Evidence-based medicine in China

In recent decades, evidence-based medicine has been propagated rapidly in China, not only to doctors but also to nurses and other health-care professionals. The *Chinese Journal of Evidence-Based Medicine*, the *Journal of Evidence-Based Medicine*, and the *Chinese Journal of Evidence-Based Pediatrics* were launched in 2001–06. Several organisations developed programmes to strengthen a national culture of evidence-based medicine, including the clinical epidemiology committee of the Chinese Medical Association (established in 1993) working with the Chinese Clinical Epidemiology Network (ChinaCLEN; registered as part of the International Clinical Epidemiology Network in 1989),1 the Chinese Cochrane Centre (which became the 14th centre of the International Cochrane Collaboration in 1999),2 the Ministry of Education’s virtual research centre of evidence-based medicine founded in 2004, and the China Medical Doctor Association’s evidence-based medicine committee organised in 2003.3

The board members of these organisations are located all around China, and have sought to disseminate knowledge of evidence-based medicine throughout the country. Programmes (usually 1–3 months) organised by the Ministry of Education, continuing education programmes, and online education programmes are available. Clinical epidemiology and evidence-based medicine have become compulsory curricula for medical students and clinical postgraduates in all universities. Medical associations in every discipline have built clinical guidelines for common diseases according to the evidence to inform clinical decision making and teaching. Evidence-based medicine has also engaged with traditional Chinese medicine. Research teams in traditional Chinese medicine have been established and the rigour of traditional medicine has been gradually raised. The Chinese clinical trial registry4 was established in 2007 and the number of clinical trials registered in China is increasing (figure).5

There are, however, several concerns about the development of evidence-based medicine in China. First, access to scientific evidence is not equal in all regions. Doctors from developed areas and large cities, such as Shanghai and Beijing, can search the literature for free at their university via databases such as Medline. But doctors in remote areas might not be able to access the best information resources, which, together with a limited knowledge of English, could prevent use of the best evidence in their practice.

Second, most of the world’s clinical evidence does not come from China. Few results from China have been included in systematic reviews6 or clinical practice guidelines. I calculated that from 1999 to 2008, 1880 clinical research articles were published in *The New England Journal of Medicine*, *The Lancet*, and *JAMA*. However, only 0.21% of these were from mainland China.7 Wu and colleagues8 analysed randomised trials on 20 common diseases published in China’s natural knowledge infrastructure database from 1994 to 2005, and found that only 7% of them met methodological criteria (according to Cochrane review criteria). Frequent errors in statistical analyses are also found in Chinese medical journals,9 which reduces the credibility of the evidence.

Third, because of a lack of funding for investigator-led randomised trials, most good-quality Chinese clinical trials are pharmaceutical premarketing trials sponsored by drug companies. Such research is more likely to have outcomes that favour the sponsor’s product, which could result in publication bias.10 Finally, although the Chinese Government has made research into traditional medicine a priority area and randomised trials have shown efficacy for some traditional therapies, because of the low methodological quality of trials and selective

---

**Figure: Growth in clinical trials in China**

We searched ClinicalTrials.gov5 on June 15, 2009, with the term “lead principal investigator/sponsor=China”.
Fomenting a prevention revolution for HIV

2010 heralds the year set by the UN to achieve universal access to HIV prevention, treatment, care, and support.¹ Despite major achievements and heroic efforts over the past decades by people living with HIV to assert their rights for treatment equity, to end stigma and discrimination, and to ensure more inclusive approaches to governing the response, much remains to be done. 80 countries still criminalise homosexuality.² People living with HIV face restrictions on entry, stay, and residence in some 57 countries.³ About 10 million people are currently denied access to lifesaving treatment.

Despite, or perhaps because of, its success, the AIDS response has itself come under attack.⁴ Coalitions of social conservatives have orchestrated a global campaign against condom promotion and supported legislation criminalising same-sex relations.⁵ Such actions increase stigma and isolate people most at risk of HIV at a