# LETTERS

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HPV VACCINATION

## HPV is not an equitable virus

DR P MARAZZI/SPL

An editorial[1] and previous letter[2] discuss human papillomavirus (HPV) vaccination in boys in terms of inequity, and the authors point out that in Australia the vaccine is given routinely to boys as well as girls. The authors say the decision is not about science, purely about finances. The trouble is HPV is not an equitable virus: it causes more severe disease in women than men.

In 2007, the Australian government agreed to pay for HPV vaccine in girls because the vaccine was effective, and it was also estimated to be cost effective—it was not proposed for boys then. In 2013, when a vaccine company applied for boys to receive HPV vaccine, they offered the vaccine at a much lower price because of lower health gains being bought—anal and possibly oropharyngeal cancer and herd immunity—and the greater uncertainty. After some negotiation on price, the Australian government agreed to pay for boys because HPV vaccine was cost effective at the price offered. Cost effectiveness is an important concept that if ignored will result in governments spending money that could be better used on other healthcare interventions.

**David Isaacs** paediatrician, Children's Hospital at Westmead, Westmead, NSW 2145, Australia
david.isaacs@health.nsw.gov.au

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1 Stanley M, O'Mahony C, Barton S. HPV vaccination. *BMJ* 2014;349:g4783. (29 July.)
2 Mitchell D, Audisio R, Cruickshank G, Cannon S, Gill T, Hayes A, et al. Boys in the UK should be offered vaccination against human papillomavirus (HPV). *BMJ* 2014;348:g3762. (11 June.)

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## GUM clinics may not see young MSM before they acquire HPV

Stanley and colleagues discuss the need to vaccinate all young people against human papillomavirus (HPV).[1] Genitourinary medicine clinics may help in preventing HPV infection by offering vaccination opportunistically to men who have sex with men (MSM), but they may miss many young MSM.

An Australian study of 200 MSM aged 16-20 found that the proportion of men with HPV infection increased with each additional sex partner, and that nearly half had anal HPV by the time they had had anal sex with four partners.[2] The median age of first insertive or receptive anal intercourse was 17.[3]

We reviewed all MSM attending this UK level 3 sexual health service from 1 August 2013 to 1 February 2014. Data on MSM who attended on multiple occasions were analysed once, giving a final sample of 134. The median age at attendance was 32 and the median age at first attendance at our clinic 28. Our data suggest that most MSM would have had multiple sexual partners with increased risk of HPV acquisition before they attend any clinic.

The economic cost of warts treatment, as well as the psychosexual burden of recurrent genital warts, has been largely ignored.[4] An Australian study found that in MSM the incidence of genital and anal warts was 0.94 and 1.92 per 100 person years respectively.[5] In our clinic sample, 22% of MSM (29/134) presented with warts during 793 years of follow-up, giving an incidence of 3.66 per 100 years of follow-up.

Opportunistic vaccination of MSM at genitourinary clinics will not adequately access young MSM before they have become infected with HPV. We therefore strongly recommend the roll out of HPV vaccination to all teenage boys in the UK.

**Emily Clarke** specialty trainee in genitourinary medicine
emilyrclarke@doctors.org.uk
**Courtney Burtenshaw** specialty trainee in general practice, Department of Sexual Health, Royal South Hants Hospital, Solent NHS Trust, Southampton, UK
**Megan Goddard** medical student, University of Southampton, Southampton, UK
**Raj Patel** consultant in genitourinary medicine, Department of Sexual Health, Royal South Hants Hospital, Solent NHS Trust, Southampton, UK

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1 Stanley M, O'Mahony C, Barton S. HPV vaccination. *BMJ* 2014;349:g4783. (29 July.)
2 Zou H, Tabrizi SN, Grulich AE, Garland SM, Hocking JS, Bradshaw CS, et al. Early acquisition of anogenital human papillomavirus among teenage men who have sex with men. *J Infect Dis* 2014;209:642-51.
3 Zou H, Prestage G, Fairley CK. Sexual behaviors and risk for sexually transmitted infections among teenage men who have sex with men. *J Adolesc Health* 2014;55:247-5.
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5 Jin F, Prestage GP, Kippax SC. Risk factors for genital and anal warts in a prospective cohort of HIV-negative homosexual men: The HIM Study. *Sex Transm Dis* 2007;34:488-93.

