bmj.com US Republicans try to restrict health insurance cover for abortion
UK news Adviser accuses minister of "lying" over "new" money, p 353
World news Switzerland is to fund complementary therapies while effectiveness is evaluated, p 355

For the full versions of articles in this section see bmj.com

Revalidation plans don't tackle poor performance, MPs say

Clare Dyer BMJ

The General Medical Council's plans for revalidating doctors in the United Kingdom to ensure they remain fit to practise pay too little attention to how to deal with doctors who give cause for concern, the House of Commons select committee on health has concluded.

"We regard this as an important weakness in the current proposals which the GMC needs to address if the introduction of revalidation is to help sustain public confidence in the medical profession," say the MPs in a report published on Tuesday 8 February.

The committee calls on the GMC to publish clear guidance to responsible officers—those with responsibility in the workplace for ensuring that revalidation is carried out—on how to deal with such doctors.

It says, "The committee is concerned that the instinctive use of the word 'remediation' in cases where a doctor's performance gives cause for concern may have the effect of pre-judging the appropriate response to a set of circumstances.

"While it is important to ensure that the rights and legitimate interests of doctors are safeguarded, the primary purpose of revalidation is to protect the interests of patients."

The MPs broadly support the GMC's conclusion that revalidation should be based on employers' appraisal and on clinical governance systems. But they cite evidence that implementation of appraisal systems is "patchy" around the country. "If an adequate appraisal system is not provided for all doctors, then revalidation, as currently envisaged, will not work," the report says.

The GMC's chief executive, Niall Dickson, said, "This report makes clear that the committee shares the joint commitment of the GMC and the four UK health departments to introduce revalidation by the end of 2012. It remains our number one priority. The report rightly highlights areas where more work is needed."

On the question of doctors from the EU he added, "We are determined to find a solution . . . to ensure patients are fully protected."

Revalidation of Doctors **is at www.publications.parliament.uk.**

Cite this as: *BMJ* 2011;342:d872

PAUL GROVER/REX

Baroness Young, of Diabetes UK, is one of those calling for GP consortiums to be made accountable

NHS reforms do not empower patients, charities say

Jacqui Wise LONDON

Eight leading health charities have criticised the health reforms in England, saying that the plan to make GP commissioning consortiums accountable to the public are far too weak.

The Health and Social Care Bill, which has just reached the committee stage (*BMJ* 2011;342:d837, 8 Feb), places £80bn of the NHS budget in the hands of the GP led consortiums. One of the stated aims of the reforms is to empower patients. But in a letter to the *Times* the charities say that the changes do little to give patients a stronger voice at the local level (8 Feb, p 20).

The letter, signed by the Alzheimer's Society, Asthma UK, Breakthrough Breast Cancer, Diabetes UK, National Voices, Rethink, the British Heart Foundation, and the Stroke Association, calls for amendments to the bill to strengthen independent scrutiny of the consortiums.

The charities say, "Plans to make GP consortia accountable to the public are far too weak. The plans will allow local authorities to replace existing democratically elected overview and scrutiny committees with their own systems. Hence, we urge the Government to amend the Bill and insist on a strong independent scrutiny function led by democratically elected representatives."

The charities say that they support the government's aim to put involvement of patients and democratic accountability at the heart of the healthcare system. But there "is a gap between rhetoric and reality," they add.

Under the reform plans the current local involvement networks are to evolve to become local HealthWatch organisations and will provide feedback to HealthWatch England. The government says that HealthWatch England will be a strong, independent body that can represent the views of patients and communities.

But the charities say that local HealthWatch bodies will not have the powers or resources to ensure that patients have a say in the local health services.

A health department spokesperson said that the letter raises constructive points. "We will work together to ensure that the bill, which is in its early stages, delivers the reality of improved patient involvement.

"Our modernisation plans would give patients, local authorities, and the public real clout over the shape of NHS services. At present it is weakened by distant administrators, inadequate powers for public and patient groups, and a democratic deficit."

