likely to be promoted may in part reflect this. Investigating this point would require complete data on employment history since graduation. The data will also include doctors in the training grades who may not want to become a consultant, and the results may be partly reflecting the preferences of this group, who are more likely to be female and work part time. However, this group is likely to be small.

Conclusions

The achievement of current government targets for the numbers of consultants are influenced by the promotion process and the quality control exercised by the royal colleges. As the proportion of female doctors increases, it will be difficult to meet government targets unless the promotion process is re-examined. This should focus on the weight given to individuals' skills and ability and the flexibility of contracts and working conditions. Safeguards will need to be in place to ensure that factors less likely to be related to ability or performance (such as sex, place of graduation, or part time working) will not influence promotion chances. Since 2000, when the data used in this paper finish, several changes have been intro-duced that have altered the career structures of hospital doctors. These include the Calman reforms, Modernising Medical Careers, further proposals for reform of the staff or associate specialist grades, and new contracts for junior doctors and consultants. It is unclear what impact these changes will have on the issues discussed in this paper.

1 Wooldridge JM. *Econometric analysis of cross section and panel data*. London, England: MIT Press, 2002:453-509 (chapter 15).
2 Baltagi B. *Econometric analysis of panel data*. 2nd ed. Chichester: John Wiley, 2001:11-27 (chapter 2).
3 Lambert TW, Goldacre MJ, Vallance E, Mallick N. Characteristics of consultants who hold distinction awards in England and Wales: database analysis with particular reference to sex and ethnicity. *BMJ* 2004;328:1347.

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Corrections and clarifications

Achieving the millennium development goals for health: Cost effectiveness analysis of strategies to combat malaria in developing countries

A mix-up during submission led to the wrong version of table 3 being included in the full version of this paper (see bmj.com) by Chantal M Morel and colleagues (*BMJ* 2005;331:1299-302, 3 Dec). The R_0 value for case management with chloroquine should be 0.35 (rather than 0.3). The adherence for artemisinin based combination treatment should be 35% (not 40%), and neither that nor the adherence for non-artemisinin based treatment needs a footnote. Values for probability of success when patients were not fully compliant should be 35% for non-artemisinin based treatment and 0% for intermittent presumptive treatment during pregnancy (rather than 35% and 10% respectively, as given). These revised values also apply to table B on bmj.com.

ABC of health informatics: Improving services with informatics tools

The authors of this ABC article, Frank Sullivan and Jeremy C Wyatt (*BMJ* 2005;331:1190-2, 19 Nov), inadvertently omitted an acknowledgment from the two tables at the top of p 1191 containing information on the analysis of approaches to changing clinical practice: internal and external processes. They were first published by Grol R. *BMJ* 1997;315:418-21.

Legislation for smoke-free workplaces and health of bar workers in Ireland: before and after study

Two errors occurred in this paper by Shane Allwright and colleagues (*BMJ* 2005;331:1117-20, 12 Nov). The model coefficients for cotinine concentrations in table 5 in the full version of this paper (see bmj.com) were wrong because they had not been corrected to take account of the conversion to SI units in table 6. The corrected table is at bmj.com (http://bmj.bmjjournals.com/cgi/content/full/331/7525/1117/DC1). The authors state that the revisions do not alter the conclusions of the paper. Also, in the abstract, the figures in parentheses after the median cotinine values are interquartile ranges not confidence intervals.

Primary care in the United States: problems and possibilities

Electronic difficulties while handling the proofs led to an error and an omission in this article by Robert L Phillips (*BMJ* 2005;331:1400-2, 10 Dec). The author's job title was wrong; he is in fact director of the Robert Graham Center. In addition, the article should have contained the following disclaimer: "The information and opinions contained in research from the Graham Center do not necessarily reflect the views or policy of the American Academy of Family Physicians."

Extra scrutiny for industry funded trials

The title of this editorial by Kenneth J Rothman and Stephen Evans (*BMJ* 2005;331:1350-1, 10 Dec) should have referred to "studies," not "trials." The authors discussed all reports containing original data, so "studies" would have been more accurate. The use of the word "trials" was the result of a late editorial intervention.

Treatment of bites by adders and exotic venomous snakes

In this Clinical Review by David A Warrell, the author's email address was wrong (*BMJ* 2005;331:1244-7, 26 Nov). The correct address is david.warrell@ndm.ox.ac.uk

Randomised placebo controlled multicentre trial to assess short term clarithromycin for patients with stable coronary heart disease: CLARICOR trial

The main text and the summary box in this paper by Christian M Jespersen and colleagues (*BMJ* 2006;332:22-4, 7 Jan) refer to the patients in the trial being followed for up to three years. The authors have clarified that the mean follow-up was 960 (range 900-1070) days.