ethics in a symbolic manner, but expanding and firmly rooting these fundamental discussions in modern medical disputes would increase student engagement and clinical relevance. Second, clinical instruction to improve communication can provide medical students with a set of techniques to better manage disputes and navigate the health systems issues that underpin mistrust. These thorny topics are rife with tension and deserve increased attention as a core component of medical education. While such reforms can learn from effective programmes outside China, they can also draw on the rich ancient Chinese tradition of humanism in medicine exemplified by Sun Simiao's "the excellence and sincerity of the great physician".[5]

There are inevitably tradeoffs associated with expanding humanistic medical training. Increased humanism within medical education is necessary but not sufficient for ensuring patient–physician trust in China. A wide range of legal, social, and financial changes are also necessary. Present medical curricula are stretched taut and most schools do have enough full-time medical humanists. However, the Chinese crisis of patient–physician mistrust provides a powerful empirical clinical context by which to promote humanistic medical training. Humanistic training to deepen modern patient–physician trust could help revive and safeguard the old Chinese moral ideal of medicine as the art of humanity.

We declare that we have no competing interests.

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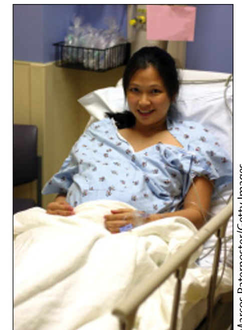
Rate of caesarean section is alarming in China

Data from WHO suggest that nearly half of all births in China were delivered by caesarean section in 2007–08,[1] which is three times higher than WHO's recommended proportion of 15%. Although the rate of caesarean section in China has decreased to about 42% in 2010, it is still the highest worldwide.

Many studies have shown that women who have caesarean section without medical necessities are at high risk of related complications or death.[2] Additionally, babies delivered by caesarean section are more likely to have respiratory problems, obesity, and other metabolic diseases.[3] These findings show the urgency of controlling the rate of caesarean sections in China.

There are five reasons other than medical necessities that might explain the high rate of caesarean section in China. First, some women's concerns about pain and vaginal tone after vaginal birth: in their opinion, caesarean section is safer, faster, and less painful, and is less likely to affect the quality of sexual life than vaginal birth. Second, some women wrongly believe that they are more likely to regain their prepregnacy shape after caesarean section than vaginal birth. Third, Chinese mothers like to choose a delivery date on the basis of luck and belief, and it is easier to deliver on a scheduled day by caesarean section than to deliever an unplanned vaginal birth. Fourth, some doctors do recommend caesarean section to women in view of the present uneasy doctor–patient relationship and possible lawsuits. Furthermore, caesarean section is financially profitable for the hospital. For example, in large Chinese cities such as Beijing, the price is about 6000 RMB (US$1000) for vaginal birth, whereas it is at least 12 000 RMB ($2000) for caesarean section in some top-level hospitals. Fifth, increasing numbers of macrosomia in China attributable to the increasing prevalence of diabetes and obesity in women,[4] and increasing pregnancies in older women will further increase the rate of caesarean section.


Marcos Paternoster/Getty Images

To effectively control the rate of caesarean section in China, the Chinese Government should develop specific policies and measures, such as use of rate of caesarean section without medical necessities as one of the hospital's overall rating components, and popularising of natural childbirth. Hospitals and communities should promote health education in women of reproductive age to provide a more accurate idea of delivery. Additionally, prevention of obesity and diabetes in women of reproductive age, which will reduce the risk of macrosomia, is also important to decrease rates of caesarean section. Women of reproductive age should also be encouraged to give birth before age 35 years.

We declare that we have no competing interests.

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The medical profession and violence against women

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We read with interest Hannah Cagney's Comment (Feb 1, p 395)[1] on intimate partner violence and HIV. The Medical Women's International Association applauds the author for bringing the issue of intimate partner violence to the notice of the medical profession.

The Medical Women's International Association is an international non-governmental organisation, made up of women physicians in more than 70 countries. Women physicians are often the first point of contact for women suffering gender based violence. We need to be part of a multidisciplinary approach that consists of law enforcement, courts, transition houses, social welfare, and re-education that allows these women safety and a chance to move their lives forward. Victimisation shapes women's lives, and if society is going to help these women, a trauma informed and grassroots approach must be taken.

Violence against women takes many forms. Commonly recognised are domestic and intimate partner violence, human trafficking, violence in conflict, emotional abuse, and sexual assault including rape, but less well known are dating violence, stalking, violence against immigrant and refugee women, honour-based violence, violence against women at work, and violence against women with disabilities.

Cultural traditions allow abuse against women in the name of the way things are always done. Female genital mutilation, the treatment of widows in many cultures, and having sex with a virgin to cure HIV are prime examples.[2] A modern form of violence is the new trend toward cosmetic genital surgery.

HIV is also a form of gender-based violence. Compared with men, women do not have sufficient access to prevention, counselling, testing, and treatment in many countries worldwide.[3] They cannot negotiate safe sex in many instances and so fall prey to HIV and other sexually transmitted infections.[3]

The Medical Women's International Association has made strong statements to condemn all forms of violence in its resolutions and its regional and international scientific meetings, and will continue doing so. The Medical Women's International Association's focus for 2013–16 is prevention and elimination of domestic and sexual violence. In 2002, the Medical Women's International Association provided a training manual about gender mainstreaming in health for physicians and other health-care professionals; the concepts covered—namely sex, gender, sexuality, gender roles, and gender equity—are all relevant to violence against women. At the 57th Commission on the Status of Women,[4] the Medical Women's International Association was able to influence the Commission on the Status of Women statement to include the recognition of the important role of the health-care system as part of an essential component of a holistic response to violence against women—a position that the Medical Women's International Association always had strongly advocated for.

It is important to ensure that health professionals are trained and supported to recognise and respond sensitively to gender-based violence and its severe physical and psychological effects over a lifetime.

KAP is President of the Medical Women's International Association. SR is Secretary General of the Medical Women's International Association. We declare that we have no competing interests.

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Department of Error

Ramos-Casals M, Brito-Zerón P, López-Guillermo A, Khamashta MA, Bosch X. Adult haemophagocytic syndrome. Lancet 2014; ***383:*** 1503–16 —In this Seminar, the first affiliations should have been: Josep Font Laboratory of Autoimmune Diseases-CELLEX, Department of Autoimmune Diseases, Institut Clínic de Medicina i Dermatologia (M Ramos-Casals MD, P Brito-Zerón MD); Department of Internal Medicine, Institut Clínic de Medicina i Dermatologia (X Bosch MD). This correction has been made to the online version as of Feb 6, 2014, and to the printed Seminar.

Zaridze D, Lewington S, Boroda A, et al. Alcohol and mortality in Russia: prospective observational study of 151 000 adults. Lancet 2014; ***383:*** *1465–73*—In Figure 2 of this Article, the first point of the right y axis of the graph for ages 35–54 years should have been 10 instead of 1. This correction has been made to the online version as of April 25, 2014, and to the printed Article.

ENCORE1 Study Group. Efficacy of 400 mg efavirenz versus standard 600 mg dose in HIV-infected, antiretroviral-naive adults (ENCORE1): a randomised, double-blind, placebo-controlled, non-inferiority trial. Lancet 2014; ***383:*** *1474–82*—In this Article, the bottom section of figure 4 was not included. This correction has been made to the online version as of April 25, 2014, and to the printed Article.