Cite this as: *BMJ* 2011;342:d903

Pfizer closes Kent plant as it trims research by $1bn a year

Nigel Hawkes LONDON

Pfizer, the world's biggest selling drug company, has announced plans to close its research and development plant at Sandwich in Kent, with the loss of 2400 jobs.

The closure is part of a plan to trim research spending from over $8bn (£4.9bn; €5.8bn) a year to less than $7bn and to focus on areas that offer the greatest promise, such as cancer and vaccines. Like other big drug companies Pfizer is responding to the declining productivity of traditional drug research and hoping to acquire new products by buying up small biotech companies.

The immediate aim is to meet earnings targets in 2012, which are threatened by two major brands, Lipitor (atorvastatin) and Viagra (sildenafil), coming off patent in the United States. Lipitor, acquired when Pfizer took over Warner-Lambert a decade ago, is responsible for nearly a fifth of Pfizer's revenues.

The sweeping changes come just two months after Ian Read, Scots born and a graduate of Imperial College London, took over as Pfizer's chief executive after the board lost confidence in his predecessor, Jeffrey Kindler.

This week he was forced to announce a 4% drop in net income for 2010 and to warn that 2012 sales would be $2bn lower than previous estimates. Analysts viewed his decision to slash research spending as positive, and the company's shares jumped by 5% on the day.

The UK view was very different. Pfizer is the major employer in east Kent, an area that otherwise lacks economic muscle, and its Sandwich plant is isolated. The lack of close university contact and its location in a rural area always made the Sandwich lab an anomaly, but its productivity was undeniable. Viagra was among many successful drugs developed there. Finding any new use for the huge plant will be difficult.

INVICTA KENT MEDIA/REX

The lack of close university contact made the Sandwich lab an anomaly, but it was highly productive

Nationally the closure of Sandwich raises serious questions about the future of biomedical research in the UK, and leading experts were quick to offer reassurances. The BioIndustry Association acknowledged that the news was "grave" but insisted it did not change the fundamentals of the UK as a location for research and development.

Nigel Gaymond, chief executive of the association, said: "The UK remains the second

Scrutiny phase brings chance of change to NHS reform bill

Adrian O'Dowd LONDON

Interested parties are hopeful that important changes to the government's planned reforms of the NHS can be achieved as the Health and Social Care Bill enters its next parliamentary phase before becoming law.

After a comfortable vote supporting it in the House of Commons on 31 January (*BMJ* 2011;342:d711) the bill is due to be scrutinised by a newly appointed committee of 26 MPs.

The committee is made up of 11 Conservatives, three Liberal Democrats, 11 Labour MPs, and one Democratic Unionist Party MP. Members include Kevin Barron, the Labour MP for Rother Valley and former chairman of the health select committee, the current health ministers Simon Burns and Paul Burstow, and Daniel Poulter, the Conservative MP for Central Suffolk and North Ipswich and an NHS doctor.

The committee stage allows all interested parties to submit written and oral evidence before the end of March and to propose amendments to the bill before it is debated again in the House of Commons in its third reading. The bill may become law as early as July this year or as late as spring 2012.

Several expert witnesses were due to appear before the committee on Tuesday 8 and Thursday 10 February, after the *BMJ* went to press.

These include the NHS chief executive, David Nicholson; the BMA's chairman of council, Hamish Meldrum; the chief executive of the healthcare think tank the King's Fund, Chris Ham; and witnesses from the NHS Confederation, the representative body for most NHS organisations, the public sector unions Unison and Unite, the health think tank the Nuffield Trust, and the NHS Alliance, which represents primary care doctors.

At more than 500 pages long the bill is the longest ever piece of legislation related to the NHS.

The King's Fund believes that the bill raises many unanswered questions. Anna Dixon, its director of policy, said, "I think the Liberal Democrats will be scrutinising quite carefully the powers of the [proposed] Health and Wellbeing Boards, which seem rather weak. There isn't perhaps sufficient requirement on GP consortia [the new commissioning bodies] to work closely with local authorities.

"Another area that Labour will major on is the establishment of the economic regulator Monitor and the powers being given to it to promote competition and how those will work out in practice, given that it does seem from the bill that they have pretty significant powers."

