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Women doctors and their careers: what now?: Women contribute less than men to non-clinical care as general practitioners in Scotland

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Five futures for academic medicine

See poll results p 672

Future of academic medicine looks bleak

EDITOR—Four factors are responsible for the failure of academic medicine. The first is the research assessment exercise, which, surprisingly, is not discussed in the ICRAM scenarios outlined by Clark for the International Campaign to Revitalise Academic Medicine.¹ The second is the inhibition of clinical research by the draconian regulations often inflicted by ethics committees. The third is the formidable problems faced by people wishing to work with animals. The last is the conflict of working for two masters—the universities and the NHS.

The scenarios have taken little account of previously successful models of clinical academic departments, which made important contributions in advancing medical science and promoting high educational standards. The research assessment exercise is inappropriate for craft specialties because it demeans staff with teaching and surgical skills, concentrating on research drawing in large funding.²

Although scenario 4 draws attention to the issues of global academic partnerships, ICRAM failed to appreciate that this was the nature of clinical academic departments before the research assessment exercise was introduced. Fixation on research excellence, worthy as this may be, has forced academic staff to withdraw from essential external commitments.

Decisions need to be made urgently before attrition results in further damage. As mentioned by Davies in her commentary,¹ the disappearance during the past four years of 42% of clinical lecturer posts has removed the seed corn of future leaders in academic medicine. Lecturers rest poorly with the research assessment exercise as they hold trainee posts of limited tenure.

With the persistence of the exercise and the current governance of universities, a strong case exists for the creation of separate universities of health sciences that are not subject to inappropriate structures driving the destruction of academic medicine.

The scenarios give limited reassurance that the current crisis is understood, painting a global commercial picture while ignoring many of our current problems. Unless immediate corrective measures are

taken to halt the erosion of academic medicine, it faces a bleak future. Patients will be the ones to suffer.

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¹ Clark J for the International Campaign to Revitalise Academic Medicine. Five futures for academic medicine: the ICRAM scenarios [with commentaries by SC Davies, T Villaneuva, Z Ortiz, AL Leong]. *BMJ* 2005;331:101-7. (9 July.)
² Banatvala J, Bell P, Symonds M. The research assessment exercise is bad for UK medicine. *Lancet* 2005;365:458-9.

Follow the money trail

EDITOR—I was intrigued by the five scenarios of the International Campaign to Revitalise Academic Medicine.¹ Certainly, brainstorming over the future of academic medicine is a fascinating exercise. But, aside from revealing facets of the interaction of medicine in general with (global) society, it is sterile.

Academic medicine—meaning the entirety of academic institutions globally—is heterogeneous and will certainly evolve differently in different societies as a function of local issues and cultures. But, most importantly, in any given location it will evolve in response to its sources of revenue, which are quite varied.

In the large private universities of the United States major funding comes from research grants (federal, pharmaceutical, and philanthropic) and only a small fraction (5-10%) from student tuition. As donors' budget priorities change, so will academic priorities, as will the direction of the academic enterprise.

Certainly, medical schools will remain committed to a basic curriculum of human biology and clinical experience. But they will do this by using faculty staff hired for other purposes (clinically remunerative procedures and grant generating enterprises) since tuition alone cannot reimburse the faculty satisfactorily.

So, if you wish to see academic medicine's direction in any given situation,

look upstream to see where the money is coming from, not downstream, into the babble of salon conversation.

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Mutual respect is essential

EDITOR—The revitalisation of academic medicine discussed by the International Campaign to Revitalise Academic Medicine should begin at medical school.¹ Thus tomorrow's doctors—those who will be shaping medicine from 2025 and beyond—will be better equipped to ensure its continued progress.

Medical training does not sufficiently prepare students for, or expose them to, the possibility of working outside traditional hospital or general practice. Students need more options in academic medicine, and opportunities to carry out research projects should be easily available. For example, all students at the University of Southampton undertake a research project in the fourth year, although intercalating is optional. Alternative pathways should exist for medical students who subsequently decide on an academic career. Creating a clear path of career progression in academic medicine is imperative.

