Ulster Medical Society

THE ROBERT CAMPBELL MEMORIAL ORATION
17 February 2011
From Ink to iPad, Belfast to Brazil;
The BMJ Journey
Dr Domhnall MacAuley
British Medical Journal

Professor Margaret Cupples:

Can I say you're very welcome, and I think we probably should get started with tonight's Robert Campbell Memorial Oration, to which we are very happy to welcome Dr Domhnall MacAuley, and I'm looking desperately for him in the audience, he seems to have disappeared?—there you are, thank you. Thank you for coming.

Tonight it's a varied audience, and it's great to see the younger people amongst it. We had a very good presidential dinner at our last meeting, and that also was attended by a mixture of age. We're very grateful to the young people, because we really depend on another generation coming to follow through a great tradition of an interchange between the various disciplines connected with medical practice.

Robert Campbell himself was a physician of note. He was also a surgeon. He was born in the late 1800s, in 1866 near Templepatrick, and he was the son of a manse. In early life, he had scarlet fever, and the second encounter that he had with significant illness was when his mother died when he was aged nine, with puerperal eclampsia. He proceeded to come from Templepatrick down into the city to go to RBAI, and then to Queen's College, which he entered in the Faculty of Arts. He graduated from there, and he was thinking of going to the Bar, but someone or some people persuaded him otherwise, and he adopted a career within medicine, so he attended Queen's College again, in the late 1800s, and he was first in his year and qualified with honours. He proceeded to go to England, to St Thomas', where he was a house surgeon; became an anatomy demonstrator, came to succeed in getting his FRCS and his LRCP; did a spell in Chester, and then returned to his native home in Belfast, where his first job was as an honorary surgeon to the Children's Hospital, then in Queen's Street.

He had various connections with medicine and surgery, but chiefly in respect of surgery, and he was an honorary surgeon and appointed to the Royal Victoria Hospital, and a lecturer in surgery at Queen's. He joined the Ulster Medical Society, became its president in 1916, and got a variety of acclaim given to him, both in his delivery of lectures and his writing of textbooks, and his work in the surgical theatre.

He earned the acclaim, he himself said there were three requisites for a successful career in medicine. One was a sound knowledge of professional work, a second was a sound personal character, as shown by conduct and manner, and that was someone who would be sober and kind to their patients, and the third aspect was one in which he did not in fact sell himself, and that was pushfulness, or the spirit of self-advertisement. He himself was said to have this, as a completely foreign aspect to his nature. He hated all pomp, boastfulness, show, and detested sham and humbug.

So, when he died in 1920, he had a legacy, and that was set to be the Robert Campbell Memorial Oration, and it was to be given to a man in the first instance, but happily that was extended to include womenhood, but the person did have to come from Belfast, and had to show excellence in either medicine or in surgery, and the people who have fulfilled this role over the years have had distinguished careers, and we're very pleased to honour Dr Domhnall MacAuley tonight as one of those people who has excelled in everything that he has done, from starting off as a general practitioner, in other parts apart from Belfast. He did his training in England, not unlike the man he's going to represent this evening, and he has gone from strength to strength, from here, through editorship of the British Journal of Sports Medicine, to editing part of BMJ, and he travels widely. So his title tonight is "From Ink to iPad, Belfast to Brazil; the BMJ Journey". Domhnall, thank you.

Dr Domhnall MacAuley:

Well, thank you very much, Margaret. It's tremendous to be here, and it's a great honour, and I really do appreciate it—thank you very much.

We have a VIP in the audience tonight, and you know, you don't often get a chance to do this. I'm sure many of you haven't had a chance to do this, but can I point out a VIP?—this is my mother here. (*applause*)

And it's not entirely unrelated, because I work, just as (?? 0:05:01), and I see there are lots of old friends here and some new friends, who I haven't met before, so look, this is very relaxed. Stop me, ask any questions—you know me well enough, I'm quite happy to stop at any stage along the way. But I work one day a week. I'm still a real doctor one day a week, and I'm one day a week here in Stewartstown Road, and that, of course, is where I grew up and where my mum and dad were GPs, and where I came, and only Dr (?? 0:05:25) will remember that far back, that I've been coming here for about 30 years long, I guess, that's as long as I've been coming along. There's one or two others here who have been coming along as long as that as well, but I work one day a week in general practice, and four days a week for the BMJ.

How do you that? Well, you do it now because of modern technology, so I do an awful lot of teleconferencing. I'm in London maybe a couple of days most weeks, and the rest of the time I spend really travelling around different parts of the world, I guess.

I want to just structure this, try a little bit for everybody, so there'll be a little bit for readers, so that's for you, and then there's a lot of people who are still doing the medical research, talk a little bit about what it's like being an editor, a little bit about some of the work coming from Belfast, and a little bit of a few other things there. Just looking around there, there's

something for everybody, including the person who I didn't see at the back, who was my first boss. She snuck in at the back, I think, and I was Kathleen Logan's houseman—no, I will not tell you when that was, but it was a while back.

So here's the first one: what is the BMJ? Now, you're looking at me—what do you mean by, what is the BMJ? It is obvious really. How many people remember this as the BMJ? Right guys, the bad news is, you're past it! You've had it. This isn't really the BMJ anymore. What is the BMJ?

Well, let me take it back a little bit to think, and this is, even the most cynical among you, when you went to medical school that first day, what did you want to do? You had some little bit inside you there that wanted to do good for humanity, wanted to change the world a little bit, and in fact, that's the kind of ethos within the BMJ, and what we're really trying to do is, and this is what determines all the decisions that are made—it's all about helping doctors make better decisions, so when they talk about the content or editorial decisions or what we do, everything is dictated by that mantra: will it help doctors make better decisions? So when you talk in terms of making, of doctors making better decisions, what does that mean?