These were quite complex reforms, she added, saying, "It will be very challenging for the Commons bill committee in the short time it has to effectively consider all aspects. There will be more opportunity for that in the Lords."

The BMA wants major changes to the bill before it becomes law and has called for ongoing implementation of the reforms to be halted in the meantime. It is worried that enforced competition in the new system, in which different providers of health services can undercut each other on price, will make it difficult to achieve the best quality care for patients.

The BMA wishes to see several amendments to the bill to ensure that the new NHS Commissioning Board is autonomous and that commissioning consortiums are not undermined by political interference. It also wants consortiums to be required to involve consultants, medical academics, and public health consultants in developing clinical pathways.

Clare Gerada, chairwoman of the Royal College of General Practitioners, said, "We believe that the reforms as currently set out will damage GP-patient relations and invite excessive competition in the healthcare market, which will be driven by price to the detriment of quality."

The college wants to see various amendments that would mean that the reforms are piloted in one or two (diverse) regions of England and then assessed before being rolled out nationally. It would also like to see the National Institute for Health and Clinical Excellence continue to provide definitive guidance to the NHS on the use of new drugs.

Cite this as: *BMJ* 2011;342:d837

home next to the US for the pharmaceutical and biotech industry, and indeed Pfizer's commitment to their Cambridge site, where they have announced there will be a new Pain and Sensory Disorders Unit—as their global hub in Europe demonstrates this."

Mark Walport, director of the Wellcome Trust, said that Pfizer had made it clear that the closure was not a reflection on the climate for biomedical research in the UK. Richard Barker, director general of the Association of the British Pharmaceutical Industry, insisted that the UK bioscience environment remained "world class."

The worry is that the business model that has made stock market darlings of the drug companies is broken and that nobody has discovered an alternative. The pipeline of new products is insufficient to maintain them in the manner to which they have become accustomed.

Cite this as: *BMJ* 2011;342:d771

Stages of the Health and Social Care Bill

- The bill is now in its committee stage, during which it will be examined in detail. This stage is expected to finish on 31 March.
- The 26 MPs appointed to the bill committee will go through each clause, question witnesses, and discuss written evidence from interested parties to consider and debate any amendments.
- After committee stage the bill returns to the House of Commons for its report stage, when the amended bill can be debated and further amendments proposed.
- Immediately after this is the third reading, a final chance for the House of Commons to debate the contents. If MPs vote to approve the bill it then goes to the House of Lords, where the same steps are repeated.
- After the Lords' process the bill is passed back for the House of Commons to look at the Lords' amendments, and the reverse also takes place. The bill goes back and forth until both houses agree it.
- The bill receives royal assent, becomes an act of parliament, and is then law.
- The government is keen to have the bill become law before the summer recess on 19 July, but given its size and the scale of change it proposes the process could take until spring 2012.

DEPT OF HEALTH

Kevin Barron, Simon Burns, and Paul Burstow are on the committee that is scrutinising the bill

"Disruptive" doctors are often found to be perfectionists

Jane Feinmann LONDON

Doctors' disruptive behaviour will no longer be tolerated simply because they are good clinicians, warned Alistair Scotland, director of the National Clinical Assessment Service, last week.

Speaking at the annual conference in London of the advisory body, Professor Scotland said, "The usual approach of saying, 'I know he's a prat, but he's the best cutter in the hospital,' is no longer acceptable, because a team that isn't at peace can't be regarded as assuredly safe."

The conference heard that the stereotype of its clients as scalpel throwing surgeons was inaccurate. With more than 1000 referrals in the past year the service reports that the doctors who were most likely to be referred were older clinicians, particularly male consultants and singlehanded GPs. But most of the 279 clinicians who were referred for psychological assessment were "emotionally stable, sociable, highly agreeable, and conscientious," said Jenny King, a behavioural assessor for the service and a chartered psychologist.

"In fact the vast majority were people pleasers whose problem was an unhealthy degree of perfectionism," said Dr King.

