LETTERS

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IS CLINICAL EXAMINATION DEAD?

It avoids mismanagement

Patel does not go far enough.[1] Why not programme robots to take a history, order a vast array of scans to avoid missing anything, and print out evidence based treatment?

But I wonder how the robot would have coped with some patients from my case files. For example, the patient who was referred with varicose veins but had a symptomless grapefruit sized renal mass that turned out to be a carcinoma, the patient with an inguinal hernia and an unnoticed mass of lymph nodes above the clavicle, and the patient scheduled for pneumonectomy for cancer but who also had undetected homonymous hemianopia. And a nurse came to my rescue when she smelt acetone in the breath of a child with a distended abdomen and diuresis.

Patel says clinical examination is quackery with an "atrocious" level of sensitivity. I am sure he will repent if he reads Lisa Sanders's book, *Diagnosis*, which gives frightening examples of the mismanagement of patients who had been well investigated but not well examined.[2]

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Competing interests: With millions of the world's people short of food and clean water, RHA objects to the money that wealthy countries spend on unnecessary expensive medical tests.

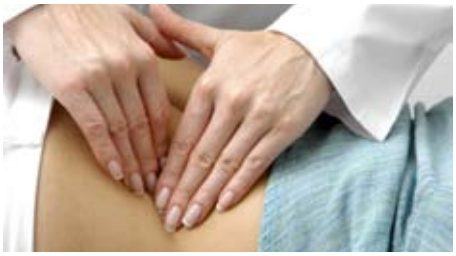
1 Patel K. Is clinical examination dead? *BMJ* 2013;346:f3442. (29 May.)
2 Sanders L. Diagnosis: dispatches from the frontlines of medical mysteries. London: Icon, 2009.

Cite this as: *BMJ* 2013;346:f3982

. . . finds silent signs . . .

Although I am sympathetic to Patel's questioning of the mystical powers conferred on some aspects of clinical examination,[1] the practice article in the same issue on the easily missed diagnosis of acute limb ischaemia speaks clearly to the role of direct observation and palpation.[2]

Patients with diabetes and peripheral vascular disease are often placed in further peril by the co-existence of sensory neuropathy,[3] which has removed a crucial, innate protection mechanism. Damaging architectural abnormalities can pass by unnoticed, hidden under silent socks, while limb threatening lesions fester away under mute dressings. In the rush to process and measure, there remains a place to pause and examine.



AJ PHOTO/SPL

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Competing interests: None declared.

1 Patel K. Is clinical examination dead? *BMJ* 2013;346:f3442. (29 May.)
2 Brearley S. Acute leg ischaemia. *BMJ* 2013;346:f2681. (8 May.)
3 National Institute for Health and Care Excellence. CG119. Diabetic foot problems: Inpatient management of diabetic foot problems. 2011. http://publications.nice.org.uk/diabetic-foot-problems-cg119.

Cite this as: *BMJ* 2013;346:f3983

. . . is the stuff of medicine . . .

Listening for split heart sounds may be quackery, as Patel argues,[1] but there are multiple aspects of the physical examination which I rely on as a general practitioner. Many of these have an evidence base, and all have a placebo effect. Findings such as a normal pulse rate, normal respiratory rate, normal temperature, normal blood pressure, clear chest, no enlarged glands, no pus on tonsils, normal abdominal examination, normal pelvic examination, and central nervous system "grossly intact" keep patients away from accident and emergency departments and secondary care doctors and their endoscopes, etc.

We gatekeepers rely on these primitive techniques and thereby minimise harms. If this is quackery, then I am glad I am retiring soon.

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Competing interests: None declared.

1 Patel K. Is clinical examination dead? *BMJ* 2013;346:f3442. (29 May.)

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. . . and can be evaluated

Patel argues that clinical examination is redundant in an age of readily available investigations.[1] Surely a more helpful approach is to evaluate and use components of clinical examination in the same way as we would other diagnostic tests? What is the sensitivity and specificity and positive and negative predictive value of examination manoeuvres in different clinical scenarios?