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THE EXAM SCAM

## Appeals from candidates in MRCP(UK) examinations

Sokol recently discussed the appeal process for medical royal college and faculty examinations.[1] His historical reference to the Royal College of Physicians might lead readers to believe that the candidate described had taken an MRCP(UK) (membership of the Royal Colleges of Physicians of the United Kingdom) examination.

This is not the case. MRCP(UK), which delivers examinations around the world on behalf of the three UK colleges of physicians of Edinburgh, Glasgow, and London, does not charge any candidate a fee for an appeal.

Over 25 000 attempts are made at the Part 1, Part 2, PACES (Part 2 clinical examination), and specialty certificate examinations each year and the current appeal rate across these examinations is 0.4% overall. We believe that this reflects the fact that our examinations are conducted fairly, that we have developed robust and transparent guidelines and procedures for investigating and assessing appeals, and that we apply these fairly and consistently. Our appeals regulations are available on the MRCP(UK) website and explain the process in detail.[2]

Furthermore, to minimise any concerns about appeals having an adverse effect on any candidate, the MRCP(UK) appeals process, which is mostly carried out using documents, is entirely anonymised. Candidates are referred to only by their examination code numbers, and all relevant documents are redacted so that the names of candidates are removed. If an appeals hearing is convened, the candidate is informed of its composition well in advance, and the panel will always contain a lay representative.

We trust that this information will dispel any unnecessary concern or uncertainty in the minds of current or future MRCP(UK) candidates that might have been caused by Sokol's article.

**Andrew T Elder** medical director, MRCP(UK), London NW1 4LE, UK andrew.elder@mrcpuk.org

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1 Sokol D. The exam scam. *BMJ* 2014;349:g4808 (28 July.)
2 MRCPUK (Membership of the Royal Colleges of Physicians of the United Kingdom). The Federation of the Royal Colleges of Physicians of the United Kingdom examination appeals regulations. www.mrcpuk.org/sites/default/files/documents/Appeals-Regulations.pdf.

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SHOULD RESEARCH FRAUD BE A CRIME?

## First you find the "criminals"

Bhutta and Crane debate whether research fraud should be a crime.[1] In the United States, the Office for Human Research Protections (OHRP) of the Department of Health and Human Services (HHS) investigates allegations of misconduct in biomedical research involving humans. It investigates studies that are HHS federally funded, or when a federal-wide assurance extends government requirements to non-federally funded research.

It has jurisdiction over more than 10 000 such institutions that receive billions in research funding each year from the National Institutes of Health and other HHS agencies.

OHRP has the authority to sanction individual researchers, but it has never done so. Instead, it imposes sanctions, rarely, on universities. According to its data, which I reported, OHRP opened one investigation in 2013.[2] So far this year, it has opened three, I recently learnt.

Those are just opened investigations, and not cases seen to closure with a finding and enforcement action. This represents an acceleration of the trend of declining numbers of investigations occurring over the past five years—a time when the office has downsized its staff and other activities.

The HHS Office of Research Integrity, as others have noted, pursues cases of fabrication, falsification, and plagiarism; its jurisdiction overlaps with OHRP's. By contrast, its caseload and findings have been growing, fuelling an increase in retractions. It could be argued the cases that come to OHRP are more likely to result in harm to patients than those involving fabrication, falsification, and plagiarism.

Theresa C Defino journalist, Report on Research Compliance, Rockville, Maryland, USA
tdefino@aishealth.com

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1 Bhutta ZA, Crane J. Should research fraud be a crime? *BMJ* 2014;349:g4532. (15 July.)
2 Defino T. With just one investigation in 2013, OHRP seems "invisible" after SUPPORT dust-up. Report on Research Compliance. May 2014. www.reportonresearchcompliance.com/rrc-reprint-0514.pdf.

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## Fraud tactics and penalties

The cliché states that extraordinary claims require extraordinary proof. A less well known corollary is that ordinary claims often require little or no proof at all.[1] It is possible to produce substantial amounts of research that is entirely made up provided that one keeps it plausible and boring so nobody is tempted to replicate it; one adds the regulation amount of "noise" to the data; and one varies the noise occasionally to avoid getting caught by identical statistics.