We must breed a new generation of clinicians and academics who respect each other's work, recognising that each plays an important and complementary part in providing healthcare to the global community. Respect for the principles of research should be discernible in the medical curriculum. For example, by learning how the mechanisms, symptoms, and treatment



MALCOLM WILLET

of a chosen disease were discovered so the indispensable role of research in changing practice and outcomes at the bedside will be recognised. Observations of clinicians at the bedside first resulted in the identification and treatment of disease. Thus clinicians too are researchers, albeit working in a different environment to “pure” academics—provided that their inputs are acknowledged and used.

Recognising, encouraging, and rewarding the contributions of clinicians to academic work should lead to better integration between the two disciplines in the future. Changing medical school curriculums to acknowledge the importance of research to clinical work, and vice versa, is a step in the right direction.

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Wine presses of academia produce young wines that don't cellar well

EDITOR—Godlee writes that academic medicine lacks vision and leadership in relation to the report from the International campaign to Revitalise Academic Medicine.^{1,2} Universities are no longer intellectual arenas or places of scientific debate. Drug company money salts most departments. Machines can analyse whatever DNA probe until a “significant” correlation is squeezed like grapes in a wine press. The next scientific meeting is only six months away; abstracts have to be in next week. You can't rush a robust red. The label is hardly on the bottle, and we are all imbibing the next season's Beaujolais.

I recently quizzed a doctoral student by his poster why he chose that interleukin to study. He had lots of data, no real hypothesis, and admitted that his department was just “doing” this cytokine—minutiae with a P value, destined to scientific oblivion in six months.

If you stay in a department long enough you end up with a chair—until death (*viz* the House of Lords), regardless of how stultifying and irrelevant the professorial output. Few competitors apply. It's jobs for the boys, and it is usually a foregone conclusion who gets the job.

We make the error of assuming an academic is the same as an intellectual. Intellectuals don't last long now in academia as they ask questions and challenge dogma.

Our former great intellectuals would not have got into print for lack of P values, grants, and ethics committee approval. However, we need ideas to be discussed so that they can then go into the scientific melting pot. Scientific writing has stifling conventions. The casualties are style, humour, and the active voice. Homer would have died laughing. Dare anyone say “I,” let alone “the wine dark sea.”

We have become slaves to evidence based conventions. However, we so often hear statements such as “the data had a nearly significant trend to significance.” The negative study is as a rarity. *Gaudeamus igitur*.

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1 Godlee F. Where are the leaders? [Editor's choice.] *BMJ* 2005;331:0-g. (9 July).
2 Clark J for the International Campaign to Revitalise Academic Medicine. Five futures for academic medicine: the ICRAM scenarios [with commentaries by SC Davies, T Vilaneuva, Z Ortiz, AL Leong]. *BMJ* 2005;331:101-7. (9 July).

Specialised professional research system of “pure” medical science is needed

EDITOR—Clark's discussion of the future of academic medicine is stimulating but misdirected.¹ Medical science policy should aim primarily to enhance therapeutic progress and reverse the decline in major, clinically relevant “breakthroughs” over recent decades.^{2,3}

Current medical research mostly constitutes an “applied” science aiming at steady, predictable advance by an accumulation of small improvements.⁴ But more radical and risky strategies are required to solve problems which are not yielding to established methods.^{2,3}

We need a specialised research system of “pure” medical science, whose role would be to generate and critically evaluate ambitious and potentially important theories, techniques, treatments, and technologies.¹ Pure science units might evolve from existing world class applied medical research institutions, but such units must have distinctive objectives, evaluation procedures, organisation, career paths, and funding arrangements.

Will it happen? Perhaps: imaginative patrons in the funding foundations might be attracted by the prestige of helping to establish an elite new profession.