Cite this as: *BMJ* 2011;342:d876

Adviser accuses minister of "lying" over "new" money

Caroline White LONDON

A row broke out this week over whether money allocated by the UK government to extend access to talking therapies—a lynchpin of its new mental health strategy—is new or was to be found from efficiency savings elsewhere in the NHS.

David Richards, an independent mental health adviser to the Department of Health for England, was sacked on 4 February after he called the statement by the deputy prime minister, Nick Clegg, that there would be £400m of "new" money available to boost access to talking therapies "a lie."

Professor Richards, head of mental health services research at the University of Exeter, has been heavily involved in developing the improving access to psychological therapies programme (IAPT) for the health department. Better access to talking therapies is a key element of the strategy document *No Health without Mental Health*, published on 2 February (*BMJ* 2011;342:d797).

Professor Richards said in the *Guardian* that he was prompted to speak out because he had not been able to get answers to concerns he had after being told how this aspect of the strategy would be funded (www.guardian.co.uk/society/2011/feb/02/gp-bonus-spotting-mental-illness). But he emphasised that he had no wish to damage the programme or those working in it.

"Both are of the highest quality," he told the *BMJ*. "Those are not my issues. But when you are told one thing in your role as a national adviser and then you hear ministers say something else, you have to point that out as a matter of conscience. That was my Rubicon."

He explained: "I had been told on several occasions over the previous few weeks that the money was going to come out of 'cost pressures'—that it was going to have to be found from the £20bn [€24bn; $32bn] of efficiency savings the NHS needs to make."

The government insists that new funds are being made available, although it has said that these will not be ringfenced.

A spokeswoman for the health department said, "This is new money. The NHS has already been notified of PCT [primary care trust] allocations for 2011-12, which included additional funding for increasing access to talking therapies.

"We will continue to increase the funding we give to PCTs to support talking therapies."

Cite this as: *BMJ* 2011;342:d875

IN BRIEF

Cancer deaths fall in Europe: Nearly 1.3 million people in Europe will die from cancer in 2011, a study in *Annals of Oncology* predicts (doi:10.1093/annonc/mdq774). Its estimates show a fall from the 2007 figures in the overall number of deaths from cancer in men (down by 7%) and women (down 6%), but it highlights areas of concern, particularly a rising incidence of lung cancer in women.

GP is removed from drug advisory committee: Hans-Christian Raabe, a Christian GP, has been removed from the UK government's Advisory Council on the Misuse of Drugs less than a month after he was appointed (*BMJ* 2011;342:d624, 31 Jan). Home Office officials said that he had failed to disclose when interviewed for the post that he had coauthored a paper linking paedophilia with homosexuality. The officials said that this put his scientific credibility into question.

Keeping pollution controls put in for China's Olympics could save lives: Maintaining air pollution control measures that were put in place in Beijing during the 2008 Olympic Games could halve the lifetime risk of lung cancer among residents from combustion pollutants, a study in *Environmental Health Perspectives* has found (doi:10.1289/ehp.1003100). This might translate to about 10 000 fewer lifetime cases of lung cancer in the area, down from 21 200, say the scientists.

Alcohol interventions could help Scotland's prisoners: Routine screening of offenders for alcohol problems could help reduce the rate of reoffending and tackle wider social problems linked to excessive drinking, such as violence, drug use, social exclusion, and unemployment, says a report from the Alcohol and Offender Criminal Justice Research Programme. It is estimated that as many as three quarters of male prisoners in Scotland may have alcohol problems.

Using generic losartan could save NHS millions: The NHS in England could save £200m (€240m; $320m) a year if it switched patients with hypertension and heart failure to generic losartan instead of branded candesartan (Amias) without any loss in clinical benefits, say researchers (*International Journal of Clinical Practice* doi:10.1111/j.1742-1241.2011.02633.x). They reviewed 14 trials of more than 16 000 patients. Losartan recently came off patent.

