

COMMENTARY

Medical journals: evidence of bias against the diseases of poverty

A report from the WHO recently described under-representation of individuals from low-income and middle-income countries on the editorial boards of ten leading psychiatry journals.¹ Shekhar Saxena and colleagues concluded that this “unsatisfactory situation” needed to be corrected, given the global importance of mental health. But this issue goes well beyond editorial boards and mental health. There is widespread systematic bias in medical journals against diseases that dominate the least-developed regions of the world. Is this an example of what some have described as the institutional racism that afflicts parts of medicine today?²

Some of the world’s leading general medical journals include the *Annals of Internal Medicine*, *BMJ*, *JAMA*, *New England Journal of Medicine*, and *The Lancet*. These five titles lay claim to their global legitimacy for many reasons—weekly or biweekly publication, long-established histories, the credibility and power of their owners, large numbers of full-time editorial staff, membership of the International Committee of Medical Journal Editors, and influential joint statements.³ Their editorial boards matter because they help to shape the personalities and policies of these journals. The composition of editorial boards sends a signal to authors and readers about a journal’s interests. General medical journals follow the same patterns as their psychiatry counterparts (panel). Most board members come from nations with a high human development index.

The *Annals* describes itself as “the leading journal for studies in internal medicine”; *JAMA* as “an international peer-reviewed general medical journal”; and the *New England Journal of Medicine* as “one of the pre-eminent biomedical publications in the world”. The *BMJ* writes that it “seeks to be at the forefront of the international debate on health”; and *The Lancet* claims “to be a leading voice in coverage of global public-health”. The editorial boards of these five journals have a variable part to play in decision-making about research papers and editorial policy. Some may have very little influence. But the editorial boards of these journals do not seem to reflect their (indeed, our) ambitious aspirations.

The under-representation of journal content about the health needs of resource-poor peoples is even more unsettling. Obuaya surveyed these five general medical journals in 2001.⁴ He found that the frequency of research articles relevant to diseases of poverty was low in the sample he studied—zero for *Annals*, 2% for *JAMA*, 4% for the *New England Journal of Medicine*, 6% for the *BMJ*, and 16% for *The Lancet*. He concluded that “as the journals control the global distribution of biomedical news and developments they have a responsibility to ensure that they provide essential information of an adequate quality, in sufficient quantity, and at a reasonable cost”.

If the content and editorial boards of these journals do not live up to what their editors would like readers and authors to believe, what inference can one draw? Institutional racism is a highly emotive and provocative label. Many editors and readers will resist such a term. I sent an earlier draft of this commentary to the editors of the *Annals*, *JAMA*, *NEJM*, and *BMJ*, and also to past and new members of *The Lancet*’s international advisory board for their comments. Some fiercely challenged the word “racism”. Their preferred words were elitism, bias, insularity, nationalism, or regionalism. The implication of racism, commented one, was offensive; the phrase too strident, wrote another. But “institutional racism” has a very precise meaning. According to the UK’s Commission for Racial Equality, institutional racism “occurs when the policies and practices of an organisation result in different outcomes for people from different racial groups”.⁴ The term, if one accepts that it is appropriate for medical journals, does not mean that individual editors are racist. It does mean that the scientific, medical, and public-health priorities of the rich world are presented as the norm. We editors seek a global status for our journals, but we shut out the experiences and practices of those living in poverty by our (unconscious) neglect. One group is advantaged, while the other is marginalised. Since journals collectively embody the attitudes and behaviours of researchers and practitioners, the actions of editors reflect the state of medical research itself. Racism in health has been widely

Editorial boards of five general medical journals

	Total number of board members	Editorial board members: country of origin			Board members from journal’s main country of publication
		High HDI*	Medium HDI	Low HDI	
<i>Annals</i>	17	17	0	0	16 (94%)
<i>JAMA</i> †	27	27	0	0	20 (74%)
<i>NEJM</i>	17	17	0	0	9 (53%)
<i>BMJ</i>	26	21	5	0	9 (35%)
<i>Lancet</i>	24	21	1	2	6 (25%)

*Human Development Index (2002 figures); †*JAMA* also has an international advisory committee with physicians representing Eastern Europe, Latin America, China, and the Middle East.

debated^{1,5}—but similar ethnic biases in acceptance and commissioning policies at peer-reviewed medical journals or in funding policies at grant-awarding agencies have been little discussed, although they are recognised in other news media.⁶

Why might there be such an unwitting insularity at medical journals? Whether owned by a commercial publisher, a society, a trade union, or a prestigious college, journals aim to be profitable. That means editors and publishers alike steer the content of their journals to readerships that will be able to afford subscriptions, advertisers who will want to buy space, and organisations that will want to purchase reprints. Editors might also have an eye on impact factor. Research or reviews that cover diseases unlikely to be encountered in the western world will not gather the citations that some editors seek.