Well, the BMJ isn't a journal, the BMJ is a website, and what do you mean? What it is, it's a portal in which we access all the information there, so there's the research, and you can see the research is free, and we might talk a little bit about open access publishing, and free access to publishing.

There's the education component, and that's all the practice and the education and how you do things. There's the news, which is another dynamic in the BMJ, which has quite a lot of tension in putting it together between the news and the research component. Looking across, there's video, video in a medical journal? Well, video and audio is a very big part of what we do now, so when I come and I ask, what is the BMJ, there might be someone in the back who says, the BMJ is a podcast that I listen to as I cycle to work, so it's not really that rolled up paper journal that used to come through on a Saturday morning anymore—it's a multimedia organisation, designed to give all those aspects of education, including things like blogs, including various aspects of the whole type of the modern media, so what we're talking about is not just paper. The paper in a sense has gone, because this, you've been looking at the paper version here, that's your list of what the paper is, so who's going to read it? Who's the BMJ?—we were chatting about this earlier, who's the BMJ for? Who reads the BMJ?

How many GPs, how many doctors, read the paper version of the BMJ?—just off the top of your head, thinking about, just thinking overall, not just you, but how many people read the paper version, would you think? How many doctors are there in the UK?—there are about 60,000 in the UK, and many of those read the BMJ.

This is the figure for accesses to the BMJ website. 60,000 doctors in the UK, they're always very conscientious, 50,000 of those read the BMJ, say, okay? There are one-and-a-half million people access the BMJ Group website, 3.8 million unique visitors last month, and they visited 5.2 million times, and viewed 14 or 15 times, so what is the BMJ?—and who's it for?—and they're not clearly, they're not UK doctors. So how do you think about the content of the BMJ in that context, and what would you then put in the BMJ? These are the kind of debates that we have all the time.

So one of the things that people tend, at this stage somebody usually says, but my BMJ is the paper BMJ, you're losing it altogether, you're going to this website—this is all nonsense. People don't really want, really don't want a website, and you know what I say to them?—it's easy enough for you guys, because you can appreciate when I give these talks, I say, how did you get here?—and they say, well I flew here. How did you book your plane?—oh, I booked it on the internet. How did you know what the building was going to look like?—well, I Googled it, and you can see people then begin to realise that actually, what's happening is, this very subtle but definite change in the way we do things, so you might think, this website stuff is nonsense, but actually, people use the web more and more, even in the most subtle ways. What I then say is, if ten years ago your great aunt had left you a travel agency, a bookshop and a record shop, you'd think you were made for life, wouldn't you?—and that's what that slide is for. Look at what's happened to those things.

So if the BMJ is going to be HMV, where is it going to go? The BMJ is going to be Waterstones, Waterstones is wonderful, isn't it?—when was the last ime you bought a book there, where do you buy your books? Amazon?—okay, so anyway, the BMJ, we have the videos and the podcasts, and we've talked a little bit about that, and we've also this, doc2doc, and this doc2doc is this social networking site. Social networking as part of the BMJ?—well, it's part of the whole educational environment, so any of you with children who are in their teens, when they've got you out of the house now, what are they doing?—they're on social networking sites. That's the way they're learning and educating and talking, and many people here are on Facebook. Hey, there is some penetration—this is fantastic!—and then of course we have the blogs.

What it's become, is much more than this journal. It's a whole, what you might describe, in the old-fashioned way, as a university kind of concept, so we have BMJ Learning as well. What is BMJ Learning? Well, BMJ Learning is about these educational modules, and Jenny McGaughey here, who was my appraiser here, will recognise this, for that's what I did as part of my kind of contract for CPD, to do some of the BMJ Learning modules. These are now translated into about 15 languages, they're sold all over the world. There are cultural and geographic-specific versions of this, but essentially this is one of the big marketing aspects of the BMJ, in terms of generating that educational pool.

The Masterclasses… next week, the Masterclass is in India. India's the next big area for expansion for the BMJ. We will have an Indian version fully translated off the BMJ, and the Masterclasses will be there. The Masterclasses are now essentially all over the UK and in various other parts of the world. Did we have Masterclasses in Northern Ireland?—yes, one. Why do we not have any more?—because, guys, we're not big enough, that's why. Even with our, what is it, 2,500 doctors in Northern Ireland, this isn't a big enough market.

This is another thing, this is a partnership with the Karolinska Institute so the BMJ and the Open University and Karolinska are running these leadership programmes. Isn't that the kind of thing you would have gone to your local educational university or whatever to learn? So you can see how the whole concept of the Journal has completely changed. Clinical evidence—okay, iPhones, who's got iPhones?—a couple of iPhones, okay? Visits to the BMJ website using iPhones, November 2010, 152,000—you can see, the red one is the iPhone, and the green one is the iPad.

Audience member:

Google Android's taking over.

Dr Domhnall MacAuley:

Yes, well you can see how, that's the gap between those, but those are just the two that we use as the kind of… but that's the way it's moving.

Now, we talked a little bit about the different things. Before we look at this, what bits do you read in the BMJ? This is the kind of, the contrast is between what you see as the BMJ and the difficulty of looking at the BMJ in terms of an electronic media, so what bits do you read? We know the bits that we read, in a sense—you read the editorials and the discussion pieces and this and that and the other, and you read the obituaries, and this is the access online, so the bits that we may read are the editorials, okay, so the median number 2,000; the features, okay, 1,500; these kind of observations, the Des Spence-type stuff that entertains us all. Look at the difference in scale from what's accessed online, so you're talking there about the research, up to 38,000. Now, compare that to the figures we looked at earlier, and the other things that we looked at, and the clinical reviews. These are the most accessed bits internationally, so when you're there, and I'm going to put you in last Thursday and Friday's strategy day for the BMJ, where would you see the development for the BMJ? Where would you see that this must go, where are the customers? Who's going to read it, who's going to read it in the future, and how would you design the BMJ of the future?