Cite this as: *BMJ* 2011;342:d890

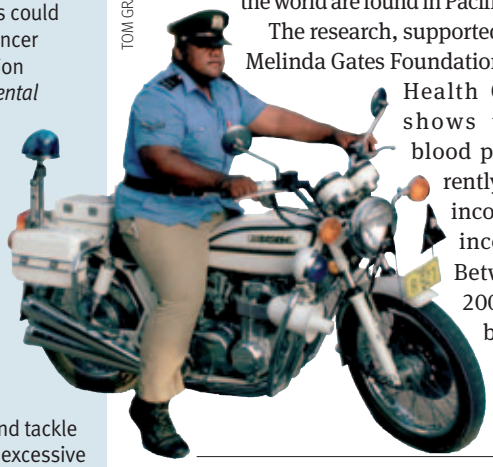
"Tsunami of obesity" threatens all regions of world, data show

Jacqui Wise LONDON

Obesity levels continue to climb worldwide, but high income countries have managed to mitigate some of the harmful effects by achieving impressive reductions in blood pressure and cholesterol concentrations over the past 30 years.

These findings come from a vast amount of data gathered from every country in the world by the Global Burden of Metabolic Risk Factors of Chronic Diseases Collaborative Group and published in three reports in the *Lancet* (www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)62037-5/abstract).

The data show that in 2008 one in three adults in the world was overweight (BMI ≥25 kg/m^2) and one in nine adults was obese (BMI ≥30 kg/m^2). Since 1980 the average body mass index (BMI) has increased in all regions, but now middle income countries have caught up with high income countries. The highest levels of obesity in the world are found in Pacific Island nations.



TOM GRAHAM/GETTY IMAGES

The research, supported by the Bill and Melinda Gates Foundation and the World Health Organization, shows that systolic blood pressure is currently highest in low income and middle income countries. Between 1980 and 2008 mean systolic blood pressure fell markedly in high income countries by 7.3 mm Hg, whereas it increased in low income countries by 3.3 mm Hg. The greatest falls in systolic pressure were seen in Australasian women and North American men. Increases in systolic pressure happened in some middle income and low income countries, including parts of Oceania, East Africa, South Asia, South East Asia, and West Africa.

Total blood cholesterol concentrations were still highest in high income countries, but the greatest decreases occurred in Western high income countries. There were increases in cholesterol levels in East and South East Asia, particularly Japan, China, and Thailand.

Majid Ezzati, study leader from the School of Public Health at Imperial College London, said: "Our results show that overweight and obesity, high blood pressure, and high cholesterol are no longer Western problems or problems of wealthy nations. Their presence has shifted towards low and middle income countries, making them global problems."

He added: "It's heartening that many countries have successfully reduced blood pressure and cholesterol despite rising BMI."

An editorial by Salim Yusuf and Sonia Anand, from the Population Health Research Institute at McMaster University, Canada, describes the situation as "a tsunami of obesity that will eventually affect all regions of the world."

But they say that the findings indicate that some of the effect of increasing obesity could be mitigated by focusing on controlling the three risk factors of blood pressure, total cholesterol, and smoking. "Directly controlling blood pressure, total cholesterol, and smoking will lead to rapid and substantial reductions in cardiovascular disease rates even while obesity and type 2 diabetes might be increasing," they say.

Cite this as: *BMJ* 2011;342:d772

International agency calls for end to "inhuman practice" of female genital mutilation

Weiyuan Cui GENEVA

An estimated 100 million to 140 million girls and women worldwide are suffering from the consequences of female genital mutilation, experts from the International Organization for Migration told a journalists' briefing on Friday 4 February.

The agency called the briefing to publicise the short and long term health problems associated with the practice, in advance of the international day of zero tolerance to female genital mutilation (Sunday 6 February).

The once remote practice, associated only with Africa, now threatens more than three million girls each year in Africa, the Middle East and elsewhere in Asia, and, with global migration, in many Western countries too, WHO experts said.

Also, each year an estimated 180 000 migrant girls are at risk of being returned to countries where they could be subjected to the mutilation, said William Lacy Swing, director general of the International Organization for Migration. "Traditional practices don't die when a migrant's boat or plane journey ends."