Such an approach keeps the useful parts of examination, saves time by allowing unhelpful components to be jettisoned, and allows rational selection of further investigation. Unthinking, undirected investigation already imposes huge costs in terms of time, resources, and iatrogenic harm: abandoning clinical examination entirely will only worsen these problems.

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Competing interests: None declared.

1 Patel K. Is clinical examination dead? *BMJ* 2013;346:f3442. (29 May.)

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Author's reply

There is a middle ground when it comes to clinical examination. Clearly never examining anyone is not a safe or prudent course for any medical professional. However, recognising the limitations of clinical examination is important, limitations that become more apparent as medical technology progresses and the other tools in our armamentarium become safer and more reliable than our hands.

Clinical examination, just like anything else, improves with volume. Teaching the detection of rare signs as routine is futile because that which we repeatedly do not find we discount subconsciously as unimportant. The clinical skill required to make a competent doctor is not reflected in what we teach. How many times outside an examination setting have I seen splinter haemorrhages, xanthelasma, koilonychia, peri-oral freckling, or Osler's nodes? Yet I teach these signs to students as mandatory for every examination. There is a profound difference between being able to detect a heart murmur, which I would argue is essential, and picking up subtle pulmonary regurgitation.

We spend years teaching clinical examination to medical students and then to junior doctors. Is it really too much to expect that even a minor degree of competency be attained with an ultrasound probe during the same length of time? This really would be a forward thinking move, especially given that many doctors are now expected to use ultrasonography routinely during invasive procedures.

The traditional way of history, examination, and then investigations does not always serve patients best, and this modus operandi is likely to become increasingly disrupted by new technology in the

forthcoming years, decades, and centuries. So clinical examination is not dead, but it is dying slowly both as an art form and in its utility: with the inexorable march of technology, this is one patient that is unlikely to be saved indefinitely.

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Competing interests: None declared.
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ALAMY

SURGICAL MORTALITY OVER THE WEEK

Media wrongly jump to blame junior doctors

The media reaction to Aylin and colleagues' analysis of the effect of the day of elective surgery on mortality fails to appreciate the authors' conclusion that the reasons behind an increased mortality remain unknown."[1] Although the article suggests that the increased mortality could be due to reduced or locum staffing, newspapers jump to blame junior doctors working at the weekend.

"It is what doctors don't tell you: avoid falling sick over the weekend, when senior doctors are off duty and hospitals are run by a skeleton staff," leads the *Independent*,[2] painting a picture of a demonic horde of junior doctors, leaderless, running amok through the hospital in a scene akin to William Golding's *Lord of the Flies*.

Both of the hospitals I've worked in have reduced numbers of surgical junior doctors working at the weekend. Statements such as "The junior doctors, they're always around, but they're not the ones making a difference here" from Dr Foster's Roger Taylor are misleading, unhelpful, and serve to undermine the public's trust in junior doctors.[3]

Junior doctors don't plan hospital staffing levels, don't want to work in under-supported conditions, and didn't design the now infamous "EWTD." The junior doctors I know return home from weekend shifts having worked hard, fighting fires to keep their patients well until Monday. Senior NHS figures should move to defend junior doctors for their hard work out of hours.

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Competing interests: PMT is a current foundation year 2 doctor.
Full response at www.bmj.com/content/346/bmj.f2424/rr/648004.

1 Aylin P, Alexandrescu R, Jen MH, Mayer EK, Bottle A. Day of week of procedure and 30 day mortality for elective surgery: retrospective analysis of hospital episode statistics. *BMJ* 2013;346:f2424. (28 May.)
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3 Triggle N. Hospital patients 'more likely to die at weekends'. BBC News Health 2011 Nov 28. www.bbc.co.uk/news/health-15895663.

Cite this as: *BMJ* 2013;346:f3992

Hospital set up over the week explains difference in mortality

After the media tsunami to Aylin and colleagues' analysis, I read the paper carefully to discover why the 30 day mortality for elective surgery on Monday and at the weekend is significantly different.[1]

The media suggest that at weekends work-shy consultants are absent, leaving junior doctors to run amok and kill patients. I have noticed that weekend elective lists are mainly waiting list initiatives undertaken by consultant surgeons (not junior doctors or external locum consultants) employed by the trust.

