Grant systems in Canada's Health Research Council

The Medical Research Council will complete its evolution into the Health Research Council of Canada (see *Lancet* 1993; **342:** 606) by opening all its grant categories and competitions to applications from outside the basic biomedical research community. And in a series of operational changes designed to decentralise decision-making, the agency will create a system in which applicants for all MRC awards are directly competing with one another for monies in one of two categories—research programme or personnel. The approach will restrict the MRC's ability to designate specified amounts of money for categories of grants (for example, equipment) or subject areas deemed to be of strategic national importance.

But MRC president Dr Henry Friesen says central committees should not be determining the priority areas; scientific excellence alone should be the standard. He argues that individual scientists spend much time evaluating the opportunities and market niches and how their peers will review their choices. If, as for businessmen, the choices are wrong, they pay a high price—failure. "I mean the priorities are determined, collectively, I submit, by the distilled wisdom of the 5-8-10 000 scientists across the country more effectively than by a committee of wise people sitting in Ottawa on a Friday afternoon."

In some respects, that same free-market ethic imbues the MRC's decision to approve the recommendation of an internal Task Force on Health Research to open its Can$240·2 million grants and scholarships pot to health research, instead of designating a percentage of its budget for such research. Because of the difficulties of directly comparing health with biomedical applications and the relative lack of expertise at peer reviewing health research, the MRC has also committed itself to "adjusting our peer review mechanisms, accordingly and appropriately, to ensure fair and equitable access to the system", said Friesen.

The MRC's process of dividing its spoils among its 23 peer review committees is for committees to rate applications on a 1–4 scale. All ratings are then put on a master list and a cut-off line, depending on availability of funds, is drawn. A guarantee that both a minimum and a maximum percentage of applications to any committee are successful provides a hedge against ratings abuse and ensures that at least some applications within any discipline are funded. If the health research community gets one new committee, they will be guaranteed roughly one-twenty-fourth of the MRC pie. But if, through time, the number of applications for health research forces the creation of several new committees, the health-research share of the pie will increase. However, since the number of committees is essentially the MRC's only remaining mechanism for distributing funds among various disciplines, committee creation would anger biomedical researchers, who were sold on the merits of expanding the MRC's scope into health research on the proviso that the funds needed for the process would be new monies. (Already a proposal to restructure the committee system was shot down by the governing council because of gripes from disciplines such as dentistry and pharmacy, and referred for further study to a newly created Standing Committee on Peer Review.)

But Friesen notes that monies available to the biomedical community will expand by about $500 million over the next 5 years through initiatives such as the Pharmaceutical Manufacturers Association of Canada/MRC Health Partnership Fund, (see *Lancet,* 1993; **341:** 1402). He also contends that the decision to peer review individual and team grants in the same competition will not prejudice one or the other in the ratings because the same benchmark will be used in assessing both types of applications.

Wayne Kondro

RACP on doctors' links with drug industry

The Royal Australasian College of Physicians has released guidelines advising fellows how to maintain an ethical relationship with the pharmaceutical industry. The basic message is simple: if you would have any qualms about the relationship being made public, don't do it.

The college warns that although doctors are not the consumers of the products, they are agents for the consumers. It also warns that doctors are not immune from skilled advertising techniques.

In clinical trials, doctors should accept payment for time or income lost but should not be paid on the basis of so many dollars for each patient enrolled. The college also says it is unacceptable for pharmaceutical companies to stipulate that research cannot be published without their permission but, surprisingly, says "it is appropriate for the sponsoring company to be given the opportunity to comment before publication".

It warns that product samples should not be accepted, since the gift of samples is usually "a marketing exercise designed to accustom the physician to prescribing a certain product or to establish a cohort of patients on long term treatment with a particular drug". It also warns that "particular care should be taken in the light of a trend to the provision of lavish dinners disproportionate to the content of the accompanying scientific presentation".

Unfortunately, the guidelines are vague when it comes to what gifts are acceptable and what are not, saying only that there is a "gradient of acceptability". Some are obviously fine and some are obviously not. The large grey area in the middle remains undisturbed by the college's deliberations.

Mark Ragg

Funding reviewed for biomedical centres in Canada

Canada's five biomedical research Networks of Centres of Excellence are among the ten (out of fourteen) that survived a competition for funding renewal for the 4-year phase II of the NCE programme, which was designed to promote collaborative research in areas of economic and social importance to Canada. The competition had been marked by controversies over funding and a change in selection criteria that emphasised industrial relevance (see *Lancet* 1993; **342:** 606). Allocations will be scaled back each year to force centres, through time, to generate more of required monies from external sources.

Protein engineering, headed by recent Nobel Prize winner Dr Michael Smith, receives Can$17·2-million for 4 years. Rated highest by the peer review committee, it was praised for having "extensive involvement of industrial partners" in its research programme. Bacterial diseases ($15·6 million), which is studying bacterial attack and host response, is cited for the "strength of its research component" but urged to improve its multidisciplinary collaboration and the participation of multinational companies. Neuroscience receives $21·94 million for its studies on recovery from neurodegenerative disorders caused by trauma or disease. Working in an area in which there is no receptor industry, this NCE was lauded for having persuaded a major bank to create a $100 million fund to help build an indigenous industry. Genetic diseases ($15 million) was recommended as the appropriate vehicle by which Canada can "establish competence in gene therapy". Inspiraplex (respiratory disease), which is studying chronic obstructive pulmonary diseases, receives $10·6 million. It was urged to improve its links with industry.

The renewal of only ten networks guarantees that $48 million of the $192 million/4 year NCE pot will be available for a new competition in five areas, one of which is health research.

Wayne Kondro