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]

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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.

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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