Fraud mostly succeeds even when found out because there is no winning strategy for a whistleblower other than leaving the laboratory and keeping his or her mouth shut. Whistleblowers are loathed even when they are right. In countries that have central research integrity authorities, report the fraud to them and let them do their work.

As for penalties, people found to be frauds should be made personally liable for misappropriated funds. This would focus people's minds wonderfully, and refund the cost of expensive investigations.

Luca Turin research scientist, Theoretical Physics, Ulm University, 89069 Ulm, Germany
lucaturin@me.com

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1 Bhutta ZA, Crane J. Should research fraud be a crime? *BMJ* 2014;349:g4532. (15 July.)

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WHO ON ESSENTIAL MEDICINES

## Who is WHO's expert committee?

Barbui and Purgato call for reforms to both the standard of applications to and the clarity of reporting of decisions by the World Health Organization expert committee on essential medicines.[1] But they don't go far enough. It isn't just the decisions that need more scrutiny but the composition of the committee too.

We are told only that the committee is made up of experts, "appointed by the WHO director general," who meet "every two years to review applications with expert assessors and decide which medicines are added or deleted." Just try to find out from the WHO website who the committee members are before a committee meeting—as opposed to when the meeting report is published—let alone their qualifications, fitness for the role, or conflicts of interest. Why is there never a call for nominations to the committee? The list of current members smacks of croneyism, the appointments process is opaque, and the decisions lack clarity. Transparency is its own reward; WHO should try leading by example.

Craig Welch health policy consultant, Garran, Australian Capital Territory, Australia
craigwelch@gmail.com

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1 Barbui C, Purgato M. Decisions on WHO's essential medicines need more scrutiny. *BMJ* 2014;349:g4798. (31 July.)

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CALCANEAL FRACTURES

## Cover line was misleading

*The BMJ*'s print cover of the issue of 2 August 2014 is misleading. It says boldly, "Calcaneal fractures: surgery provides no benefits." Griffin and colleagues mentioned clearly the exceptions to their conclusion, which the front page does not convey.[1] The authors excluded extra-articular fractures, open fractures, and "grossly displaced fractures," the last two of which were presumably all treated surgically.

Graham C Cheung consultant orthopaedic surgeon
gckcheung@hotmail.com
Gunasekaran Kumar consultant orthopaedic surgeon, Royal Liverpool University Hospital, Liverpool L7 8XP, UK

Competing interests: None declared.

1 Griffin D, Parsons N, Shaw E, Kulikov Y, Hutchinson C, Thorogood M, et al, for the UK Heel Fracture Trial (UK HeFT) investigators. Operative versus non-operative treatment for closed, displaced, intra-articular fractures of the calcaneus: randomised controlled trial. *BMJ* 2014;349:g4483. (24 July.)

Cite this as: *BMJ* 2014;349:g5208

TACKLING RACIAL DISCRIMINATION

## Requires political commitment

Macmillan Cancer Support agrees that the treatment of black and minority ethnic staff in the NHS is a good predictor of patient experience among all patients.[1] In hospital trusts where clinical staff report the highest rates of discrimination, patients with cancer are up to 18 times more likely to report a poor quality experience during their hospital compared with trusts with the lowest rates of discrimination.

The 2013 NHS staff survey shows that around one in five (19%) black and minority ethnic hospital staff had experienced racial discrimination in the previous 12 months, compared with just one in 50 (2%) white staff. All of these data remind us that racism and discrimination in the NHS are serious issues that the government and NHS leaders must tackle.

The upcoming general election is the perfect opportunity to achieve genuine, widespread change for both patients and staff. In their manifestos, political parties should commit to ensuring that all patients with cancer are treated with the greatest dignity and respect and that staff are supported to deliver this. If we are serious about ensuring patients are at the heart of the NHS, all staff must have everything they need to be caring, compassionate, and committed.

Jagtar Dhanda head of inclusion, Macmillan Cancer Support, London SE1 7UQ, UK
jdhanda@macmillan.org.uk

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1 Limb M. NHS must tackle racial discrimination against staff and patients, report says. *BMJ* 2014;349:g4781. (23 July.)

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