letters

TO THE EDITOR

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Storing up problems: The medical case for a slimmer nation

Editor – In his review of the RCP report on obesity (*Clin Med March/April* 2004, pp 99–101), I was surprised by Andrew Prentice's statement that, 'It is now accepted that obesity is caused by a combination of gluttony and sloth'. The terms 'gluttony' and 'sloth' by definition[1] imply respectively, 'greed' and 'laziness' and impute a particular psychological motivation for all cases of obesity for which I do not think there is any evidence. The terms are also highly pejorative. In my experience obese people, particularly children, are highly sensitive to the antipathy of others to their condition and suffer from shame and stigma. In view of the particular difficulty of engaging this group in treatment, would it not be more accurate and helpful to use the more neutral terms 'over-eating' and 'under-activity'?

In addition, I am surprised that Prentice gives very little weight to the contribution of individual genetic differences, nor any mention of family eating patterns nor social economic deprivation. Finally, there is also no mention at all of psychological difficulties such as depression and anxiety, which in my clinical experience of working with this group of patients are important factors underpinning their over eating. Is there no evidence or has the evidence not been collected? If we are really going to make a difference in this very serious health problem, then I think that a more in-depth approach to motivational factors is required than the use of these pejorative terms, which will only increase the stigmatisation and alienation of the obese and discourage them from engagement with treatment.

Reference

1 *The New Shorter Oxford English Dictionary*. Oxford: Clarendon Press, 1993.

DAVID SIMPSON
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In response

David Simpson castigates me for an over-casual use of the terms 'gluttony' and 'sloth' in relation to obesity. I am happy to stand corrected, but not before pointing out that he has quoted me entirely outside of the general context in which the phrases were used – namely in relation to the *general epidemic* of obesity rather than in relation to *individual cases*. The full sentence was: 'It is now accepted that obesity is caused by a combination of gluttony (driven by cheap, palatable, heavily promoted energy-dense foods) and sloth (driven by energy-saving devices, motorised transport, sedentary work, TV viewing and computing).' Both the wider context and the qualifying parentheses should have made it quite clear that I was not intending any pejorative statements about obese individuals. Elsewhere I have been at pains to point out that any such statements are most unhelpful.[1] In the intended context of population change the twin terms 'gluttony and sloth' are widely used and have two important advantages: first, their very bluntness focuses attention on the real issues; and second, they neatly lock together the two sides of the energy balance equation, an attribute considered crucial by leaders in the field of obesity prevention.

Regarding his latter comments, Simpson also misses the point that this was an editorial about the population trend in obesity and what governments and health professionals can do about it. It was not a thesis on individual susceptibility to obesity, about which I have written extensively elsewhere, addressing the points that he raises.

Reference

1 Prentice AM. Obesity – the inevitable penalty of civilisation? *Brit Med Bull* 1997;53:229–37.

ANDREW PRENTICE
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Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Medical degrees with honours; the 'dumbing down' of undergraduate examinations?

In the UK, there has been much concern and debate over whether summative assessments of school children (GCSEs and A levels) have become progressively easier over the last 20 years.[1] There is no dispute that the proportion of children achieving A grades has risen substantially.[2] The argument revolves around whether this is due to a true improvement in academic standards or the fact that the examinations themselves are becoming easier, the 'dumbing down' of standards.

Little is known about secular trends of achievement in medical undergraduate examinations. Here we report the number of students attaining honours or commendation standard at the University of Wales College of Medicine (UWCM) over the last 15 years. For comparison, we also report the percentage of students awarded an honours medical degree at eight other UK medical schools.

Medical undergraduates at UWCM may be awarded their qualifying degree as either 'pass', 'with commendation' or 'with honours'. We obtained the graduation records of all students for the period 1978–2003 and the results are shown in Fig l. A clear change appears to take place in 1995. Until then, the maximum number of honours and commendations in any single year was five. In the 10 years from 1978 to 1988, only 10 students were awarded their degree with honours. However, in 2000, 17 students in a single year were granted an honours degree. In 2003, 22 students gained honours and 27 commendation. Thus, in that year alone, 49 out of 180 students passed with some academic accolade in contrast to only 52 out of 2,700 students in the 18 years between 1978 and 1996.

Eight other medical schools in the UK provided data for the 2003 academic year. The percentage of students qualifying with honours ranged between 61% and 0%. Clearly there has been a large increase in the number of students awarded honours or commendation for their medical degrees at UWCM and the likelihood of qualifying with such a degree is markedly different amongst the different medical schools in the UK.