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1 Clark J for the International Campaign to Revitalise Academic Medicine. Five futures for academic medicine: the ICRAM scenarios [with commentaries by SC Davies, T Vilaneuva, Z Ortiz, AL Leong]. *BMJ* 2005;331:101-7. (9 July).
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“Speed networking” may be one way forward

EDITOR—One way for universities to revitalise academic medicine might be to look outward.¹ Research takes money, and competition for funding is fierce. The chances of

success are improved by demonstrating an expertise in both subject area and appropriate methods. Collaboration can be one way to achieve this, but how do you know with whom to collaborate? It's not just about the interests or the skills, of course: if successful you have to work with these people.

A recent approach we used was a modified form of “speed dating” to improve our collaborative outlook. The Academic Unit of Primary Health Care and the School for Policy Studies are active in research at the University of Bristol, but in different faculties. We were aware of some overlap in subject areas and methodological expertise, yet to date we have had little experience of working together. We devised “speed networking” as an efficient means for members from each unit to meet and identify areas for possible future collaboration.

We introduced the groups to each other through brief oral presentations that gave an overview of the departments. Members from primary health care were then stationed at points around the room and, at three minute intervals, colleagues from policy studies were invited to rotate between each station. After 24 minutes all 16 participants had had the opportunity to meet and rapidly outline their skills and interests. Thereafter followed coffee to allow interested “pairs” to follow up their introductions in more detail.

Other means of networking exist, but so far as we are aware this is the first application of a populist approach to research. Feedback from participants was positive, and we suggest that other departments looking for research relationships speed network as an ice breaker to future collaborations.

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Neonates must sometimes be allowed to die, but err in favour of life

See pp 507-9

EDITOR—Neonatal intensive care medicine and nursing are constantly improving because staff are trying to save increasingly difficult cases.¹ Staff will inevitably attempt to save cases that turn out to be hopeless, and decisions will sometimes have to be made to allow the patient to die. Such decisions have to be seen as part of a process that eventually results in more lives being saved.

Dogmatic “pro-life” stances are therefore out of place.

But what happens when there is a dispute between staff and parents?

I try to teach students that they will inevitably make a certain amount of mistaken decisions during their careers. But if you are going to err, then err in favour of life. It must be extremely painful to have saved a life and wished later that you hadn't done so. But it must be more painful to have allowed someone to die and wished later that you had put in more effort to save him or her. I therefore try to convince my students that in neonatal intensive care (as in other situations where the patient cannot communicate) if the parents want you to let the baby die, and you think the baby is worth saving, you have to remember that the baby is not the parents' personal possession, like a car or a bicycle. The baby does not belong to anyone but is a full human being in its own right. So you have to save the baby, no matter what the parents say. If the staff think that the baby should be allowed to die, and the parents want you to keep on trying, then you have to keep on trying.

I have one reservation. Where “erring in favour of life” is the policy of neonatal intensive care unit, then much more work has to be done to improve social services, so that parents will not be sent home to situations that they cannot handle.

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1 Dyer O. Parents of disabled baby lose appeal against court order. *BMJ* 2005;331:472. (3 September.)

Women doctors and their careers: what now?

The changing UK medical workforce's effect on planning and delivery of services

EDITOR—Allen highlights the changing nature of the medical workforce.¹ This has significant implications for workforce planning and service delivery. For example, the wishes of a number of flexible trainees to continue part time working in the early consultant years means that more trainees (and therefore national training numbers) will be needed to fill consultant posts to deliver the whole time equivalents required. This applies particularly in specialties with a substantial proportion of flexible trainees, such as paediatrics, psychiatry, palliative medicine, general practice, and anaesthetics.

Many specialties are well suited to sessional or part time work, be it in the operating theatre, outpatient clinic, or laboratory. The new consultant contract should make it easier to design such working patterns. In practice, part time clinical roles in hospital medicine have long been common, senior

doctors taking on professional, managerial, or private practice commitments.² However, a larger cultural change will be required to make the establishment of stand alone part time consultant posts more acceptable. With female consultants now forming a quarter of the consultant workforce—and rising—such arrangements may increasingly become the norm. Creative solutions could include two consultant colleagues job sharing, one with school age children undertaking proportionately more work in school terms, and one without, working more in school holidays, when they are unlikely to wish to take leave. This might also suit those with busy committee roles or external commitments in support of the NHS, which tend to fall within term times, and they could then contribute to clinical care predominantly during school holidays. Shift work should provide opportunities for families to cross cover childcare with day, evening, and night time work.

