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

References

1 National Institute for Health and Clinical Excellence. *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children.* London: NICE, 2006
2 Longitudinal Assessment of Bariatric Surgery (LABS) Consortium. Perioperative safety in the longitudional assessment of bariatric surgery. *N Engl J Med* 2009;361:445–54.
3 Hickey MS, Pories WJ, MacDonald KG *et al.* A new paradigm for type 2 diabetes – could it be a disease of the foregut? *Ann Surg* 1998;227:637–44.
4 Pories WJ, Swanson MS, MacDonald KG *et al.* Who would have thought it? An operation proves to be the most effective therapy for adult onset diabetes mellitus. *Ann Surg* 1995;222:339–52.
5 Sjostrom L, Narbro K, Sjostrom CJ *et al.* Effects of bariatric surgery on mortality in Swedish obese subjects. *N Engl J Med* 2007;357:741–52.
6 Greenberg JA, Robinson MK. How safe is bariatric surgery. *Nat Rev Endocrinol* 2009;5:645–6.

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

current, high profile, fitness to practise case being heard by the GMC is testament to this.

The Royal College of Physicians medical specialty working group, under the chair of Ian Starke, has been clear that a doctor should be revalidated with regard to what they do whether this is purely clinical work, research or management or more likely a combination of all three. I hope that while the latest GMC draft is out for consultation, research will be seen as relevant to revalidation as any other action taken by a doctor in the course of their duty.

CHRISTOPHER EG MOORE
Consultant clinical neurophysiologist
Queen Alexandra Hospital, Portsmouth
Specialty representative, RCP revalidation group

In response

I am grateful for the opportunity to expand on the issue of research and revalidation. Representatives of the research community have expressed concern that the competitiveness of a doctor's research could be taken into account in the revalidation process. This is not the case and would clearly not be appropriate. I sought to clarify that point in the editorial.

However, I also indicated that there could be instances where the conduct of the research was of interest to the GMC, using research fraud as an example. In other words, for the purposes of revalidation, doctors doing research should need to demonstrate only that they meet the ethical standards for research (as set out in Good Medical Practice).

We are working with clinical academics to understand how this might best work in the system of joint appraisals administered by the NHS and the relevant university under Follett principles.

PETER RUBIN
Chair, General Medical Council

Complementary and alternative medicine (1)

Editor – I must confess to some puzzlement after reading Professor Allan's editorial (*Clin Med* June pp 211). The main theme of the article seems to be a review of recent debates around the registration of complementary and alternative medicine (CAM) practitioners but it hardly seems to me to make the RCP's position 'crystal clear'. Indeed, Professor Allan even refers to the existence of a 'conundrum' surrounding the acceptance of CAM and the registration of its practitioners. To many of us there is no conundrum: the RCP and its allied bodies such as the Academy of Medical Royal Colleges should be campaigning actively and vigorously against CAM; we should be advising the public that CAM is, at best, an expensive placebo and at worst a series of risk-prone procedures which may lead, for example, to the spread of blood-borne infections or damage to vital organs by unskilled manipulation.

ROGER A FISKEN
Retired consultant physician

Complementary and alternative medicine (2)

Editor – In your recent editorial (*Clin Med* June pp 211) you claim there is a conundrum. I am not clear if you are considering a lay person or a member of the RCP, who has to make this choice when you ask 'Is it preferable to go to a registered acupuncturist who has been trained in the importance, for example, of using sterilised needles'.

For a lay person it is certainly better not to go to a practitioner whose therapies are not shown to be effective, so registration of such a practitioner can only do harm by misleading patients about the competence of the practitioner.

A member of the RCP facing this conundrum should consult the document that they received when being accepted as a member of the RCP. It is several decades since I received this endorsement, but I think it required me to maintain the highest standards of medical practice. 'Alternative' therapies cannot be thus described if they lack evidence of efficacy, so it is even clearer that no member of the RCP should offer, or accept, alternative therapies especially if the therapist is misleadingly 'registered'. If an acupuncturist uses non-sterile needles this is an assault, which is in no way excused by 'registration'.

JOHN GARROW
Learning and Teaching on Post Take Ward Rounds