These biases damage our democratic culture. Poverty is the most serious threat to the health of several billion people living on our planet. The way we discuss the responsibilities of the well off to those who live in poverty depends on the media—print, radio, and television—to present a balanced and accurate picture of the world and the predicaments of its peoples. For example, the lives of those living in poverty are rarely reported in most mass news media unless there is an acute humanitarian emergency. (A rare but exemplary instance of reporting the slow news of global health is the “Lives Lost” project launched recently by *The Boston Globe*).⁷ The values that influence judgments about the selection of content for medical journals (eg, randomised controlled trials of new medicines) are largely determined by priorities in science and public health—and commerce. This mix of forces is not wholly bad for medical research. Profit helps to protect editorial freedom. But if this commercial environment does seriously skew content away from what matters to those people the journal claims to serve, as it surely does at some journals, the culture of medicine is distorted, even harmed.

Medical research therefore becomes shaped by the commercial values and agenda of its own media. The result? That the range of public debate narrows. And here is the danger to fair deliberation about diseases affecting the poor. Where are the forces countering these prevailing pressures? For medical journals, they seem to be weak and unpredictable. If leading general and specialist medical journals cannot find ways to publish work that more accurately reflects the burden of disease and risk factors⁸ that affect large parts of the world today, the editors of those journals are failing to discharge a vital professional responsibility, one which suggests that profit has finally trumped public service.

What can be done to reverse these trends at medical journals? First, to recognise and agree that ethnic biases within our journals are a pressing problem, subverting efforts to promote equity in global health. But second, to acknowledge that simply writing about the issue is not enough. I have previously drawn attention to how editors could improve information capacity in developing countries,⁹ but progress has been patchy since then, including at *The Lancet*. A great deal depends on training and strengthening the medical and public-health research communities in developing countries. Still, editors could do more by revising their editorial boards, calling for research papers from resource-poor settings, commissioning editorials and reviews about developing-world health issues, and perhaps opening regional editorial offices. The tide may be turning. Richard Smith, editor of the *BMJ*, argues that his journal has recently “improved considerably” the content relevant to the developing world. And Jeff Drazen, editor of the *NEJM*, reports that he and his colleagues

“actively solicit” material from economically disadvantaged settings. Finally, editors could use their journals to call for greater commitment to close the 10/90 gap—where 90% of research funding is channelled into diseases affecting only 10% of the world’s population.¹⁰ There are small examples of progress here too. The World Heart Federation Council on Epidemiology and Prevention, for example, runs research training seminars for investigators in developing countries.

Given the often fragile research capacity in the developing world, these efforts will take time to have their effect. Yet they are an essential first step. Perhaps editors will only seriously change their current policies when readers and advertisers demand it, when agencies such as WHO and non-governmental organisations campaign hard for it, or when research originating from developing country settings is improved in both quantity and quality. Nevertheless, a radical cultural transformation is needed within the editorial offices of leading medical journals today to reverse a deeply embedded ethnic bias. The public-service remit of journals needs to be carefully defined and protected. Community responsibility is one of medicine’s core values;¹¹ medicine’s global responsibilities need to be strengthened in medical journals today.

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MRI for neonatal encephalopathy in full-term infants

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Encephalopathy in an infant within the first few days of birth often reflects a major neurological disorder with a significant risk of long-term disability.¹ Determining the cause and prognosis remains challenging. Signs of neonatal encephalopathy include seizures, lethargy or coma, poor tone and feeding, and difficulty maintaining respiration; and early descriptions focused on intrapartum asphyxia as the primary cause. In 1976 Sarnat and Sarnat² pointed out the importance of staging encephalopathy with behavioural and electroencephalographic criteria, and 10 years later Levene et al³ reported that rating the clinical severity of encephalopathy is better than the Apgar score for predicting neurological outcome after asphyxia. Evidence, especially from the Western Australian case-control study by Badawi et al,⁴ suggests that a diverse group of disorders, many beginning antenatally, in addition to asphyxia are associated with encephalopathy in newborn babies. These disorders include maternal and