The custom comprises a range of procedures involving partial or total removal of the external female genitals or other injury to the female genital organs for non-medical reasons. Not only does it confer no health benefits on girls

Switzerland is to fund complementary therapies for six years while effectiveness is evaluated

MAURO FERMARIELLO/SPL

The government said the plan would help clarify "controversial aspects" of five remedies

Ned Stafford HAMBURG

Complementary medicine in Switzerland will be covered by public health insurance from 2012 until the end of 2017 as part of a temporary scientific evaluation plan to determine whether state coverage should be made permanent.

The plan, outlined by the Swiss Department of Home Affairs and which will include oversight from an "internationally recognised institution," comes after two thirds of Swiss voters in 2009 approved a referendum in support of state reimbursement of complementary medicine.

The five therapies included in the plan are anthroposophical medicine (which focuses on the body, life force, soul, and spirit and can include natural substances as well as conventional drugs), homoeopathy, neural therapy (in which local anaesthetic is injected near nerve centres), phytotherapy (or herbal medicine, which uses extracts from natural sources), and traditional Chinese medicine.

Under Swiss law only medical services that meet three requirements—effectiveness, cost effectiveness, and suitability—can be added to the list of treatments reimbursed by public insurance schemes.

Confronted with a legally binding referendum the home affairs minister, Didier Burkhalter, announced provisional public health insurance coverage combined with a scientific evaluation. A department press release said that the plan would help clarify "controversial aspects" of complementary medicine.

Jacques de Haller, president of the Swiss Medical Association, described Mr Burkhalter's plan as a "superb decision."

Cite this as: *BMJ* 2011;342:d819

Researcher didn't get ethical approval for 68 studies, investigators say

Clare Dyer BMJ

Joachim Boldt, a German anaesthetist who published widely, failed to obtain ethical approval for much of his research, show the preliminary results of an investigation by the medical association of the Rheinland-Palatinate.

The findings were given in a joint statement on 4 February by the editors in chief of 11 major journals that carried Professor Boldt's work, published on the website of each journal.

One of the journals is *Anesthesia and Analgesia*, which in October 2010 retracted an article by him that compared the use of a high dose balanced hydroxyethyl starch preparation with an albumin based regimen as a priming solution for cardiopulmonary bypass (*BMJ* 2010;341:c7026, 7 Dec). The article had no approval from an institutional review board and no patient consent, and an investigation by the hospital where he carried out his work concluded that no convincing evidence existed that the study was ever done.

The State Medical Association of Rheinland-Palatinate serves as the institutional review board (IRB) for Klinikum Ludwigshafen, where Professor Boldt worked. He has stepped down from his role as chief physician at the hospital.

The association reviewed 74 articles under Professor Boldt's name describing clinical trials that require IRB approval under the German Medicinal Act, including the retracted article and another submitted to the journal *Anaesthesia* but not published. Although the articles typically stated that IRB approval had been obtained, in 68 cases the association could not find any evidence that it had been.

The association identified a further 30 articles involving research that did not fall under the act but that was required to conform to an ethical code that included IRB review. IRB approval could be found for only six.

Cite this as: *BMJ* 2011;342:d833

and women but it can cause severe bleeding, urination problems, and lifelong consequences that include childbirth complications and deaths of newborns.

It is mostly carried out by traditional practitioners. Often no anaesthetic is given, and "a razor blade, a piece of glass, or knife is used to cut the most sensitive part of the body," Berhane Ras-Work, director of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, told the briefing.

Ms Berhane Ras-Work said, "It is torture. It is inhuman. It is degrading treatment of women. It is against the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, and so many other conventions . . . There is no excuse for genital mutilation to live with us."

Cite this as: *BMJ* 2011;342:d832

STEPHANIE SINCLAIR/VII/CORBIS

A young girl screams as she is circumcised in Bandung, Indonesia. The families of 248 girls were paid to have their daughters circumcised in a mass circumcision to celebrate the prophet Mohammed's birthday

The 10 "most wanted" have allegedly cheated the US government of more than $124m

List of "wanted" US healthcare thieves is posted on the web

Janice Hopkins Tanne NEW YORK

It used to be that "Wanted" posters of bank robbers and murderers were tacked to the wall in local post offices in the United States. Now the Office of the Inspector General of the federal Department of Health and Human Services has moved into the internet age.