Just to finish off that first part, that just comes to this business of where the journal has gone from ink to iPad. When I started to do the Journal of Sports Medicine about 15 years ago, what happened was I got a great big brown envelope full of written papers, and you'd write your comments and send these back. Now, you never see paper. The only paper I see is the same BMJ as you get. We never see paper at all, it's all electronic, and it may be in the future that there will be decisions made not to create a paper version.

Here's one for you, it nearly caused a riot. There was a suggestion that retired members may not want to get the BMJ every week—what do you think of that?

Audience member:

Not much.

Dr Domhnall MacAuley:

No, well I… look, there was a revolution, this just wasn't going to happen, but you know, these are the kind of ideas that are floated, and it's really important to have someone there as your advocate in it, but that was one of the things that was suggested, that we could do away with that. So the BMJ, has anyone got an iPad? The BMJ on the iPad, I have to say, is just beautiful.

Audience member:

It's a bit pricey though, you're forking out.

Dr Domhnall MacAuley:

No no, hold on, here's another thing—you're absolutely right, and I'll claim credit for this, okay?

Audience member:

(?? 0:19:47)

Dr Domhnall MacAuley:

I know, wind it back a wee bit. It's £9.95 for four issues, and all these guys hanging round the BMJ office, not many of whom are doctors, said, that's no problem, those doctors could pay for it. I said, hold on there—your BMA sub is £420. If you pay £420, and for most people, your only relationship with the BMA is your BMJ, unless there's some practice problem or you need help, or advice on your pensions or whatever, but for the vast majority of people on day-to-day business, your only contact is the BMJ, and I said, you cannot do that, so it will become free. I was given the credit for that, £9.95 every four weeks, and I take the credit. But this iPad, it's just, isn't it beautiful? It is just fantastic.

Okay, researchers, any researchers here, there's a couple of people that have done a bit of research. For researchers, what is the BMJ? For most researchers, the BMJ has one purpose, and one purpose only, and that is the BMJ is there to publish my paper, and it doesn't matter what else we do. I'm looking round here, because every time I speak to the media, there's always somebody there hanging round, loitering about, with a paper that we rejected, or they're there, and they think it's the best thing since sliced bread, and they just want to ask me about it, and you're sort of looking to see, who is it going to be this time?—but that's the purpose, and this is a very narrow view of what the BMJ is, and basically the only thing they're interested in is the impact factor, which is fourteen, and they want to get their paper in the Journal—pe-

riod. That created a tension, because if you're that researcher, what you're interested in is, yes, yes, yes, you aim to increase knowledge and improve health, oh yes, yes, of course, but you just want your paper there. Your researcher says that exercise [obscured by cough], there is nothing else to it, you don't even want to know it's in the BMJ, you just want that ticket in your file. From an editorial perspective, you can hear from what I was speaking earlier, we have a different perspective. We're not really interested in academic content per se, we're interested in helping doctors make better decisions. Now doctors, as you can see, it's generic group, it's not just clinicians, it might be public health, it might be health policy and it might be researchers, but it's all about helping people make better decisions.

So let me give you the secret of getting in the BMJ. If this is what you came for, this is what you get. There are three things that we report in the paper, this is the secret: is it new, is it true, and will it help doctors make better decisions? Now, what do we mean by, is it new? We want to know, is it novel, is it interesting? is it something, the first publication? We don't want something that's been published over in America, and this is the second publication duplicating or replicating over there, we're not interested in that, so it has to be new. Is it true?—now, we don't mean, is it fraudulent, and we do get fraudulent stuff, and I can talk to you about that if you want as well, but what we mean is, is it methodologically sound? Is it robust, is it true? Can we have confidence in the findings? The third thing is, as I said again, will it help doctors make better decisions?

So what happens is, and I'll talk you through a little bit, but we have our editorial manuscript meeting on the Thursday afternoon, and we talk about twelve papers. More or less all the papers that have got to that meeting are fairly good. There might be one or two have slipped through, that we find a fatal flaw at the last hurdle, but essentially they're all pretty good. Sometimes even at that stage, they fail on, is it new, because someone has come across some other work in the meantime to show that it's duplicated, or it's been shown before, but the fundamental question is, will it make better decisions, and that is, I'm afraid, Alan, the biggest problem we have with that is epidemiology, because epidemiology very often is part of the scientific process. Is it new, is it true, will it help doctors make better decisions—that's where it kind of falls down. Some fantastic, really methodologically rigorous excellent stuff, but it just doesn't make that final, make that push decision, and that's been a problem because there is that tension.

The kind of things that we get that we don't publish—prevalence studies, we don't do prevalence studies. Excellent work, super work, we just don't publish them, they don't really take that next step. Cost of illness studies—we don't do cost of illness studies, or burden of illness studies. There are other journals for that, we don't do that. Surveys of self-reported practice: what did you do?—we want absolute observed practice, so questionnaire studies of asking people what they did or what they think, basically what people say they do and what they do don't always correlate, so we just want people, what they've done, audits—not interested in.

Now, placebo-controlled trials, that's very interesting—we're not absolute on that, but what we're really interested in is, comparative effectiveness, comparing an intervention with the current best treatment. That's one of the things that comes up as well.

So what happened? Well, I used to edit the British Journal of Sports Medicine, and that, what we're doing there is, we're a specialist journal. You're there trying to help researchers. You had an advocacy role, you're trying to make the best paper, you're trying to improve things as much as possible. The BMJ is a ruthless rejection machine. You read for a reason to reject. As soon as you get that reason, bang, it's off. We may only read the abstract of your paper, so it's really, really important to get that right.

