Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within 3 weeks of receipt of *Clinical Medicine*. Letters should be limited to 350 words, and sent by email to: clinicalmedicine@rcp.ac.uk

Mitigating the hazards of false dichotomies

DOI: 10.7861/clinmed.Let.23.3.1

Editor – The recognition that dichotomising the risk of hyperglycemia into diabetes and prediabetes may render a disservice to patient care[1] has its corollary in the recognition of the continuum of risk of incident atrial fibrillation (AF) associated with hyperglycaemia[2] or blood pressure.[3] The following are pertinent examples of this continuum of risk.

Using data available from electronic medical records collected from the National Taiwan University Hospital, Hsu *et al* compared 14,309 pairs of patients with prediabetes and normal glucose test results. In that comparison the Kaplan-Meier analysis revealed that the risk of AF was significantly (log-rank $P<0.001$) greater in patients with prediabetes. Furthermore, the multivariate Cox regression model indicated that prediabetes was independently associated with a significantly increased risk of AF (hazard ratio 1.24, 95% confidence interval 1.11–1.39, $P<0.001$).[2]

In their 35-year follow-up study of 2014 apparently healthy men (when evaluated at baseline) in the age range 40–59, Grundvold *et al* showed that men with baseline systolic blood pressure (SBP) 140 mmHg or more, and those with SBP 128–138 mmHg, had 1.60-fold (95% confidence interval 1.15–2.21) and 1.50-fold (1.10–2.03) risk of atrial fibrillation (AF), respectively.[3]

These longitudinal studies imply that, over and above the presence of a continuum of cardiovascular risk associated with 'above threshold' blood glucose or 'above threshold' SBP, the other prognostic operative factor is the duration of exposure to risk factors. Accordingly, the earlier the initiation of measures (including lifestyle interventions) to mitigate AF risk associated with prediabetes or systolic BP >128 mmHg, the greater the probability of mitigating the long-term risk of incident AF and related cardiovascular outcomes. In effect, risk management of AF should not be conditional on a formulation of a conventional diagnosis of diabetes or hypertension. ■

OSCAR MP JOLOBE
Retired geriatrician, Manchester, UK

References

1 Siopis G, Scibilia R, Kiat H. Dichotomising the risk of hyperglycaemia into diabetes and prediabetes. *Clin Med* 2023;23:188–9.
2 Hsu T-C, Yang Y-Y, Chuang S-L, Lin L-Y, Chen T H-H. Prediabetes as a risk factor for new-onset atrial fibrillation: the propensity-score matching cohort analyzed using Cox regression model coupled with random survival forest. *Cardiovasc Diabetol* 2023;22:35.
3 Grundvold I, Skretteberg PT, Liestol K *et al*. Upper normal blood pressures predict incident atrial fibrillation in healthy middle aged men. A 35 year follow up study. *Hypertension* 2012;59:198–204.

ChatGPT in medical practice, education and research: malpractice and plagiarism

DOI: 10.7861/clinmed.Let.23.3.2

Editor – We found that the recent article on early applications of ChatGPT in medical practice, education and research very interesting.[1] Authors utilising ChatGPT professionally for academic work should exercise caution, according to Sedaghat, who stated that it is unclear how ChatGPT handles hazardous content, false information or plagiarism.[1] Sedaghat pointed out that while ChatGPT can make radiological reporting simpler, there is still a chance of inaccurate statements and missing medical information.[1] Sedaghat came to the conclusion that while ChatGPT has the potential to alter medical practice, research and education, it still needs refinement before it can be used frequently in the field of medicine.[1]

It is acknowledged that the ChatGPT is a helpful AI tool and that it may one day be advantageous in research, education and medical practice. But as Sedaghat pointed out, the key issue is the accuracy of the data produced. Furthermore, the issue of malpractice and plagiarism should be addressed.[2] All processes remain the user's responsibility. Using a computational tool is not a negative thing, but using it incorrectly is unethical.[2] A possible unethical use is employing ChatGPT to write an article without input from the user for primary content drafting, validation and final approval.[2]

We believe that it is critical to continue to develop the current version of ChatGPT in order to make it more useful in the future. To prevent any unintended malpractice or misconduct, it is also necessary to review and reformat the specific code of conduct for using ChatGPT in medical practice, teaching and research. ■

AMNUAY KLEEBAYOON
Private academic consultant, Samraong, Cambodia

VIROJ WIWANITKIT
Adjunct professor, Chandigarh University, Punjab, India; adjunct professor, Joesph Ayobabalola University, Ikeji-Arakeji, Nigeria

References

1 Sedaghat S. Early applications of ChatGPT in medical practice, education and research. *Clin Med* 2023;23:278–9.
2 Kleebayoon A, Wiwanitkit V. Artificial intelligence, chatbots, plagiarism and basic honesty. *Cell Mol Bioeng* 2023;16:173–4.

© Royal College of Physicians 2023. All rights reserved.