I assumed that the weekend cohort of patients were sicker, but this assumption was dispelled on reading "weekend patients tended to have less comorbidity, fewer admissions, longer waiting time . . . and lower risk surgery than the Monday patients."[1] This fits with the typical case profile selected for weekend waiting list initiatives.

So if it is not the patients, the operators, or the complexity of cases then it must be because hospitals at weekends are set up to deal only with emergencies. Increasing the burden on tight resources with elective cases results in immediate complications not being recognised or managed appropriately, in comparison with during the week, increasing morbidity and mortality.

I fear that this paper may be used to perpetuate the myth that seven day working for consultants is the answer. Consultants don't work in isolation: all members of the workforce need to be present to make seven day working effective. This includes secretaries, porters, occupational therapists and physiotherapists, pharmacists, laboratory technicians, and cleaners (apologies for those I've missed).

In the current climate of austerity seven day working is not feasible. Perhaps we should accept that weekends are only for emergencies and ensure that we do the best for this group of unwell patients. Elective work should be for weekdays, when there is expertise to manage postoperative care appropriately.

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Competing interests: None declared.
Full response at www.bmj.com/content/346/bmj.f2424/rr/648746.

1 Aylin P, Alexandrescu R, Jen MH, Mayer EK, Bottle A. Day of week of procedure and 30 day mortality for elective surgery: retrospective analysis of hospital episode statistics. *BMJ* 2013;346:f2424. (28 May.)

Cite this as: *BMJ* 2013;346:f3996

IMPORTED MALARIA

Don't forget the children

We were disappointed by the paucity of information about children in Whitty and colleagues' review of imported malaria[1] since 15-20% of imported malaria occurs in children.[2] In the only paragraph on severe or complicated malaria in children the authors quote a paper on endemic childhood malaria in Kenya.

Children with imported malaria often present with non-specific symptoms, gastrointestinal symptoms being common. When compared with adults, children are less likely to complain of chills, arthralgia/myalgia, or headaches and more likely to have hepatomegaly, splenomegaly, or jaundice.[2]

The prospective British Paediatric Surveillance Unit's study of 290 children with imported malaria identified that a quarter of them had previously had malaria, highlighting missed opportunities to educate families on malaria prevention.[3] In addition, a third of children with falciparum malaria fulfilled World Health Organization criteria for severe or complicated malaria, although only a quarter of these children required intensive care. A further study of children admitted to intensive care identified that severe or complicated imported malaria differed from that seen in children living in malaria endemic areas. Children admitted to intensive care in the UK for severe malaria had cerebral malaria or shock (occasionally with bacteraemia).[4]

Most importantly, malaria is often not considered in the differential diagnosis of fever in children, mainly because a travel history is not obtained. This has resulted in avoidable deaths in children.[3] Moreover, because malaria remains rare in children in the UK, its treatment varies considerably.[3] Specific guidance for the treatment of imported childhood malaria was updated recently.[5]

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Competing interests: None declared.
Full response at www.bmj.com/content/346/bmj.f2900/rr/649824.

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Cite this as: *BMJ* 2013;346:f4042

BAD MEDICINE: STATINS

Statin misuse is bad medicine

As is his wont, Spence is provocative in arguing that statins are bad medicine.[1] Heart attacks are multifactorial, due to risk factors (not disease) such as cholesterol and sloth. But in the UK they have been declining dramatically in incidence and mortality for over 40 years.[2] Survival, and thus prevalence of ischaemic heart disease, is increasing, partly thanks to statins.