Now, let's put it in perspective. I'm going to make you one of the editors for today. Tomorrow. What's your day like tomorrow? Imagine a normal working day, so you've had your day, it's Friday, you've had your lunch, you switch on your computer screen, and you now have to read 15 papers for the BMJ. That's what happens when your paper goes in, so you've got to really make it easy for that editor. What's the editor looking for?—he's looking for something new. You know what?—there's very little new in medicine, very little. If you've had one research idea in your career, if you just have one good research idea in your career, you will have an academic career that lasts you a lifetime. If you have two good research ideas, you're a genius. It is very rare, when you switch on that PC, that you see a paper that jumps off the screen, and you say, "Gosh, that's really interesting". So then you've got these 15 papers, what about the abstract? You've got to get the abstract absolutely right, because if you mess up on the abstract, it's binned. It is a ruthless… Now, we'll talked a little bit about appeals, but that's the process—about 5% are accepted.

What happens? Your research is submitted, there might be 8,000 papers. The paper comes to you on your Friday afternoon, you have to decide what to do. You have an option, do you reject it straight away? If it's something you're not absolutely sure about, you can send it to a second reader, just someone who may be an expert in that particular field, say it was endocrinology, it's not my strong point, so I would ask somebody else to have a look at that. If you feel it's robust and it's new and you've had a look at the method which is the key thing, then you send it to what's called a screening editor, so it comes to the screening editor. Now, there are three of us that are screening editors, there's Trish Groves, who's the Deputy Editor, and there's Elizabeth Loder, who's based in Boston, and there's myself, so we do the second opinion on these papers, and then we decide whether it goes for review or not. So you've had it seen by two editors, and it goes for external review, and about 1,500 of those go for external review, and we usually have two, and maybe three reviewers.

Then it comes back, and then you have to make the decision as to where it's going to go there, of course, then we'll reject it, and then it goes direct to our epidemiology editor, who then makes the decision as to whether there's enough to go to the manuscript meeting, and then it goes to the manuscript meeting. At the manuscript meeting, are you counting all the people along the way?—at the manuscript meeting then, we have two external advisors, an external statistician, who's Doug Altman's team, and he'll have a team of guys who do those, there's about eight of them on the team, and then we have an external clinical advisor, and they range across all the clinical specialities. Then we have our editors—now, what is the BMJ? So who are those people reading, who are our readers? Where are they?—and that reflects in our editorial board as well, because now we have, for example, at today's meeting we had Elizabeth, who's in Boston, we had Gerard Rogler, who's in Vienna, we had Wim Weber, who's in Maastricht, we had Kirsten Patrick, who's South African, but in London at the moment, and in fact we only had one person from London in the office, everyone else was on the phone, and then there was myself, and you can decide with your own politics, where I live.

That's what our editorial board is like, and those are the people judging the papers. Now, it's very interesting, because what are the things that are important, for example, in general practice now? Things like QOF and points and those kind of things, are they of interest to our international readers?—absolutely not. They've no interest whatsoever, and our European editors will say, I don't understand that, what does that mean?—and that really is increasingly directing the type of work that we publish.

Last Friday, on reflection of some of this data, we decided that in future we will have to try and take out those words that are only applied to a British audience. For example, QOF, general practice—now, that's not, we're not taking away the concept of what we do in primary care, but taking out words that are purely British concepts, which is general practice. The American GP is someone who has never really done any post-graduate training, and just happens to see patients. It's not that same concept as we would have maybe in the UK or the Netherlands or Scandinavia, where it's very developed, so those type of words will be taken out of the BMJ in the future.

Should we publish papers on malaria? Again, these are things that, should we publish papers that come from particular developing countries? These are really difficult things, because it's really important that those are published, they do have, very impact worldwide, they do help doctors make better decisions. You know what, folks—nobody reads them. Any qualitative researchers here? Nobody reads qualitative research. To get a qualitative research paper into the BMJ now, it really has to jump off the page, and really has to be absolutely extraordinary, because the pendulum, we published a lot of qualitative research, and I'm in trouble here after this meeting, I can tell—but we used to publish a lot of qualitative research, and now it's swung really far away from that. It's very, very difficult to get qualitative research into the BMJ.

Now, one of the things that we try to get across is, if you were an artist, or if you wanted to buy a painting, you wanted to buy a painting in Belfast, you would know where to go to get a particular style, a particular type of painting, and it's exactly the same, submitting papers for the BMJ. We publish a particular type of painting. We don't publish research because it's good, we publish it because it's of a particular type, and that's the thing, it's about taking your piece of work to the art gallery, and that does create a lot of tension, because we do reject a lot of really, really good work that just doesn't fit.

The other thing that causes difficulty, from an editorial perspective, is the business of open peer review. We will not accept reviewer's comments unless they're signed. We will not even consider them, so unless you're prepared to sign your review, we won't... we are very, very hot on transparency. Every aspect of the process must be open and transparent, so we will not accept reviews that are not signed. It can cause problems, some people are reluctant to give reviews under those circumstances, but on balance, we feel that that's best for the authors, and do we look at appeals?—yes. Do we make mistakes?—of course we make mistakes! Will we consider appeals?—we do, and we often do. The difficulty is that some people just hit the appeal button every time, and you get to know who they are, and they're useless, but people appeal because the topic is important. Unfortunately we don't look at appeals if the topic is important, but if we've made a mistake in our understanding of the paper, yes, then we look at appeals, and one of the aspects of that is, it's building up the relationship with the various researchers, so that if, for example, you submit a paper, and you come back and you say, do you know what?—I think you might have made a mistake, then that's part of what we do in terms of an editorial outreach, is to build up those links and understand, because we don't want to... one of the things that we're concerned about, no research is perfect. There's no such thing as a perfect piece of research. What we want to be sure is, we don't reject the very best piece of work that is possible in that context, looking for something better, but if it's the very best that can be done.