Part time consultant posts or reduced clinical commitments appeal not only to those with young children but also to those with caring responsibilities for older relatives and those approaching retirement. This may be one way to address some of the concerns about work life balance articulated clearly by hospital consultants.³

Work patterns have changed in recent years for many reasons. Junior doctors work shorter hours. Junior doctors report unemployment, yet the UK seriously lacks senior doctors in comparison with other countries at similar stages of healthcare service health provision. Men and women in medicine increasingly state they want a personal and family life, and, like people in other occupations, doctors seek flexible training, employment, and career development compatible with the different stages in their lives.

Many patients rely on relatives to bring them to clinics; others are themselves at work in the day and prefer evening, Saturday morning, or appointments outside term time. And some doctors prefer to work at times when others in the family are able to provide care for their dependants.

If the investment made in the medical workforce is to be fully realised as benefit for patients then arrangements for career planning and development and the conditions of work must be compatible with the life and work choices of doctors and the population they serve.

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- 1 Allen I. Women doctors and their careers: what now? *BMJ* 2005;331:569-72. (10 September.)
- 2 Morrell NW, Black CM. Flexibility and diversity in consultant careers. *Clin Med* 2002;2:185-7.
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Women contribute less than men to non-clinical care as general practitioners in Scotland

EDITOR—Allen is rightly optimistic about women's current and future contribution to medicine.¹ She also rightly emphasises the combined impact of the feminisation of general practice and part time working, which has implications not only for the delivery of services but also for the development of the specialty.

The problem is probably worse than she portrays because the common definition of full time (>26 h/week) is usually derived from government figures based on previous contract status. We conducted an anonymous survey in Scotland of all general practice principals and non-principals (now all called performers) in the summer of 2004 about current in-hours workload and anticipated workload over the next five years (response rate for principals 67.2% (2541/3783) and 65.2% (749/1149) for non-principals).

We found that women under 40 outnumber men in general practice, outnumbering them in all age groups in the Lothian region. Overall, men spent an average of 7.9 and women 6.7 sessions on in-hours clinical General Medical Service (GMS) activities. However, women declared as full time under the old contract still worked fewer hours than full time men (7.5 v 8.1 sessions, $P < 0.01$).

Allen's hope that women would contribute more time to work as they got older was partially supported by our research, but nevertheless in every age group women's average working hours were significantly fewer than men's.

The differential, however, is perhaps more worrying with regard to NHS and educationally related non-GMS activity (GP training, medical student teaching, administration, appraisal, special interest, research). Men spend more than half as much additional time as women in many of these areas (1.1 v 0.73 sessions weekly on average). Men and women were not significantly different only in medical student teaching and medical research (all the other areas $P < 0.01$). Although the proportion of time spent by women on these activities increased over the age of 40, it never reached parity with that of the men.

Given that most truly full time general practice doctors in Scotland are now over 45 and that they are predominantly male, a crisis is clearly looming not only for the delivery of general practice itself but also, perhaps more seriously, for the development of the specialty as a whole. Women will

have to become much more involved in future if the specialty is to thrive in Scotland in the next 20 years.

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1 Allen I. Women doctors and their careers: what now? *BMJ* 2005;331:569-72. (10 September.)

Foundation year for newly qualified doctors

A house officer writes

EDITOR—Although I sympathise to an extent with the views of the foundation programme's organisers and the Modernising Medical Careers quango,¹ I think that there are some big defects. This is based on my experience as working as a house officer.

Postgraduate training seems to have been hijacked by self styled medical educationists who come mainly from academia and have a different agenda from the many trained doctors and doctors in training who work on the coalface of clinical medicine.

