

link with academic reward is the cause for this malfunction. Science is a human effort and is thus inevitably contaminated with all human weaknesses.⁴ Individual researchers or groups who accept a false coauthor cannot be controlled by signing solemn statements, even when their roles are explicitly described in the contributor section. Those who lie can lie at any time, and asking for signatures or contribution descriptions would not change this fact.

As long as publication is the sole basis for academic advancement, a solution is unlikely to be found. However, it would be worthwhile to construct a simple system of self-regulating authorship rules, applicable to less authoritative journals and to less organised environments, in which the coauthoring of significant papers means even more than in mainstream science.

The basis for such a system could be partial authorship,⁵ under which an article bears one unit of authorship that is equally divided among authors. A scientist's production is judged by his or her sum of partial authorships, so they would be reluctant to accept undeserving colleagues, and the system would function without outside control. This system could be made more sophisticated by ascribing higher partial authorship to the first or last author, by associating the article's authorship units with a journal's impact factors and by further weighting of the authorship-journal association by use of impact factors corrected by the size of the research area.⁵

We are aware that partial authorship is not a new idea. However, false authorship is not new either, and, as Horton's article¹ proves, calls for action. Even an imperfect solution is better than a lasting dilemma.

Ana Marušić, Matko Marušić

Croatian Medical Journal, 10000 Zagreb, Croatia
(e-mail: cmj@mamef.mef.hr)

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Randomised trials are not unethical

Sir—F L Hinsen and N S Ambrose (March 20, p 1012)¹ suggest that it would be unethical to randomise patients with distal rectal tumours to anything less than a total mesorectal excision on the basis of studies with historical controls and on the finding that 30% of such patients would have tumour deposits in the mesorectum that would be left behind. History of oncology has taught us otherwise. The presence of such metastases may reflect a poor prognosis rather than be a determinant of prognosis.

For example, in the NSABP-B04 trial² that compared total versus radical mastectomy for breast cancer, 40% of those randomised to radical mastectomy had involved lymph nodes. According to this finding, it would be deemed unethical to randomise patients to anything other than radical mastectomy. However, only 17.8% of those randomised to total mastectomy had axillary recurrence and there was no difference in survival, even though the patients with pathological nodal involvement had a worse outcome.

In a review of adjuvant chemotherapy for oesophageal cancer,^{3,4} the meta-analysis of eight studies that used historical controls showed a reduction in mortality by as much as 68% ($p < 0.000001$). Such results would have deemed a randomised trial unethical. However, 12 randomised trials were undertaken during the same period and their meta-analysis, with a 95% power to detect a 10% difference, did not reveal any survival benefit.

Call randomised trials difficult, very difficult, or nearly impossible to do—but please do not call them unethical. It is the uncontrolled experiments that perpetuate unproven and potentially harmful treatments.

Jayant S Vaidya, Michael Baum

Department of Surgery, Academic Division of Surgical Specialties, Gower Street Campus, Royal Free and University College Medical School, University College London, London W1P 7LD, UK

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Typhoid Mary

Sir—Philip Mortimer's article (April 17, 1354)¹ on the spread to England of Koch's message on the typhoid carrier state and the sad story of Mr N the milker was well received. However, Mortimer underplays the historical importance of the USA's first typhoid carrier, "typhoid Mary". His citation from a 1954 textbook is a disservice to her discoverer, George Soper, to the New York City Department of Health, to her long epidemic career (it was not 26 cases but 54, with four deaths, in nine different epidemics), and to Mary herself.

Mary Mallon was a Catholic, Irish-American immigrant, surviving on her own as a cook in a turn-of-the-century, Protestant-dominated city, controlled by a quasi-police health bureauopathy. She justifiably refused to accept its new dictum about typhoid carriers. That was her tragedy. Judith Walzer Leavitt's definitive book² describes her discovery and its aftermath. Typhoid Mary, not Mr N, deserves better appreciation and respect.

John S Marr

22 Lia Fail Way, Cos Cob, CT 06807, USA

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DEPARTMENT OF ERROR

Risk of cervical cancer and geographical variations of human papillomavirus 16 E6 polymorphisms—In this letter (Oct 31, p 1998) the legend to the figure should read aminoacid changes in the Italian multivariants: R10G, Q14H, Q14D, I27R, D64E, H78Y, L83V.

Transmission of Mycobacterium tuberculosis from patients smear-negative for acid-fast bacilli—In this article by M A Behr and colleagues (Feb 6, 1999, p 444) figure 2 should have appeared where figure 3 was placed, and vice versa.

Transmyocardial laser revascularisation in patients with refractory angina: a randomised controlled trial—In this study by P M Schofield and colleagues (Feb 13, p 519), in figure 2 the key should have been solid line for medical management, dashed line for TMLR.

A pill a day, or two, for hepatitis B? In the commentary by Geoffrey Dusheiko (Mar 27, p 32), the last sentence of the 4th paragraph should have read "It [BMS 200475] decreases supercoiled HBV DNA, but its safety in human beings is unproven".

Elective caesarean-section versus vaginal delivery in prevention of vertical HIV-1 transmission—In this article by the European Mode of Delivery Collaboration (*Lancet* 1999; **353**: 1035–39), the acknowledgments should have included The French trial was supported by the Agence Nationale de Recherches sur le Sida, Trial ANRS 050.