Statins are not bad medicine, but the misuse of them is. Used appropriately, they offer a proved (in randomised controlled trials), cheap, safe, effective, and reasonably acceptable way of avoiding heart attacks. A reduction of 30% in fact. Spence rightly points out that in people at low risk the number needed to treat (NNT) is reciprocally high. This is true for all medicine. Penicillin, for example, works most efficiently in patients with pneumonia, moderately well in preventing the risk of pneumonia, and is useless in people who will not get pneumonia. Absolute risk rules, OK? People with a 100% chance of heart attack will have a 1 in 3 chance of avoiding it with a statin, for £1 a month.[3]

Spence quotes selectively: "In low risk patients older than 60 and taking standard statin treatments, the [NNT] per year to prevent cardiovascular events is 450." This is true but the average man of 60 in my practice has a 20% risk of cardiovascular disease over 10 years. This translates to a one year risk of 2%, and reciprocally to an NNT of 50 (if treatment were 100% effective). Statins affect only about 33% of cardiovascular disease, resulting in a demonstrable NNT of 150.

At today's generic prices, cheap statins are extremely cost effective prevention and should be offered to anyone at moderate or high risk. Start low and go slow. Let the patient decide whether treatment is acceptable.

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Competing interests: None declared.

1 Spence D. Bad medicine: statins. *BMJ* 2013;346:f3566. (31 May.)
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Cite this as: *BMJ* 2013;346:f4046

MEETING NEEDS IN LEARNING DISABILITY

The importance of human rights

The editorial by Hollins and Tuffrey-Wijne on premature deaths among people with a learning disability disregards the violation of health rights inherent in the inadequate standards of healthcare to which some are subjected.[1]

A survey in 2010 by ICM on behalf of Mencap showed that more than a third of doctors and nurses think that the NHS discriminates against patients with a learning disability.[2] Nearly half of the doctors (including 61% of general practitioners) considered that they receive lower standards of healthcare. The recent confidential inquiry into premature deaths of people with a learning disability, recommended by the 2008 Michael inquiry, established that the risk of someone with a learning disability dying as a result of inadequate medical care is more than four times that of the remainder of the population.[3]

The most authoritative right to the highest attainable standard of physical and mental health is article 12 of the International Covenant on Economic, Social and Cultural Rights, as comprehensively defined by the 65 paragraph explication of health specific rights known as general comment 14.[4 5] This article specifically proscribes discrimination on grounds of mental disability, applies to everyone, and has been ratified by more than four in every five countries.

During the GMC's consultation over *Tomorrow's Doctors*, Doctors for Human Rights urged that medical students receive human rights education. The underwhelming response was a stipulation that graduates "recognise the rights and the equal value of all people and how opportunities for some people may be restricted by others' perceptions."

Abolishing discrimination, albeit unconscious, against marginalised groups requires that the profession observes human rights values in everyday medical practice, which means formal human rights education. Failure to recognise and confront the underlying discrimination as the abuse of human rights risks compounding the abuse.

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Competing interests: PLH has specialised in physical healthcare for people with a learning disability in hospitals, the community, and a hospice over 36 years. He had a role in developing the UN's general comment 14 of the International Covenant on Economic, Social and Cultural Rights.

Full response at www.bmj.com/content/346/bmj.f3421/rr/649109.

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5 United Nations. The right to the highest attainable standard of health. General comment No 14, para 18. Geneva: UN, 2000. www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.

Cite this as: *BMJ* 2013;346:f4047

Don't forget eye care

Eye care is an important part of meeting the needs of people with a learning disability.[1] People with sight impairment and those who help care for them report huge benefits after having been put in touch with social service departments through the certification and registration process.[2]

A recent audit examining registration for diabetic eye disease in Croydon found that patients with learning disabilities and additional sight impairment were at greater risk of not being certified (and thus not being provided with the necessary support) than those simply with sight impairment. Reasons for this are likely to be difficulties in determining eligibility, as it can be difficult to assess vision, and difficulties in communicating the potential advantages. We urge those considering the unmet needs of people with learning disability to be aware of sight impairment.

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Competing interests: None declared.