In the reams of literature and hours of talks it seems that care for patients has been forgotten, with numerous assessments (with funny names) of topics and skills learnt at medical school and talk of audit and portfolios. I just want to do a good job for my patients, and that is what I have been eagerly waiting for since my finals.

I recognise that we need to have some sort of close supervision in the embryonic days of our medical careers, but we also need to provide a service, and we can learn by providing good clinical care with senior supervision to as many patients as we can. I and many colleagues believe that after six hard years at medical school we are becoming deskilled and disheartened. Is this what I went to medical school for?

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1 Hays R. Foundation programme for newly qualified doctors. *BMJ* 2005;331:465-6. (3 September.)

Nobody knows whether the foundation programme works

EDITOR—I am baffled how Hays can come up with an article where he claims that the pilots for the foundation years have worked.¹ So far as I am aware nobody knows if it has worked, and nobody will

know if it progresses to be successful until August 2007. Foundation year 1 started this year, but foundation year 2 is now in its second year as a pilot scheme and does not officially begin until August 2006. So what are doctors who have completed their foundation year 2 this year or next year meant to do? Where do they go from there?

They will not get entry on any specialist training rotation without the necessary qualifications or experience required. The supposed implementation of the new style specialist training for Modernising Medical Careers does not start until 2007, hence we have a lot of doctors in limbo who are looking for posts and are not able to find any posts as senior house officers.

All specialties are competitive, and nobody will want somebody with less experience and no higher diploma or degree to train as a specialist registrar in their scheme. Not even the royal colleges know what impact the foundation scheme and Modernising Medical Careers is going to have on training, so for Hays to suggest that it is successful is ludicrous. Much more information is required by doctors undertaking training as to what they should do in terms of attaining higher diplomas and experience.

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Will this development benefit overseas doctors?

EDITOR—The foundation programme brings a welcome change to the training system in the United Kingdom.¹ Having passed the exams of the Professional and Linguistic Assessment Board (PLAB) in 2000, I worked in UK hospitals as a house officer for six months before being kicked out to another hospital and then another. Finally, after working in six different hospitals and obtaining membership of the Royal College of Physicians (MRCP), I got a post as a specialist registrar.

By this time I had completed the US medical licensing exams and moved to the United States. The training, which is similar to the foundation programme, includes rotating among different subspecialties. I was attached to one hospital, which created a special bond to serve this hospital. No major examinations are involved in residency. This helped me to concentrate on clinical work.

I hope the foundation system will start in every hospital in the UK. This will eliminate the unnecessary paperwork that junior doctors have to go through every six months or every year. This is especially true for overseas doctors who have to concentrate on obtaining a job and sorting out their visas rather than on caring for patients.

I hope that the UK learns from US residency programmes and starts a matching programme nationwide for foundation year trainees, to save manpower and resources. This could have a positive impact on patient care.

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1 Hays R. Foundation programme for newly qualified doctors. *BMJ* 2005;331:465-6. (3 September.)

GMC assessment of junior doctors' competency is inadequate or inconsistent

EDITOR—In his article on the new UK foundation programme, Hays says that assessment will focus on practical aspects of medical work rather than examinations.¹ An examination already exists, however, that is explicitly set to correspond with the level of knowledge expected of a doctor at the end of foundation year 1.

This is the Professional and Linguistic Assessment Board Test (PLAB), administered by the General Medical Council to assess whether international medical graduates have the ability to practise safely as senior house officers in UK hospitals.² It takes the form of a written paper (part 1) and an objective, structured, clinical examination (part 2). Pass marks for the part 1 extended matching question (EMQ) examinations in 2004 ranged from 59.6% to 65.5% (Jo Mullin, GMC PLAB test section, personal communication, 2004).

We conducted an audit of UK graduates taking up senior house officer posts in accident and emergency medicine at a major London teaching hospital. A paper comprising 50 extended matching questions was derived from a popular PLAB revision aid^{3,4} and then edited by an experienced former PLAB examiner to confirm that it accurately reflected the standard of the PLAB examination. Twenty eight senior house officers sat the test in November 2004 and March 2005. Only four scored less than 60% (mean mark 64%, SD 11%) but, of these, two scored only 38% and 40%—well below the pass mark and more than 2 standard deviations below the mean.