Medical students are recruited from the highest academic achievers. The number of degrees awarded with honours or with commendation at UWCM may now be a true reflection of their achievements at medical school, and it could be argued that the problem is not so much with the present but with the past, when criteria for giving out these accolades were too strict. However, even if such an argument is accepted, it still leaves the problem that the honours degree is being 'devalued' by becoming increasingly common. Fifteen years ago, a student with honours from UWCM would have stood out as being of particularly high academic calibre, since only a handful of honours would have been given out. Nowadays, seeing honours or commendation on a curriculum vitae is far less useful in identifying those with truly outstanding undergraduate achievement.

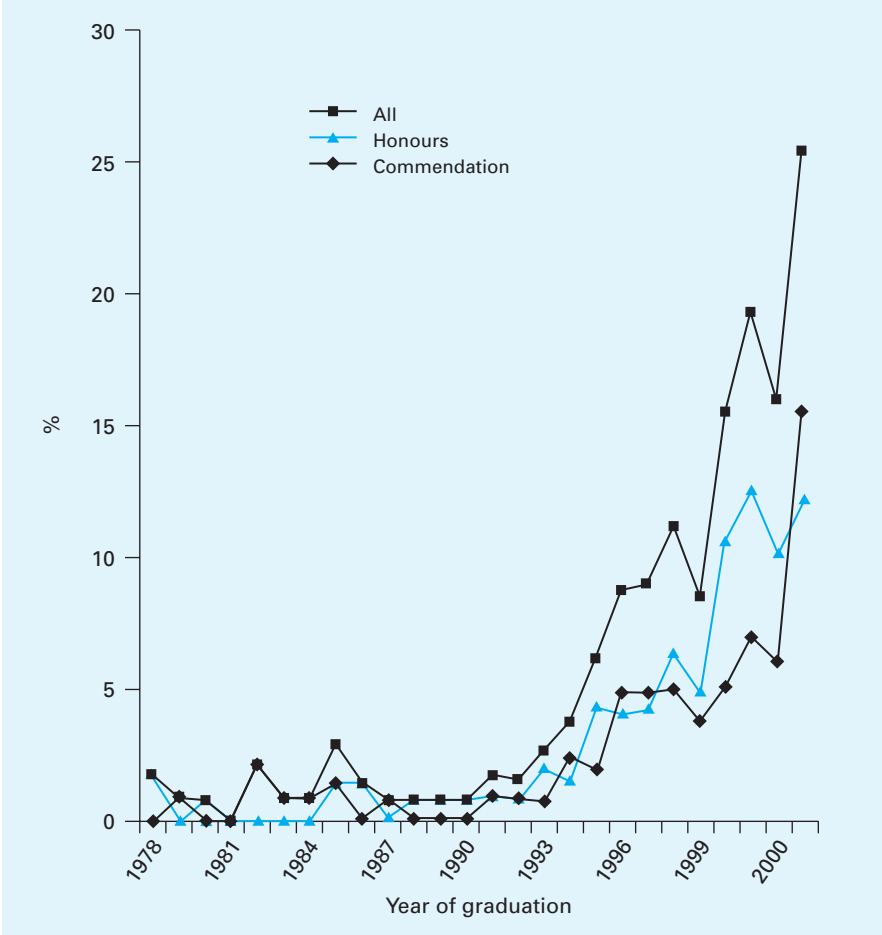

Fig 1. Students in UWCM awarded honours (▲)or commendation (◆), or both (■) in their medical degree, as a percentage of total number of students passing each year.

The greater number of honours and commendations may reflect a real and substantial improvement in the standards of students and their teachers. However, although a modest improvement may have occurred, it is difficult to reconcile what we saw of students and doctors on the wards over the last decade with the vast improvement in standards required to explain the difference in awards over that period. There has certainly not been a massive rise in the pass rate in postgraduate examinations such as the MRCP to parallel the success at the undergraduate level.

We must not dismiss the possibility that the greater numbers are a reflection of 'dumbing down' in medical education. In recent years, there has been a move to set assessments that test core knowledge, ie to concentrate on the very minimum standard required of a student. This might have been at the expense of strategies that truly differentiate excellence from mediocrity. At UWCM the rapid rise in the number of honours and commendations closely parallels the introduction of a new curriculum based on the principles outlined in the General Medical Council document *Tomorrow's Doctors*,[3] and an overhaul of the institution or its curriculum should be reflected in such a dramatic change in examination results.

The exponential rise in students being awarded qualifying degrees with honours and the large differences between medical schools is academically unacceptable. Urgent steps must be taken to provide uni-

formity of academic criteria for the award of different grades of qualifying medical degrees in the UK.