On its website (http://oig.hhs.gov/fugitives) the department has posted photos and profiles of people who are wanted by the federal government on charges of healthcare fraud and abuse, together with tips on how to turn them in to the authorities. The department's 10 "most wanted" healthcare fraud fugitives have allegedly cheated the government and taxpayers of more than $124m (£77m; €91m).

Among them are the three members of the Benitez family who, the department alleges, submitted fraudulent claims totalling $110m from their Florida HIV treatment clinics to Medicare, the government insurance plan for elderly and disabled people. The department says that the treatments were medically unnecessary or were never administered.

Leonard Nwafor and his colleagues in the Los Angeles area are said to have billed Medicare for $1.1m and collected $525 000 in fraudulent claims for durable medical equipment such as motorised wheelchairs, scooters, and hospital beds. He was sentenced in his absence to nine years in prison.

Besides the 10 "most wanted," the inspector general is seeking more than 160 other "wanted" fugitives. The inspector general, Daniel Levinson, asked for the public's help.

Cite this as: *BMJ* 2011;342:d831

Australian medical journal says no to drug advertising

Melissa Sweet SYDNEY

A medical journal's decision to stop accepting pharmaceutical advertisements has prompted calls for journal publishers to break their links with the drug industry.

An editorial in the latest *Emergency Medicine Australasia* (doi:10.1111/j.1742-6723.2010.01393) says that the journal's move is a response to growing evidence about the detrimental effects of the drug industry in medicine, including claims that the industry distorts research findings and engages in dubious and unethical publishing practices.

George Jelinek, a former editor of the journal, and Anthony Brown, editor in chief, wrote, "Marketing of drugs by the pharmaceutical industry, whose prime aim is to bias readers towards prescribing a particular product, is fundamentally at odds with the mission of medical journals."

The editorial says that the industry spends vast sums on advertising, which has been shown to change doctors' prescribing practices. A study referred to in the editorial showed that spending on advertising generates on average $US5 in revenue per dollar spent.

"Meanwhile doctors (and indeed journal editors) generally deny that they are influenced, yet clearly they are," write the authors. They also say that journals have contributed to the problem by soliciting drug advertising from the industry.

Professors Jelinek and Brown say that the specialty of emergency medicine is able to take a lead on this issue because, "unlike many other specialty groups, such as cardiologists and oncologists, we are not particularly targeted by the drug companies, as we prescribe in the short- rather than the long-term."

Professor Jelinek declined to tell the *BMJ* how much income would be lost to the journal but said that the loss would not be a "huge hit" and that readers could afford to pay a little more for the journal. "It's OK for doctors to have to pay more for their professional education," he said. "We get well paid."

Peter Mansfield, a GP and the director of the pressure group Healthy Skepticism, welcomed the journal's move and said that research evidence indicated that stopping drug industry advertising would result in lower healthcare costs and better healthcare.

He encouraged other journals to take similar steps and to rethink their business models.

"I do think it's a landmark event," Dr Mansfield said. "Change can be like an earthquake: for a long time forces build up, but nothing changes until the earth tremors before the big quake. History may show that this was a tremor heralding major change."

Ian Kerridge, a haematologist and director of the Centre for Values, Ethics and the Law in Medicine at the University of Sydney, welcomed the move as a "valuable first step" that should be taken more widely. But journals should do much more to disentangle themselves from industry, he added.

He said, "Most of the revenue journals get is not from advertising but from industry buying reprints or supplements of RCTs [randomised controlled trials] that they sponsor," he said.

Cite this as: *BMJ* 2011;342:d884

New male doctors earned 17% more than female doctors in US in 2008

KAREN KASMAUSKI/SCIENCE FACTION/CORBIS

The gap between male and female doctors' starting pay widened between 1999 and 2008 from 12.5% to 17%

Bob Roehr WASHINGTON, DC

Newly trained male doctors in the United States are paid on average $16 819 (£10 450; €12 350) more a year than their female colleagues, a new study has found. More discouraging is that the pay gap has widened over the past 10 years.