Okay, what about an editor? How do you whether we're any good? Everything we do is audited to the last dot. This is the number of papers that I've seen in the last year—641 new papers in the last year, and my decision tree all along there, the numbers that are still active, the numbers that are declined. Why would I decline a paper?—because it's yours, okay? I don't generally edit or have anything to do with papers from Northern Ireland. It's unfair, we're too small a place, everybody knows everybody, so I decline it, so there are six declined. The numbers of revisions, the number accepted for publication, so there's 48 out of those 641 that have been accepted for publication—that's not bad; 543 rejected.

Elizabeth, who's based in Boston, has done 200, and Harvey Marcovitch, the paediatricians among you may know, used to be the editor of Archives of Diseases in Childhood. He's been over in Northern Ireland a couple of times for various things to do with the GMC. Chris Martin is the neurologist in Southampton, some of you may have come across Chris as well. So our target time is a decision within 48 hours, well a decision to reject it in 48 hours. What do you reckon would be a good median time for my decisions? What would you think would be a good median time, if you were looking at me for my decisions?

Audience member:

More than ten minutes. (*laughter*)

Dr Domhnall MacAuley:

Funny, that's interesting because, one of the things, in the old days, when you wrote a paper, and you had it all typed up, and you licked the envelope and you sent it away off, and you didn't have to think about it for about three months. I do first reads often on a Thursday, so you may submit your paper on a Wednesday, and I try to get everything done as soon as I can, so you may get your decision within three hours of your paper being submitted, and I'll have a lovely email from the researcher saying "You know, I just wasn't psychologically prepared for such a quick rejection!" But anyway, there's my median time for decisions, 2.7 days, and that's the type of thing that they're trying to go, so there we are.

Now, I've told you a little bit about, well, you've seen what the BMJ was like in the past. I've told you a little bit about what it is at the minute. What is the BMJ going to be like in the future? What is the future of medical publishing? Well, Richard Smith, who I'm sure some of you have heard, and many have heard speak, says there are too many, they don't meet information needs, they're not relevant, they don't add value, are too expensive, too biased, too slow, too pro-establishment, more concerned with authors and readers—time to throw it all out. What do you think?

Actually you're right. The future of medical publishing is very, very uncertain, in the same way as your record shop, so what's going to happen in the future? Well, these open-access publishing facilities are really increasing. PLOS One has been incredibly successful. Its impact factor has shot up, it's a very attractive facility, it's a very attractive place to publish your work. BioMed Central, where are you, Mark?—okay, even we at the BMJ, we'll be prepared, there's our paper, there's the paper we did with Mark Tulley here, we've put up the protocol up on BioMed Central. It's an open-access publishing house.

Why would you publish in open access? Well, because you can, because the impact factor's going up, and that seems to be the way it's going. So how is the BMJ going to respond to that? Well, we're responding in the sense, in terms of open access publishing as well. So one of the things we saw first of all was the opportunity to publish case reports. The BMJ doesn't publish case reports. The only way of getting a case report in is a Ten Minute Consultation, which I look after, or Easily Missed. I'll talk about Christmas, Stanley, afterwards, if you want? The Christmas edition is very interesting. Easily Missed, what are the criteria for Easily Missed? The criteria for Easily Missed is that I read that, and I think, goodness, I must remember that, good. That's about it. It's something that you think, gosh!—I hope I haven't missed something like that in practice, I must remember that in future, and that's one of the advantages of having the sort of joint condition editor-type role, and then the thing we've just launched this week is BMJ Open, and BMJ Open is the facility for publishing… now lads, it won't let you get the paper in straight away!—great minds, okay!

Audience member:

(?? 0:43:07) want any contact!

Dr Domhnall MacAuley:

So BMJ Open just launched. There are 20 papers on BMJ Open. It's an open-access publishing, you can publish there. Now, what does that mean? It means you have to pay to publish. There's a very light touch editorial process, but you can publish, and that is our response to this competition from the open access, because basically many of these open-access publishers, including BioMed Central and PLOS, do have a light touch editorial process, and this is democracy in publishing.

When you think about it, you have invested a huge amount of money in your research, you send it to us, and we charge you to buy it back. Wasn't that a great job? But now that business is coming to an end, because of this democracy within publishing, and the ability to publish in the open access.

I'm going to go to peer review. Is peer review a good process? Peer review is a hopeless process. It can add a bit of value at some times. Overall, it is very limited, and what's likely to happen in the future, something like this model here, where the pre-publication peer review is open-access peer review. Now, at the moment, I told you about our editorial process. We're aiming for transparency. When you get a rejection letter from me, you will get the rejection, the reasons why you were rejected. We are moving towards a process where you will be able to look and have access to all our files on your paper. There's absolutely no reason why that shouldn't be the case, and why we made that decision, but why should it just be us that makes that decision?—and what the chemistry and physics are doing is, you submit your paper, it's put on a website, your peers can make comments on it, they can peer review it, an open-access peer review, and then you can revise your paper in response to their comments, and then the journal will publish it, so you have your peers looking at your work well before it gets out into the public domain.

This is just a model. It's a bit complicated-looking, but you can see the referees, the official referees, but this is a scientific community here, then it goes to the editor, and then it's published, and you can see,

that's hopefully a much better way of doing it, and we're experimenting with that, and it's likely that will come in probably in the next couple of year in the BMJ.

Just a few things from Belfast. Alun, I didn't know you were going to be here, thank you very much for coming. This is the paper that came from your epidemiology group, and it was the front page of the BMJ, and I'm very pleased to say we were able to get a poster size version of that for the department. So I'm really interested, and really keen, to see this type of work coming from Belfast.

You can see it was there, on the front page of the Journal. Now, how would you get work from Belfast into the BMJ? Now, this is an interesting concept here, because the BMJ is not interested in work from Belfast. The BMJ is not interested in work from Northern Ireland. The BMJ is interested in work with a generic importance that will help doctors make better decisions, so what reason this got in was because the patterns of alcohol consumption in culturally divergent countries, it was a different pattern of alcohol consumption. It was nothing to do as to where this work was from.