References

1 Tomlinson M. *Inquiry into A level standards, Final Report*. London: Department of Education and Skills, 2002.
2 Qualification and Curriculum Authority. *GCE A Level examination results 1992–2001*. London: Qualification and Curriculum Authority, 2003.
3 General Medical Council. *Tomorrow's doctors: recommendations on undergraduate medical education*. London: GMC, 1993.

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Gastrointestinal cancer and the 'two-week wait'

Cancer mortality rates in the UK compare unfavourably with rates in other developed countries. The 'two-week wait' referral guidelines for suspected cancer were implemented in the hope that urgent assessment would improve cancer outcome.

We prospectively collected data for all patients with a suspicion of gastrointestinal (GI) cancer, during the first six months of the system's operation (July–December 2000). 465 patients were referred (222 upper GI and 243 lower GI). We saw 399 (85.8%) within 14 days, 64 of whom (13.8% of the total) were diagnosed with cancer.

The average delay to assessment was 11.4 days (cancer cases = 8.2 days) and to diagnosis was 41.3 days (cancer = 32.3 days). Of those waiting longer than 14 days, most delays (34 of 66) were due to patient cancellation or non-attendance. Excluding these cases, we saw 93.1% within two weeks and 99.4% within four weeks. Interestingly, of the 43 patients who did not attend, only one was subsequently found to have (incurable lung) cancer.

Of the 'upper' cancer cases, 100% were assessed within two weeks, and 85.7% were diagnosed within four weeks. Despite this rapid assessment, only two of the 28 'upper' cancer cases (7%) underwent potentially curative surgery and were alive at six months follow-up. This represents less than 1% of the total 'upper' referrals. Of the 'lower' cancer cases, 32 of 36 (88.9%) were seen within two weeks; 25 colorectal cancers were diagnosed; 16 (64.0%) underwent potentially curative surgery (Table 1).

Fewer males (39.6%) were referred than females (60.4%), but most cancer cases were male. Overall 20.7% of males and only 9.3% of females had cancer. The average age of patients referred was 66.2. Only one cancer was diagnosed in a patient under the age of 55 (a 37-year-old female with metastatic breast cancer). Increasing age was associated with an increased likelihood of a final diagnosis of cancer.

The proportion of patients diagnosed with cancer (13.8%) is consistent with that of previous studies[1] and reflects the relatively low specificity of most of the referral symptoms.

The low proportion with curable gastro-oesophageal cancer reflects the poor prognosis of a cancer that typically presents at an advanced stage.[2] Surgical cure is unlikely once 'two-week wait' symptoms, such as weight loss and dysphagia, have developed. The prompt investigation of all dyspeptic symptoms in those aged over 40 might increase the proportion of patients with early and operable cancers,[3] but would further compromise specificity.

The evidence that colorectal cancer outcome is influenced by delays measured in weeks is poor. Perhaps two weeks is of little consequence compared to the median delay to presentation of over three months for patients with GI cancer.[4]

Substantial resources and considerable reorganisation have allowed our hospital to see almost all patients within two weeks. Rapid assessment may provide reassurance to the large majority who do not have cancer, but is unlikely to influence outcome significantly in those who do. Ultimately, funds might be better used implementing screening programmes,[5] or improving care once cancer is diagnosed.

Table 1. Cancer cases and operability.

Referal type	Cases referred	Cancer type	Number	Potentially curative surgery (% of total cancer cases)
Upper	222	Oesophageal	14	2 (14.3%)
		Gastric	5	1 (20.0%)
		Pancreas	3	0
		Miscellaneous	6	0
Lower	243	Colorectal	25	16 (64.0%)
		Miscellaneous	11	1 (9.1%)
Total	465		64	20 (31.2)

References

1 Boulton-Jones JR, Gamble S, Robinson MH, Goddard WP *et al*. The impact of the two-week wait scheme for suspected gastrointestinal cancers. *Clin Med* 2003;**3**:483–4.
2 Allum WH, Powell DJ, McConkey CC, Fielding JWL. Gastric cancer: A 25 year review. *Br J Surg* 1989;**76**:535–40.
3 Hallisey MT, Allum WH, Jewkes AJ, Ellis DJ, Fielding JWL. Early detection of gastric cancer. *BMJ* 1990;**301**:513–5.
4 Holliday HW, Hardcastle JD. Delay in diagnosis and treatment of symptomatic colorectal cancer. *Lancet* 1979; **1**:309–11.
5 Selby JV, Friedman GD, Quesenberry CP. A case control study of screening sigmoidoscopy and mortality from colorectal cancer. *N Engl J Med* 1992;**326**:653–7.

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