We welcome the comments of Tucker and Folkar and note their contention that it is not the reduction in hours per se but the response of the employer, through rota design, that may be responsible for any negative effects. Underpinning this conclusion must be the fundamental assumption that that the same workload can safely be achieved, for both patients and staff, with reduced hours and less staff. Little guidance was available in meeting the 48-hour limit. We agree that enhanced rota design might improve the impact of EWTD implementation, but note that the authors refer to the '*likely* (our italics) impact of EWTD-compliant work schedules'. We are thus unclear if they were able to show that it is possible, without increasing staff numbers, to construct such a rota, meet full EWTD compliance and maintain workload and safe patient outcome? We would thus be concerned if attention were prematurely drawn away from the reduction in hours towards the responsibilities of the employer. We acknowledge that there are many uncertainties. Although our study has obvious limitations we sought to be as objective as possible in an attempt to lessen the speculation of ourselves and others. Contrary to the expectation of some, we did not find a reduction in standards of care. We did, however, find that sickness among trainees was markedly increased. This requires explanation. Surely trainees deserve more formal assessment of alternative ways of providing safe patient care while meeting EWTD compliance before it can be confidently stated that a working week of 48 hours is good for their welfare and training? We would hope such a view is shared by Tucker and Folkar and endorsed by all those with responsibility for junior doctors.

HUGH F MCINTYRE
Consultant physician
The Conquest Hospital
East Sussex

What about physical activity and exercise medicine?

Editor – Adlan *et al* lay bare an institutionalised and unbalanced portrayal of obesity treatment and their conclusions appear misleading (*Clin Med* April 2010 p 206). Obesity and type 2 diabetes are symptoms of pandemic physical inactivity and poor diet making their results far from surprising.[1] The authors omit any reference to physical activity preferring to concentrate on diet and medication as the only alternatives to bariatric surgery. Physical activity is of fundamental importance as a primary treatment (along with diet) for obesity, type 1 and type 2 diabetes. It is concerning that they conclude there is a lack of effective alternative treatments, while evidence for physical activity interventions suggests the contrary.[2–4]

Moreover, recent systematic and Cochrane reviews evaluating surgery for obesity are inconclusive, as long-term data on numerous outcome measures remain unknown.[5,6] Recent research suggests that the most obese and those with existing comorbidities are at the greatest risk of post-bariatric surgery mortality and this could be very relevant to many patients in a secondary care diabetic clinic, when compared to those managed in primary care.[7]

Admittedly, there is a deficiency of training on physical activity and exercise medicine within undergraduate and postgraduate medical education, a lack of comprehensive physician training to counsel patients effectively on lifestyle modification (and physical activity promotion) and a lack of provision of well-constructed physical activity schemes across the UK for patients with chronic disease.

However, is it not misleading for surgery to be portrayed as the only effective 'magic bullet' treatment for obesity and made increasingly available? Lee *et al* demonstrated in a prospective study, following 21,925 men, that obesity-related health risks are reversed by physical activity even without weight reduction, while the benefits of leanness are lost through physical inactivity.[8]

When these issues are addressed and considered holistically, perhaps physicians will be better placed to manage patient expectations and treatment with balance and, most importantly, with a sound evidence base.

RICHARD WEILER
Specialist registrar in sport and exercise medicine
Charing Cross Hospital, London and
general practitioner, Hertfordshire

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In response

We are grateful to Weiler for his response. A close reading of our report would show him that our aim was to demonstrate the high prevalence of obesity qualifying for bariatric surgery in hospital diabetic clinic attendees. In doing so we hoped to highlight the lack of an adequately funded multidisciplinary bariatric surgery service. It was not our intention to make direct comparisons of treatment options for obesity eg exercise versus bariatric surgery. However, there are several points we would like to make.

- We do not portray surgery as a 'magic bullet'. The indications for bariatric surgery in these patients are well defined in National Institute for Health and Clinical Excellence guidelines as quoted and is reserved for those who have failed a trial of diet, exercise and drugs.[1]
- There are numerous studies in well-motivated obese diabetic patients,

where increased levels of exercise have made a difference both to risk and to outcome. But we encounter difficulties in motivating our patients (often with multiple co-morbidities such as coronary heart disease, osteoarthritis of weight bearing joints etc) to increase physical activity as a means of achieving and maintaining long-term weight loss.