People say to me, well, why not work from Belfast that deals with some aspect of the Troubles? Well, what about Palestine? What about Egypt? What about Afghanistan? What about Bosnia? In the overall world story, we're neither players, and we're history, so when people are talking about research from here to the BMJ, it really must be work that is stand-alone in an international context, and looking at the papers that come in, we haven't got away from that.

You can see how it made headlines here. What we're interested in as well is work that made headlines internationally, and what we can do is, we can give you a feed of where the downstream, where your research was picked up everywhere, and that's just a piece in Italian from this piece of work that was done in Alun's former department.

Now, the other thing we're interested in is post-publication peer review—what is that? Anyone here never published in the BMJ? Anybody never published?—never published anything, wants to publish?—guaranteed a publication tomorrow? If you want to publish in the BMJ, you can have a Rapid Response in there tonight. My Rapid Responses are, the paper version that we all get is history. The papers are published online as soon as they're edited technically, so your paper could be online three weeks before it appears in the paper version. What that means is, people can respond to that paper and make a comment on that paper online, and what can happen then is, your paper, and you may have seen this, a paper, together with letters corresponding to that paper, are in the same issue of the BMJ. You kind of think, how did that happen? Well, it happens because people have made a Rapid Response to that paper, and we've published that Rapid Response in the BMJ. The Rapid Response, a light touch, so you can do a Rapid Response to any paper in the BMJ, and you'll get something in the BMJ tonight. If you're interested, okay, it's not going to make your research career, but let me ask the most senior researchers here, put your hand on your heart and tell me honestly, there's not a little bit of vanity in seeing your name in print. There is, and it's likely the bit that gets you started, so you might have your Rapid Response. I've told you how to get a Ten Minute Consultation, I've told you how to get an Easily Missed; you have three publications in the BMJ by the weekend. That could be enough to get you started. If you then are interested in a research career, what are you fill in in that box that says publications, when you've got nothing? It's not earth-shattering stuff, but it shows you have the interest to do something.

Post-publication peer review, this is the business of what happens after it's published. Now, interestingly enough, I've put in a little comment, because that particular paper, I got a note, he didn't think I had any connections. People have no idea that, I'm just a name at the BMJ, they have no idea where you're from or where you're connected, and he wrote to me about that paper on alcohol, and he made a very interesting comment, that he's the editor of Evidence-Based Medicine, and this is all part of this post-publication peer review, and what he said was, "Alcohol consumption was measured at baseline. Would we even consider publishing a study that assessed past weeks' use of aspirin?—didn't measure it again, and then reported on ten-year outcomes?" So that's the kind of thing in terms of the post-publication peer review, it's all part of this process. It's no longer this static process of publication in the Journal.

Another thing we do is a CME, and you may have wondered what that CME on the Journal is, and this is, a paper is selected every week for CME, run by the Cleveland Clinic in the States, and this gives doctors in the US an opportunity to earn their CPD points through this joint partnership with the Cleveland Clinic, and again, Mark, you'll recognise that that's your paper there that was in the BMJ.

We also look at the downstream effect, so what happens in this group with McMaster, what happens to these papers?—and again, Mark, there's your paper come in as the number seven paper in terms of the quality of the research that month, ahead of the New England Journal of Medicine, British Journal of Psychiatry, Archives of Diseases of Childhood, but that's in terms of the context of what happens, and just a little bit about the media. People say, God, that stuff picked up in the BMJ, so that was a hopeless paper—yes, we have no control over the media whatsoever, and a couple of examples, just on the relationship with the media—this comment here on daylight—do you remember that last year? This one went absolutely global—completely disproportionate. This was a personal review in the BMJ, it had no research, no data, nothing whatsoever, and it took over everywhere, and you have no control over that whatsoever, and what we do, we separated completely the press release team from the editorial team, and they try to select the papers that will make impact, and that one just was completely disproportionate.

This is the paper we published that had a major impact. I don't know if there are any obstetricians?—no, well the GPs will know the model of home birth in the Netherlands. It used to be a big thing, we talked about it all the time, and how the home birth in the Netherlands, they were just as good as, or even better, than hospital births, and it was held up as the model of appropriate maternity care. We published this paper from Utrecht, which pretty much took that whole process apart, and it's absolutely amazing, the effect that that had, because you have very militant people on the kind of home birth, groupies, and we were virtually taken apart for publishing this, that it was absolutely disgraceful, that could possibly suggest that there was anything wrong with home births. There were questions in the Dutch parliament, and there has been a major enquiry into maternity care in the Netherlands as a result of this work. Amazing how certain of these papers can have a really major effect.

And this has got a bit buried. Hands up everybody who's read this week's BMJ?—anyway, this was a couple of weeks ago, and this was a very reasoned, (?? 0:55:29) discussion on breastfeeding, saying that the current UK guidelines, that you should have six months' breastfeeding, really were questionable. Well, this went absolutely ballistic! This was considered absolutely, we've all gone back and looked at this paper, that was very well-balanced. It has gone absolutely ballistic.

