of collusion, the guidelines enter even more tricky ground. One person's "collusion" is another's "cooperation," and the NHS has been more used to the rhetoric of cooperation than that of competition. But the guidelines' authors make a good case concerning the perils of collusive behaviour. They argue that collusion between providers allows them to exploit market power—to act as monopolists even though they are not monopolists. Collusion between purchaser and provider can prevent the entry of other organisations offering better quality services, thereby reducing patient welfare. The guidelines point out that many collusive acts, even within the internal market, would violate British company law concerning restrictive practices. They also mention prospective problems with European competition law—a growing area that will almost certainly affect the NHS internal market.⁴

Even if the guidelines are followed to the letter, they will

not resolve all the problems with the internal market. Although they address the problem of market exit, they say little about the mirror image problems of market entry—that is, how new providers are to be encouraged to enter markets where there is little existing competition. They say nothing about management costs or about patient dumping, yet the growth of NHS management costs and the premature discharge of long term patients into the community are, after hospital closures, the two most politically salient issues of the moment. And, even more serious from an economic perspective, there is nothing that would relax the stringent financial conditions under which most trusts operate. These seriously hamper trusts' ability to exploit the opportunities the market would give them.

However, as Alan Langlands, the NHS chief executive, says in his foreword, these guidelines are only the beginning; and overall they are an impressive beginning. This is the first departmental document that takes some of the lessons that economists have learnt from the operations of markets both inside and outside the health sector and applies them to the NHS internal market. The arguments are clear and comprehensive, and the policy guidance is operational. If the guidance is properly followed through, then the health service—its patients, its purchasers, and its providers—will be the better for it.

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Questioning academic integrity

Be prepared to defend yourself on live television

Academic conflict of interest has suddenly been given a high profile in Britain. The media have discovered that the Portman Group, which lobbies for the drink trade, offered £2000 each to five academics to produce anonymous criticisms of a book on alcohol policy.¹ The media, which have been awash with stories of "sleaze" in public life, are also concerned about the funding by the drink trade of the Alcohol Research Group in Edinburgh.^{2,3} These stories are forcing academics to reconsider the rules of academic life.

Alcohol Policy and the Public Good upset the Portman Group because it argues that increasing the taxation of alcohol reduces alcohol problems and that the current safe limits on alcohol consumption have a scientific basis.⁴ Published in association with the World Health Organisation, the book is the result of a two year review by an international group of 16 well known researchers chaired by Griffith Edwards, professor of addiction behaviour, University of London.

The Portman Group managed to obtain a prepublication copy from the WHO regional office in Copenhagen, and George Winstanley, director of strategy for the group, wrote to the academics, giving them a clear idea of what he wanted in the review:

"I do not think that this book can be allowed to go

unchallenged. Apart from its excessive length, it is in my opinion, unsatisfactory in the way it selects the evidence and draws conclusions from it. Results are reported and research cited selectively. Evidence which does not support the views expressed is frequently ignored. But I am far from an expert . . ."

Mr Winstanley told the academics that their 2000 word pieces would be collected into a "readable whole" and published by the group with no attribution except to say that "the group has consulted widely." The only academic whom we know to have received such a letter was Nick Heather of the Centre for Alcohol and Drug Studies in Newcastle upon Tyne. He refused to cooperate, and I am quoting from the letter to him. Although the others are not known, Mr Winstanley presumably selected those likely to produce arguments that would please his masters.

The day after this story appeared the *Independent* ran a story about the Alcohol Research Group in Edinburgh receiving funds from the Portman Group and the Scottish Whisky Association.² Professor Martin Plant and Dr John Duffy are the two main academics associated with the group, and Dr Duffy is known to be sceptical about the scientific validity of the safe limits that were originally recommended by three medical royal colleges in 1987.⁵ The

group has never made any secret of the source of its funding, but the public is sceptical about the relation between alcohol researchers and the drink trade.

Academic integrity

These two stories have prompted a vigorous debate over academic integrity and raise several complicated issues. The first issue is the propriety of lobby groups. Most people concerned about health are disgusted by the activities of organisations like the Portman Group or Forest (Freedom Organisation for the Right to Enjoy Smoking Tobacco), but these groups have a democratic right to campaign on behalf of their legal interests. They do, however, have access to much greater funds than most health groups, and they have disproportionate influence with government because of the economic muscle they represent. The Portman Group has also produced educational material on drinking,⁶ and many parents would probably prefer that such material came from a less biased source.

The second more difficult issue concerns academics accepting large sums of money to produce material that is used anonymously by a clearly biased group. Two thousand pounds for 2000 words is far more than the *BMJ* pays, but some columnists working for national newspapers would be paid more. Many surgeons would charge much more for operations that would need much less time than that needed to research and write 2000 critical words. In other words, £2000 may be the market rate.

What many will find more disturbing is the anonymity, but this issue is muddy as well. The *BMJ*, like most medical journals, uses anonymous peer review, and some journals—for instance, the *Lancet*—and most newspapers still publish anonymous editorials. Indeed, the highly respected *Economist* is almost entirely anonymous. Anonymity pretends a greater objectivity and authority than individuals can achieve. But in this case the audience for the Portman Group's book will inevitably doubt the authors' motives and the neutrality of their arguments. Anonymity is probably doomed to disappear from intellectual life but is currently alive and well.⁶

A third issue is the funding of research by organisations that have a clear interest in the results of that research. Nine years ago the *BMJ* published an anonymous editorial (which I'll now say that I wrote) arguing that it was wrong for researchers to take money from the tobacco or alcohol industries.⁷ The arguments were that the industry was given undeserved respectability and that the money might buy off a potential opponent, distort the research agenda, and possibly influence the results. Many people might still accept those arguments in relation to the tobacco industry, but they now sound precious in relation to the drink trade—mainly because of the accumulating evidence that small amounts of alcohol consumption are associated with reduced overall mortality.⁸

The fourth issue is conflict of interest. Substantial evidence has accumulated that doctors and others are influenced by financial and other conflicts of interest: bias is subtle and pervasive.⁹ The International Committee of Medical Journal Editors (the Vancouver group) has issued a statement on conflict of interest.¹⁰ The *BMJ*'s policy is that such conflict cannot be eradicated but should always be disclosed.¹¹ We now give the source of funding for all research papers published in the *BMJ*, and we send all authors of editorials and papers and referees a form asking if they have any conflict of interest. Such a form is not sent to all authors of letters—for logistic reasons—but we send a form to the authors of letters for publication whenever we think that there may be a potential conflict of interest. We have received many notifications of conflicts, and we have published several statements of conflicts. We will soon, we hope, be publishing a review of our experience. Broadly, the policy seems to be supported.

Academics: no place to hide

The final issue is the validity of giving public health advice based on fragile data. I was a member of the working party of the Royal College of Physicians that together with the royal colleges of psychiatry and general practice produced the safe limits, and perhaps we didn't acknowledge as adequately as we might have the paucity of the data we had on which to make a judgment. We chose to act as doctors must act everyday in giving advice on inadequate scientific data; and, as it turns out, the guess was probably a good one.

Perhaps the only confident conclusion from these complicated issues is that doctors and academics must consider very carefully the ethical implications of all their actions. A good guide when you are faced with a difficult decision is to consider whether you would be happy to be questioned about the decision on live television. Will those academics who have taken £2000 to write knocking copy on the WHO's book be happy to defend their actions on television (or in the letters pages of the *BMJ*)? If so, they should declare themselves.

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Editor

BMJ

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