How many doctors completing the foundation programme would be found wanting if tested by this benchmark? We think there is a strong case for a PLAB style examination to form part of the assessment process for both foundation years, thereby providing a level playing field for UK and international medical graduates. Alternatively, if examinations are no longer thought to be relevant, the PLAB assessment should be revised.

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- 1 Hays R. Foundation programme for newly qualified doctors. *BMJ* 2005;331:465-6. (3 September.)
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P+ Details of the other three authors are on bmj.com

Melanoma incidence has risen in Europe

EDITOR—Welch et al say that the increased incidence of cutaneous melanoma is a result of overdiagnosis because of increased diagnostic scrutiny, rather than an increase in the true occurrence.¹ They observed that incidence rates of melanoma among American citizens aged 65 and older were strongly correlated with biopsy rates and that mortality from melanoma remained stable.

We wish to comment on this from a European perspective. Although increased biopsy rates have undoubtedly emerged and contributed to increased detection of melanomas, there are indications, at least in Europe, that part of the increase in melanoma incidence is true. Mortality due to melanoma in Europe was not stable, pointing to real increases in the incidence of melanoma.

In many European populations death rates from melanoma have been, at least up

to 1997 and in the Netherlands also up to 2002 (figure), continuously and significantly increasing over time in all age categories, but especially among elderly men.^{2 3}

These increases affected young people (aged 25-49) in the magnitude of 2-3% per year in some north and west European countries and up to 8% in Spain. At older ages, more populations exhibited increases; in men above age 70 these varied between 2.7% (Netherlands) and 7.5% (Spain) yearly and in elderly women between 0.8% (Norway) and 7.7% (Spain).

Moreover, in many populations increases in incidence and mortality have been observed for up to five decades,² which also argues in favour of at least part of the increases in melanoma incidence being real. For biopsy rates to cause the observed linear increases over time, they would have to have been increasing linearly for decades, which we find unlikely.

When the observed increases in mortality from malignant melanoma in Europe, mainly among elderly men, are taken into account, part of the observed increases in melanoma incidence seems to be “real.”

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1 Welch HG, Woloshin S, Schwartz LM. Skin biopsy rates and incidence of melanoma: population based ecological study. *BMJ* 2005;331:481 (3 September.)

2 De Vries E, Bray F, Coebergh JWW, Parkin DM, European Network of Cancer Registries. Changing epidemiology of malignant cutaneous melanoma in Europe 1969-1997: rising trends in incidence and mortality, but recent stabilisations in western Europe and decreases in Scandinavia. *Int J Cancer* 2003;107:119-26.

3 de Vries E, Schouten LJ, Coebergh JWW, Working Group of Cancer Registries. Rising trends in the incidence of and mortality from cutaneous melanoma in the Netherlands: a Northwest to Southeast gradient? *Eur J Cancer* 2003;39:1439-46.

Government did not suppress health inequalities report

EDITOR—Shaw et al repeat claims that the government suppressed its health inequalities report.¹ This is nonsense.

Tackling Health Inequalities, actively promoted and announced via a press release issued to 1300 journalists and media outlets, received widespread coverage, including stories in the national and regional press.

Professor Sir Michael Marmot, the report author, was extensively interviewed.

We as the government can, therefore, hardly be accused of a hushed up release.

We are determined to reduce health inequalities. The report showed that we are moving in the right direction and highlighted the further work that needs to be done.

However, the report's data dated back to 2003. Last November we published the Choosing Health White Paper aimed at improving health and tackling health inequalities. Health trainers are one of many initiatives in Choosing Health which will help narrow the inequalities gap by helping people to make healthier choices in their daily lives. Infant mortality, a key indicator of health inequalities, has fallen in the routine and manual group, as well as the total population. Government initiatives including Sure Start, better neonatal services, stop smoking services, and breastfeeding campaigns are all having an impact.