- We disagree with the implied suggestion that bariatric surgery is unsafe in a multidisciplinary setting. The composite end points of death, major thrombosis, reintervention and prolonged hospitalisation were 1% for laparoscopic adjustable gastric banding, 4.8% for laparoscopic Roux-en-Y gastric bypass surgery and 7.8% for open Roux-en-Y bypass surgery, in a multicentre study,[2] compared to mortality rates alone for aortic aneurysm of 3.9%; coronary artery bypass surgery of 3.5%, and oesophagectomy of 9% in the USA.
- While we agree that further long-term data are needed, current data are encouraging for long-term weight reduction,[3] reducing diabetes prevalence[4] and reducing mortality.[5]

However, till more evidence is forthcoming it may be helpful to remember Greenberg and Robinson's views:

In a perfect world, primary prevention through diet and exercise would alleviate the need for any surgical intervention. Unfortunately until we begin to see success with primary prevention...bariatric surgery will remain an important – and reasonably safe – tool in our armamentarium.[6]

MA ADLAN
Consultant physician
A DRODGE
Specialist registrar in diabetes and endocrinology
LDKE PREMAWARDHANA
Consultant phsycian
Section of Diabetes and Endocrinology
Department of Medicine
Caerphilly Miners' Hospital
Caerphilly, Wales

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Royal College of Physicians medical record keeping standards audit

Editor – In an environment where thousands of clinical audits are completed each year you would be forgiven for assuming that the maths behind the audits would be clear cut. However, in reality it is questionable how many audits contain subtle inconsistencies in the analysis of results that can dramatically affect the overall outcome of the audit. These oversights may not be picked up on first glance, if ever.

I became aware of the complicated nature of statistics in relation to audits while undertaking the 'Royal College of Physicians (RCP) medical record keeping standards audit' using the provided audit tool. The tool measures a department's performance against each of the RCP set standards by averaging the percentage scored for each standard in each set of medical records. This gives an average percentage performance for the sets of records. While the technique of averaging the percentages is not mathematically incorrect it is questionable whether this method is the most appropriate for this set of data as it assumes that all the entries have identical weighting. An example of this is that if one set of records with 99 pages scored 99/99 or 100% and another set with one page scored 0/1 or 0%, the average of these would be 50%. It may be more appropriate to consider a department's performance across all pages in all sets of records. In this case, the overall score would have been 99 out of 100 pages, or 99%. With such a large difference between the outcome of these methods it is important to understand the calculations before making any change to practice based on the results of this audit.

Here you can see that a simple and seemingly minor variation in the method of results analysis can produce a considerably different set of results. When conducting an audit using a pre-configured audit tool, you will likely take it for granted that the tool is making the calculations that you would expect. It is important to understand what the tool is trying to achieve and scrutinise the underlying statistical methods used to analyse the results. With so many audits being completed it is impossible to say how many inadvertent errors in the interpretation of results have gone unnoticed, although it would suffice to say that this is not a one-off.

JESSICA TUCKER
Foundation year 2 doctor
Royal Berkshire Hospital, Reading

Revalidation: a General Medical Council perspective

Editor – It was with considerable interest that I read Rubin's editorial on revalidation: a General Medical Council (GMC) perspective (*Clin Med* April pp 112–3). As we know it was the GMC that proposed revalidation as a way of improving the self-regulation that we enjoy as doctors. To that end many of us have been working with our employing organisations, colleges, the Academy of Royal Colleges and specialty groups to find a useable yet robust method of appraisal fit for revalidation.

I therefore take issue with the statement 'research is of no relevance to the process of revalidation, except in rare instances'. On the contrary, good medical practice, informed consent, ethics approval, confidentiality, honesty, integrity and probity, especially with the high finance that accompanies pharmaceutical research, is all the more important. The