It was picked up reasonably by the Guardian, but the complete resistance to the whole breastfeeding lobby was absolutely astounding. If you read last Friday's BMJ, you'll see an article by Chris Martin, and Chris Martin did a little tour of all the blog sites and websites to do with maternity care, mums.net and all, and there was a vitriolic attack on this paper. Some sacred cows, you daren't… or what about this? This was really very, very interesting. It was, and I mean, Fi Godley put her neck on the block for this, I mean, to accuse The Lancet of fraud is a pretty serious accusation. There hasn't been a peep out of The Lancet, no response whatsoever. I don't think she'll be getting a Christmas card next year, but what's happened is, again there is a very, very active group of supporters, the anti-vaccine lobby is very, very active, and what happened, just like we've heard about this last couple of weeks in Bahrain or Egypt, there is a whole Twitter movement to say, the BMJ are anti-Wakefield, and this is appalling. And what happens is, we get email bombed by thousands upon thousands of people, attacking us for this principle. Fi Godley got a picture in an email of what she delicately describes as a child's poo, because this was relating to the gastroenterology. We've all had to watch our email boxes for getting a whole bunch of these emails—very much like anything, any time we ever publish anything to do with Israel or Palestine. There is an incredibly powerful lobby that, as soon as we mention it, we're email bombed at the BMJ. It's really quite sensitive stuff.

Finally, I just happened, when Margaret asked me about this, I just happened to be putting together, I put together the issue for Brazil, and I'll talk a little bit about it. In the, earlier, we're really quite active in China, but this Brazil issue, the BMJ's interest in Brazil was encouraged actively by the Brazilian government. They decided that primary care was the way forward in the development of their health service. You may have seen all the stuff about Lula, their President. He was the person who put together the whole health structure for primary care in Brazil, and I was able to go out, I put the issue together, when you contacted me, Margaret, we'd put together, and I was out at the conference, and it was fantastic to be able to speak at a conference the very day our Brazil issue came out. In Brazil, they have built health centres for every 3,000 patients in the country—it is a vast country, (?? 0:59:47) with a GP, a nurse and a lay health worker for each of those units, and they've built similar health centres around, and what they've done is, they have leapfrogged all the sort of adolescent growing processes we've had with primary care, so that in Brazil, which is a developing country, they are fully computerised, they send their referrals electronically to the hospital, they send their x-ray requests electronically to the hospital, they get all their letters back electronically, they send their prescriptions electronically to the pharmacist. Everything is paperless, they've jumped completely over this whole tension we've had about, oh, should we do this, should we do that, should we have records, how do we do it?—and it's absolutely astounding to see it… because all their records are on a major electronic database, they have an incredible potential for research. They have every consultation coded from day one, and what absolutely fascinated me was, in one of the practices where I went to visit, they had three maternal deaths within a year, three shot by their drug dealers, and two shot by the police—but there wasn't a bar on the window. Their DDAs were kept in a cupboard, and there was absolutely no problem with security at the health centre at all… so anyway, to move on, that was our issue in Brazil, and we'll stop there now.

The Christmas edition is static, the thing about the Christmas edition is, it must be a good size, and sorry John, a bit too much medical history, we have to restrain the medical historians, but it's asking that original question, and doing it in a proper scientific way, and it's not, will it help doctors make better decisions, but it's a great idea if it sounds good. I'm happy to answer any questions on anything you want to ask me.

Professor Margaret Cupples:

Thank you very much, Domhnall. I know the evening's going on, but I think we could listen to you for a little longer, and hopefully we will do so, downstairs over a cup of tea or coffee, but I've thrown the floor open—a couple of questions perhaps?

Dr John Craig:

You mentioned about the peer review process. One thing that's concerned me is that the editorials aren't always necessarily peer reviewed, is that correct?

Dr Domhnall MacAuley:

You'll see at the bottom of the article, where there's peer review, that most of the editorials are peer reviewed. It'll tell you whether it's peer reviewed, but they are all peer reviewed.

Dr John Craig:

There was one recently, which, basically, I'm a neurologist, and epileptologist, that says Carbamazepine is the drug of choice for women with epilepsy. I mean, I know there have been replies to it, we've thought about composing one as we are specifically interested in this, but we couldn't find anything to write about the article, it says…

Dr Domhnall MacAuley:

You don't think about it, you respond immediately. We're very interested in our post-publication peer reviews. It's really, really important, because that sets the record straight, because that is then electronically tied up to that… because people get it wrong, so it's really important to have the opportunity to put that right, and there's no problem about putting that right.

Dr John Craig:

I think it was mainly, the feeling was, it was having read that particular article, I thought it was a very good reason why editor… which do carry weight. We think we live in an (?? 1:03:51) space, medicine society, but editorials carry far more weight for most individuals than the actual paper on which it's based inside, and I suppose it's a bit like the paper saying something bad about you, and then the retraction. If the first two pages, is how bad a person you are, the retraction is three lines on page 19, the chance to reply properly really isn't appropriate sometimes to the mistakes that can be made.

Dr Domhnall MacAuley:

What I suggest you do, if you highlight that one to me, I'll go and have a look and let you know just for interest, but they are peer reviewed and they usually have two peer reviewers, and that's usually because very often that peer reviewer is someone who has refereed the paper, because they've already looked into it into considerable detail, but it is really, really important, and we'll accept that mistakes happen, and we're absolutely with you on that business about the retraction, and that's why it's really, really important that when you look up anything electronically in the BMJ, it has all that post-publication peer review there, and there are some papers will have 14, 15, up to 20 responses to that, and it's that dialogue that is really, really important.

So do respond, your comments carry great weight, and it's really important that the experts respond to those things if we get it wrong, we get it wrong. We're not perfect, don't forget.

But your opinion's important, and that's the thing about the democracy of the web—everyone's opinions is important.

Professor Margaret Cupples:

One more question.

Professor Robert Stout:

I've got two unrelated questions, if you don't mind. So you say that, you look at whether a contribution is new, when you're deciding whether to publish it. I get the impression that there's a certain degree of fashion in what is published as well, not just in the BMJ, but in other journals. There are particular times there seem to be a lot of articles on the same sort of topic are appearing?

The other question I want to ask you was this question of the email bombing that you mentioned—surely this is a matter of serious concern? This is an attempt at bullying, isn't it?—and something, is there any way of countering this and dealing with it?