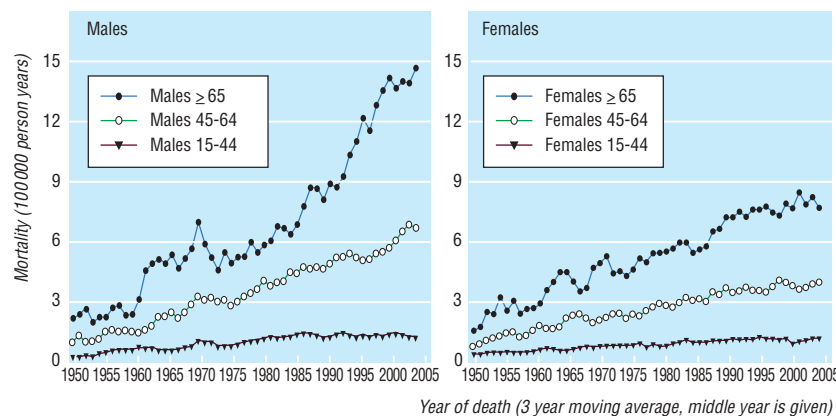
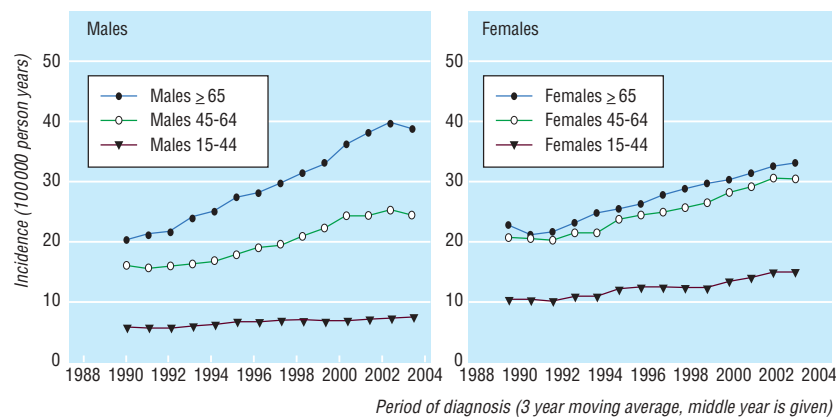
Progress is slower in more disadvantaged areas, which is why spearhead primary care trusts are piloting many of the key Choosing Health recommendations, including health trainers, in those areas.

Health inequalities are and will continue to be a government priority.

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Competing interests: None declared.

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Age specific incidence of and mortality from cutaneous malignant melanoma in the Netherlands, 1950-2005

Short term outcomes lead to long term questions

EDITOR—Lavender et al add evidence to the debate about a randomised controlled trial comparing vaginal birth with caesarean surgery.¹ However, we need to think even more widely, and more long term, about this possibility, as highlighted recently by the term breech trial. Researchers randomised

breech babies to vaginal birth or caesarean and concluded, in the year 2000, that caesarean birth was safer. Virtually overnight, vaginal breech birth disappeared as an option for women worldwide.

Follow-up of children from the term breech trial at age 2, published in 2004, found that differences between groups had disappeared: vaginal breech birth was no more risky for offspring in the longer term.² Many health professionals are unaware of this about face, and the equation of caesarean and breech remains unaltered.

The term breech experience highlights the importance of adequate sample size² and long term follow-up, but even two years is inadequate after a caesarean. Pregnancies after a caesarean have an increased risk of unexpected stillbirth³ as well as ectopic pregnancy, placenta praevia, and placental abruption,⁴ which increase mortality for mother and baby. If, as with the term breech trial, the results of a randomised controlled trial lead to more women having caesareans (and subsequent caesareans), these risks will become notable in population terms.

Finally, we must consider our scant understanding of the sophisticated and finely tuned psychoneuroendocrinology of labour and birth, and of the longer term implications of interference in this highly evolved reproductive act.⁵

Our current ignorance of the implications of depriving mother and baby of normal birth and our recent ignorance of the implications of depriving mother and baby of breast feeding have many parallels. Until we know what we are really offering and include extensive follow-up over decades, a "term cephalic trial" may be as foolish as a randomised controlled trial of breast feeding compared with formula feeding.

