Human Resources and Social Security (MHRSS) stipulates a retirement age at 55 years for female medical staff, while men can work until age 60 years. Therefore, female doctors, who graduate from medical school at about age 30, have only 25 years for career development.

The publication pressure of an evaluation system based on academic articles and violence against medical doctors in large hospitals, also affect women.[2,3] And some female doctors choose to quit public hospitals for private practice (including Yu Ying—a famous blogger and emergency physician at Peking Union Medical College Hospital, Beijing).[4]

Fortunately, the Chinese Government has begun to provide more support for professional development for female doctors. The National Natural Science Foundation now allows females to apply for youth funding up to age 40 years (compared with age 35 years for males), giving female doctors more funding opportunities to support their research. MHRSS also grants female doctors nearly 6 months maternity leave and 1 h every day for nursing in their infant's first year.

Nevertheless, female Chinese doctors still face difficult challenges. Further reforms are needed to propel female doctors forward in their careers.

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China's National Mental Health Working plan

We noted several incorrect comments made in an Editorial (June 27, p 2548)[1] regarding China's National Mental Health Working plan (2015–20)[2] that were ungrounded and misleading.

First, the government's plan did mention strategies to address discrimination against people with mental illnesses. This document very clearly stated that one of its goals was to "actively build a society in which patients with mental disorders are understood, accepted, and cared for".[2] Additionally, the plan[2] stated that relevant government bodies need to use the media to disseminate core concepts about mental health (such as mental illnesses being preventable and treatable, and that people should be caring and not discriminate), and to guide the public to "understand mental disorders and psychobehavioural issues", and to "treat those patients with mental disorders with respect".[2]

Second, in high-income countries suicidal behaviour is often associated with a mental disorder, whereas in China about a third of people who die by suicide and two-thirds of those who attempt suicide do not have a mental disorder.[3] The government's plan was focused on mental health and did not use the word suicide, but included measures that can improve suicide prevention.[4] For instance, a requirement included improving the competencies of health-care institutions in the recognition of depression to increase the treatment rate by 50%.[2] Another requirement in the plan was that at least one telephone helpline be set up in every province, crisis intervention teams established in all provinces and in 70% of the cities, psychological consultation or crisis intervention centres be set up in higher education institutions, and psychological guidance offices be set up in primary and middle schools.[2]

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Did Ebola relatively spare children?

In her Correspondence, Judith R Glynn,[1] as others before,[2] reports lower incidence of Ebola among children than among adults. This finding might result from age-related biases in Ebola surveillance. Ebola cases are reported through clinical care, contact tracing, or burial records. Paediatric cases (especially in children aged younger than 5 years) are more likely to be missed by this system than are adult cases. First, children aged younger than 5 years die from Ebola more frequently and faster than adults.[2] Case management teams (eg, ambulances, contact tracers, and safe burial teams) thus have less time to reach such paediatric cases before their possible burial. Second, children with symptoms matching the case definition of suspected Ebola might have sought clinical care less frequently than adults. Before the Ebola outbreak, only

a third of children aged younger than 5 years with fever in Guinea visited a health facility, whereas around 60% of adults did so when they last experienced symptoms of malaria.[3] Similar age differences in care-seeking probably persisted during the Ebola outbreak. Finally, children might have been reported as contacts of Ebola cases less often than adults, especially when index cases were other children, thus missing subnetworks of transmission. Interactions between children are difficult to monitor, and might have been omitted during contact tracing interviews with adult informants. These three factors lead to fewer opportunities to diagnose and report paediatric Ebola cases than for adult cases. The burden of Ebola in children might thus be larger than estimated by surveillance data, and should be reassessed through: serosurveys measuring Ebola antibodies;[4] and verbal autopsies assessing the number of unreported Ebola deaths in affected communities.[5]

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EXAMINE: targeting risk and treatment in diabetes

Type 2 diabetes mellitus is associated with both microvascular and macrovascular complications. For this reason, the US Food and Drug Administration includes specific requirements for cardiovascular safety assessment before the approval of new anti-diabetic drugs. In 2006, a population-based case-control study[1] showed a significantly increased risk of myocardial infarction in patients using glibenclamide. That same year, the ADOPT study[2] revealed an increase in the incidence of heart failure with rosiglitazone compared with glibenclamide (hazard ratio [HR] 2·20, 95% CI 1·01–4·79; p=0·05). More recently, saxagliptin, the first DPP-4 inhibitor to be tested on cardiovascular outcomes, was found to increase the number of admissions to hospital for heart failure compared with placebo (4% *vs* 3%; HR 1·27, 95% CI 1·07–1·51; p=0·007).[3]

However, in the EXAMINE study,[4] alogliptin did not increase the incidence of major adverse cardiovascular events among patients with type 2 diabetes and who had a recent acute coronary syndrome. In post-hoc analyses, Faiez Zannad and colleagues[5] (May 23, p 2067) found that hospital admission for cardiac failure was the first event in 85 (3%) patients taking alogliptin compared with 79 (3%) patients taking placebo (HR 1·07, 95% CI 0·79–1·46; p=0·657). It would be interesting to know if some differences in cardiac failure were recorded between men and women or among different dose cohorts.

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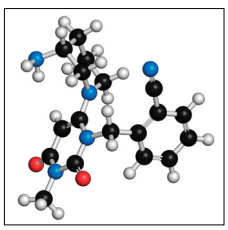
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Two common medical fallacies are that more is better and every drug in a class is the same (known as a class effect). The association of dipeptidyl peptidase-4 (DDP-4) inhibitors with an increased risk of heart failure is supported by the SAVOR-TIMI 53 (saxagliptin) and EXAMINE (alogliptin) trials.[1,2] With the publication of the much anticipated TECOS trial,[3] this adverse effect appears to not be a class effect because sitagliptin did not cause an increase in the risk of heart failure. All five available DPP-4 inhibitors have similarity of either a primary or secondary amine group, which contributes to electrostatic interactions with DPP-4.[4] A pharmacological comparison of the available drugs in the class of DPP-4 inhibitors is summarised in the table.

Each individual drug can be divided into three major categories on the basis of their ring structures: saxagliptin and vildagliptin are cyanopyrrolidines, linagliptin and alogliptin are xanthine-based agents, whereas sitagliptin is the only phenethylamine.[4,6] The selectivity profile for DPP-4 versus DPP-8/9 was originally believed to relate to in-vivo