

## 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](mailto:clinicalmedicine@rcp.ac.uk)

### Streams, rivers and data lakes: an introduction to understanding modern electronic healthcare records

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Editor – It is encouraging to read the works being undertaken to identify and analyse processes of digitalisation in healthcare systems.<sup>1</sup>

The authors identify inefficient and inaccessible medical information between trusts through differing digitalisation models. Concurrently, they highlight a lack of mainstream facility to communicate and integrate these. This raises the need for insights as to why there is not a single unified digital system in place for the NHS as it seems to be the clearest solution for the issues raised in your article. Indeed, a recent article published by the Boston Consulting Group<sup>2</sup> references 'core enablers for digital – physical patient care', outlining six key enablers for successful digitalisation. Using these as a framework it becomes apparent that the NHS is in a strong position to adopt a unified system.

Of note, there is a clear 'ecosystem' in the NHS through the commercial medicines unit (CMU) which makes deals applicable for the entire service and is responsible for buying and securing the supply of medicines prescribed in NHS hospitals in England.<sup>3</sup> Such deals ensure hospitals pay equivalence for medications within the NHS.

As such, would it not be feasible for the NHS to set up a parallel body to the CMU to 'buy and secure' the supply of electronic patient recording systems from one provider for all hospitals thereby creating a seamless service whilst ensuring clinicians have necessary access to patient history?

Another key strength for this is that the current crop of monolithic electronic system providers are well established, meaning they have real-world experience of creating easy-to-use systems with several iterations of improvement in user experience and interface (some have several apps in addition to their main platform, including for patients, eg for taking clinical images) leading to better user satisfaction for both patients and clinicians.

The opportunities raised from a comprehensive and fully integrated digital healthcare system in terms of research, efficiencies in clinical activity and (to be truly forward thinking) incorporation of AI technologies, amongst others, highlight it as an investment worth making and it will be interesting to see the path taken by healthcare providers. ■

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### References

- 1 Idowu EAA, Teo T *et al*. Streams, rivers and data lakes: an introduction to understanding modern electronic healthcare records. *Clin Med* 2023;23:409–13.
- 2 Cazzaniga S, Corzo V, Dahlgren S. *Digital solutions reduce waste in the health care system*. Boston Consulting Group, 2023. [www.bcg.com/publications/2023/waste-reduction-in-health-care](http://www.bcg.com/publications/2023/waste-reduction-in-health-care) [Accessed 23 July 2023].
- 3 NHS England. *Commercial medicines unit*. [www.england.nhs.uk/medicines-2/commercial-medicines/commercial-medicines-unit/](http://www.england.nhs.uk/medicines-2/commercial-medicines/commercial-medicines-unit/) [Accessed 23 July 2023].

### Assessment of obesity

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Editor – In their article<sup>1</sup> the authors do not address one of the two fundamental flaws in BMI, that it is proportional to height, the other being it takes no account of composition and little of distribution.

It assumes the body is a cylinder of constant height and so works better than ponderal index for those around median height because girth increases with obesity.

However, the error caused is not small. It invalidates any comparison between populations of differing heights separated in time or space. Consider the height range 1.50 to 2.075 m. The BMI of a tall person of the same body mass as a small person BMI 25 would be 34.5 and compared to one of average height, 1.75 m, 30.5. When fit tall people have a BMI in the obese range this is frequently attributed to muscle mass rather than simply to height. The consequences of over-recognition of overweight in the tall and healthy likely to be less relevant than the under-recognition of undernourishment in the tall and elderly. For a BMI of 19 the same range would be 19 to 26.25, with the majority appearing to be adequately nourished. The slight exaggeration of the growth of population obesity is of little practical consequence as perhaps is the overestimate of obesity in the tall, but the underestimate of undernutrition in the tall and elderly is potentially dangerous.

Unlike BMI the preferable alternative, waist to height or span, does not need a scales, takes into account fat distribution, is independent of height, and particularly if span is used does not underestimate undernutrition in the elderly. ■

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