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Competing interests: SJB has had four home births, including one breech birth.

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Israeli army's shoot to kill policy

Israeli soldiers confirm the policy documented in journal

EDITOR—My personal view last October on the Israeli army operations in the Palestinian territories occupied by Israel, attracted support as well as vilification on *bmj.com*.¹

I noted that two thirds of all Palestinian child fatalities had been caused by small arms fire (from relatively close range), in fully half of the cases to the head or upper torso—the sniper's wound. My statement that "clearly, soldiers are routinely authorised to shoot to kill children in situations of minimal or no threat" has now been confirmed in emphatic fashion—the authority being Israeli soldiers who have committed these acts themselves.²⁻⁴ They refer to one of the cases I described.

Several dozen former soldiers calling themselves "Breaking the Silence" are exposing the cynicism of the Israeli defence forces' mantra that everything possible is done to minimise the risk to Palestinian civilians. These soldiers testify that they were ordered in briefings to shoot to kill unarmed civilians, including children, even when there was no threat and in periods of calm. They were ordered to "fire at anything that moved" and were told "every person you see on the street, 'kill him.' And we would just do it."⁴ The attitude was "so kids got killed. For a soldier it means nothing."⁴

The desire to avenge Israeli casualties and inflict collective punishment was an important factor. In Gaza in May 2004, "the commanders said kill as many people as possible,"⁴ and there were standing orders to shoot anyone on a roof or balcony, whoever they were. One former soldier said this was why the Moghayer children (aged 16 and 13), collecting washing and feeding pigeons on the roof of their home, were shot. Israel's defence forces claimed that they had been blown up by a roadside bomb, until journalists were shown the bodies in the morgue, each with a single bullet wound to the head. I mentioned this case in my *BMJ* article.

Can those who saw my paper as antisemitic lies face "Breaking the Silence"? Will the Jewish organisations that made hostile statements about the *BMJ*, amid calls for the acting editor to be censured or removed, apologise? And who will challenge the Israeli Medical Association for its silence at the ongoing violations of the Geneva Convention I documented?⁵ ^{w1}

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Competing interests: None declared.

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Reference w1 is on *bmj.com*

Reply from the president of the Israeli Medical Association

EDITOR—Summerfield's letter presents nothing new. No one has ever denied that occasional abuses do take place within the Israel Defense Forces (IDF) due, in part, to the pressure of fearing for your life in an unconventional war, where women and teenagers serve as suicide bombers, and boys as young as 11 are exploited by Palestinian terrorists.¹

As an example, a Palestinian woman, Wafa al-Bas, recently took advantage of a humanitarian medical clearance granted by Israel to attempt a suicide bombing at Israel's Soroka Hospital, where doctors had worked tirelessly to save her life after she was severely burnt in an accident at home. She was on her way to Soroka for the implied purpose of receiving continued treatment, but her true goal was, by her own admission, to kill as many people as possible, including children.² This event, like others, emphasises the need for a less simplistic view of an extremely complex situation, as well as the need for strict vigilance at check points.

Such events in no way excuse abuses or human rights violations, and the IDF is, and should be, subject to review. In this case, the IDF reports on its website a military police investigation of the allegations raised in the "Breaking the Silence" exhibition.³ The Israeli Medical Association, too, looks into any claim brought to our attention, and our courts try, and when appropriate convict, soldiers for violations of human rights. However, such exceptional abuses do not negate the underlying ethics of an entire army, just as they don't for the British army, despite documented claims of abuses committed by its soldiers in Iraq.⁴

Finally, at a time when Israel has evacuated thousands of its own citizens from their homes, making unprecedented, and risky, concessions for the sake of peace, I would hope that the *BMJ* would choose to promote mutual acceptance, rather than once again selecting a partisan element of a complex conflict and publishing it in a medical journal.

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Competing interests: None declared.

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