Dr Domhnall MacAuley:

No, you just have to live with it, that's the way it is, but it is brilliant, and does it work?—it does. We're very reluctant to publish anything to do with Israel or Palestine now, it's just so uncomfortable.

Are there fashions?—yes, and do you know what happens?—what's absolutely fascinating is, you will sometimes have nothing at all, and then you'll get two papers on almost identical topics, and you're left, or maybe someone has published something, maybe we've seen the paper and it's three weeks ahead of the last, I'll say other paper, on exactly the same topic, and the second paper's better than the first one. We're really stuck, it's a real struggle. So why do people think of the same idea at the same time?—I don't know. I presume there's some kind of nudge at a conference, or people think, gosh, maybe that's a nice idea, or somebody mentions something and it'll be an interesting idea. But you're absolutely right, there are fashions—no question about it, and things come in and things go out of fashion. One of the problems is, when you publish a couple of articles, maybe I can think of something, if you publish something on a topic—calcium, okay?—calcium, osteoporosis, calcium and vitamin D, I don't want to see another paper on calcium and vitamin D, because we published on it, and now everybody's throwing themselves in (?? 1:07:34), so it's trying to get that little game and get ahead of the game and get that new angle and things.

Breastfeeding, we really don't want to see much on breastfeeding. There's been so much, what's new about it? These are the kind of things where you think, what's really new about that?

Another one, I'm hesitant to say it, it's a bit unfortunate, maybe a bit unfair—health inequalities. What a health inequality, what a paper on health inequality, is going to tell us something we don't know about health inequality? Smoking, I hope I'm not dismantling people's whole research here!—how many more papers do we need to say, smoking is bad for you? Really, Margaret, I'm sorry.

Professor Margaret Cupples:

No, no, I see one more question coming.

Professor David Hadden:

It's not a question, it's really a statement—I just wanted to congratulate the BMJ on unveiling the problems around the MMR dispute, because I think that was very well done, properly done, in deep, deep detail, and we enjoyed reading it and we learnt, and we were alarmed at the background to it all.

Dr Domhnall MacAuley:

It is scary stuff, and the whole of research misconduct is a very, very tricky and difficult area, and we struggle with that all the time, it's very, very difficult.

Professor David Hadden:

And the link back to the legal aid?

Dr Domhnall MacAuley:

There is an interesting article in this week's BMJ, asking about Brian Deer, and saying, did he have, were his articles subject to the same rigorous peer review process that all the other ones we had had? There is a fair point in that as well, so I think it's really important that we're absolutely transparent about what we do, but thank you very much for your thoughts, it's very much appreciated.

Professor Sidney Lowry:

Fiona Godley, is she still the editor of the BMJ?

Dr Domhnall MacAuley:

She is, yes.

Audience member:

She's made some very sharp comments about an American doctor and the pharmaceutical companies earlier this year or last year. Do you worry about libel tourists?

Dr Domhnall MacAuley:

Do we worry about libel, full stop?—yes, we do, and we have not quite an in-house legal team, but we have a permanent relationship with a legal team who read everything that could possibly we could go to court for, and the BMJ's been to court on a number of occasions. And there are… I mean, you'll have seen about Peter Wilmhurst, we've seen about Peter Wilmhurst and he's been taken to court by a pharmaceutical, an equipment manufacturing company he was doing work for on, well it was originally with migraines. The big multinationals will take journals and researchers to court if they're in the wrong, if they're perceived to be in the wrong, or if they could possibly be in the wrong, and it's a bit of a disincentive, if you're a researcher, and you get a writ from a company. There are different ways of doing this.

Dr Stanley Hawkins:

Not perhaps another form of bullying at times?

Dr Domhnall MacAuley:

Actually the BMJ is very hard on pharma. I worry about that a little bit. I worry that we're unjustifiably hard on pharma. I think we have to be absolutely rigorous in what we do, but the danger is that we might go too far. We don't publish many pharma studies, and I think, sometimes I think that perhaps we, our perception publicly is such that it scares off some of the good pharma studies, but we are a bit hard on pharma. I see Jenny's nodding her head. We try to be fair. I agree with you about the MMR and I agree with pharma, but there is also something, we've really got to be careful that we don't become the journal of anti-everything. We have to be pro some things. Margaret's sort of dragging me by the neck!

Professor Margaret Cupples:

No. You're being encompassed by people downstairs, I think, but can I say thank you, Domhnall, for a very enlightening lecture. You've shown us a little bit behind the scenes of the BMJ. I think you've revealed something of a kaleidoscope and a revolution that's ongoing, and I think you've certainly lived up to the high standards of the Robert Campbell Memorial Lecture.

One of the most outstanding lectures in the past was given by Sir Alexander Fleming, about the discovery of penicillin, and that was attended by the Duchess of Abercorn as a VIP, so thank you for coming, Mrs MacAuley, tonight, and you're welcome as our VIP, and I'd like to present this to you on behalf of the Society.

Dr Domhnall MacAuley:

I'm sure Robert Campbell didn't have the opportunity to (?? 1:13:05).

Professor Margaret Cupples:

Thank you, but I'll just invite you all to join us downstairs for a cup of tea, for members of the Society to sign the register please, and for everyone who's here, there's a certificate of attendance that you can add to your updated modern e-portfolio, or portfolio record, for appraisal and revalidation, and to advise you, on 3rd March for the next meeting, which will be given, the lecture will be given by Professor Ian Graham from Dublin. He is the Professor of Cardiovascular Medicine in Trinity, Professor of Preventive Cardiology in the Royal College of Surgeons, Head of Cardiology and Vice-Chairman of the Board of Management of the Tallagh Hospital, and he's going to talk about cardiovascular disease prevention and management, best current practice, so you'll all be very welcome, and John has just reminded me, there are tie pins and brooches in the one box for sale, for anyone who's interested. Thank you very much indeed.