In 1999 female doctors received an average starting salary of $151 600 a year, 12.5% lower than the men's salary of $173 400, shows the study, published in *Health Affairs* (2011;30:2193-201). By 2008 the gap had widened to nearly 17%, with

Research finds life is a three second experience

DAVID GRAY/REUTERS

Hugs at the Olympics lasted an average of three seconds regardless of sex and nationality

Bryan Christie EDINBURGH

Competitors at the 2008 Beijing Olympics have shed light on what seems to be a universal condition—we experience the world in time frames of three seconds.

A video analysis of hugs shared by competitors at the games has showed that these embraces lasted for an average of three seconds, irrespective of the sex and nationality of those involved.

The findings are said to reinforce the idea that intervals of about three seconds are life's basic units of time that define our perception of the present moment.

The research, published in the latest edition of the *Journal of Ethology* (doi:10.1007/s10164-010-0260-y), was carried out at the University of Dundee. It involved a frame by frame analysis of video recordings of the Olympic finals in 21 sports, among them badminton, wrestling, and swimming. A total of 188 post competition embraces were timed between athletes from 32 nations and their coaches, team mates, and rivals.

Emese Nagy, who led the research at the university's school of psychology, said it has already been shown that people tend to operate in these three second bursts. Goodbye waves, musical phrases, and infants' bouts of babbling and gesturing all last about three seconds.

She said, "What we have is very broad research showing that we experience the world in these three second time frames. Many basic physiological events, such as taking a breath and exhaling, last about two or three seconds each. When music and dance and other things are broken down, we can see that these actually consist of singular movements bound together."

This has been referred to as "feeling of nowness," she said. Most of the existing three second research had been done on individuals, and Dr Nagy wondered whether the pattern would hold for an experience shared between two people, especially one as intimate and emotionally charged as an embrace.

"I was watching the Olympics and thought that this was the perfect example illustrating how people experiencing these feelings want to share them with other people. It was a shared moment which we could clearly mark the beginning and end of," she said.

The three second rule was found to apply in these embraces, providing further support for the hypothesis that we go through life perceiving the present in a series of about three second sequences.

Cite this as: *BMJ* 2011;342:d750

women being paid $174 000 and men $209 300.

The study used survey data collected between 1999 and 2008 from doctors exiting residency training programmes in New York state, which has the largest number of such programmes in the US. It focused on responses from 8233 doctors (4918 men and 3315 women) who said that they had been offered and had accepted a job where care of patients and clinical practice would be their main activity.

Anthony Lo Sasso, senior author of the study, told the *BMJ* that previous research attributed much of the observed difference in pay between male and female doctors to men having more senior positions, working longer hours, and being more likely to be in higher paying specialties, among other factors.

The professor of health policy and administration at the School of Public Health at the University of Illinois, Chicago, said that the study sought to neutralise those factors by focusing on the transition point to first employment. It also compared pay within medical specialties.

Professor Lo Sasso said that he was surprised to see the consistent worsening of the differential between men and women in this population of doctors who were just beginning their practice. He said that the researchers looked at alternative explanations, "but nothing could make this large and widening gap go away."

He added, "Whatever is going on is something broad based, something affecting women regardless of specialty." He speculated that perhaps women "are more likely to forgo some salary in order to gain some type of non-pecuniary job attribute, such as a favourable or 'no call' schedule."

Responding to the findings, Eliza Chin, president of the American Medical Women's Association, said that their ramifications were "shocking, particularly for young physicians getting their first job. We would expect in this day and age that the gender gap [in pay] would be getting smaller."

Roberta Gebhard, who co-chairs the association's gender equity task force, said, "We feel that gender discrimination exists at many levels in American medicine . . . Women face a hostile environment."

She said that men are disproportionately in positions to hire, fire, and promote doctors and that they are more comfortable advancing those who are most similar to themselves.

Linda Brodsky, the task force's other co-chair, said that many young women are not good negotiators and that when they do act tough in negotiations this creates a "dissonance to the people who are hiring them," as they are not then fulfilling the stereotype of a caring provider.

Cite this as: *BMJ* 2011;342:d798