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Cite this as: BMJ 2013;346:f4044

HEARING LOSS IN ADULTS

A tailored approach is needed

Hearing loss in adults is common yet often overlooked.[1] The number of people affected has been estimated to rise to 14.5 million by 2031,

with hearing loss becoming one of the top 10 diseases affecting the population.[2] Around a quarter of people aged 41-70 are affected by at least a moderate level of impairment but only around 3% use hearing aids, a figure barely changed since the 1980s despite advances in technology (P Dawes, British Association of Audiovestibular Physicians annual conference, March 2013).

Partly this may be because of the stigma associated with hearing aids and a reluctance to seek help. Delay may be considerable, leading to psychological distress at the breakdown of communication in social circles. Perhaps because of the hidden nature of hearing loss, irritated friends and relatives often find it perfectly acceptable to aggressively chastise those affected.

Additionally, degree of impairment does not predict degree of disability, highlighting the role of multiple levels of integration and modulation between brainstem and cortex in processing auditory information. Some patients have functional difficulties despite "normal" audiograms, their problems occurring at higher processing stages and for whom hearing aids may not be appropriate This means that the whisper test alone may be insufficient, particularly as room acoustics are unlikely to be ideal. Room dimensions can have a profound impact, in the order of 20-30 dB in extreme cases.[3] In short, a mere change of position by a couple of centimetres may be enough to completely negate any potential accuracy of threshold detection in an uncontrolled environment. The UK Biobank project reflects this by using "speech in noise" tests for assessment (available on the Action on Hearing Loss website[4]), and we as audiovestibular physicians advocate a holistic approach to tailor rehabilitation strategies to each person.

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Competing interests: JA and AT are affiliated with the British Association of Audiovestibular Physicians. As audiovestibular physicians they promote a holistic approach to diagnosis and rehabilitation of hearing and balance disorders.

Full response at www.bmj.com/content/346/bmj.f2496/rr/649721.

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Cite this as: *BMJ* 2013;346:f4048

ABORTION IN BIPOLAR DISORDER CASE

Who will take responsibility?

After reading Dyer's summary of the case in which a woman with bipolar disorder has been judged able to abort her baby, I am left wondering who is going to sign the 1967 Abortion Act form.[1]

The medical profession (represented by the psychiatrist caring for Miss B) is "100% certain" that she does not have capacity to make the decision to terminate. Are the required two doctors prepared to disagree with this and sign? If so, what will be their legal position if and when Miss B subsequently restarts treatment and regrets her decision? Is there a legal precedent for the judge taking over this responsibility and bypassing the requirements of the act?

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Competing interests: None declared.

1 Dyer C. Woman with bipolar disorder can abort her baby, judge rules. *BMJ* 2013;346:f3387. (24 May.)

Cite this as: *BMJ* 2013;346:f3898

RESPONSE Diabetes UK replies to Dr Aseem Malhotra

In his Observations article in the issue of 25 May Dr Aseem Malhotra implied that Diabetes UK's view on the link between sugar and type 2 diabetes has been influenced by a corporate partnership.[1]

While we defend his right to criticise our view, we were disappointed that he called our integrity into question because he disagrees with us, without providing any evidence to support his implication. He hadn't raised this with us directly first and allowed us to demonstrate our absolute commitment to an evidence based approach.

We would never allow our view of the science to be swayed by a corporate partnership. We have a long history as an evidence based organisation giving independent advice, and we are committed to continuing this. Indeed, our very survival as a trusted charity—supporting people with diabetes, policymakers, and others with robust independent advice, and campaigning for people with diabetes—depends on it.

Of course, some people believe that charities should not have any corporate partnerships, but this would significantly diminish our ability to make a difference for people with diabetes. Most people realise that, just as the *BMJ*'s editorial stance is not influenced by its advertisers, so a charity can accept money from a company without being in its pocket.

At Diabetes UK we achieve this by having systems to ensure that we enter into corporate partnerships only with appropriate organisations. We also foster the kind of separation that exists between the *BMJ*'s advertising and editorial departments between our fundraising directorate and those working in research and policy. This means that any judgments we make about research are entirely evidence based and do not include any input from colleagues in fundraising. Our corporate partners know from the outset that we reserve the right to be ruggedly independent and that we may be critical of their position or actions from time to time.

In terms of our comments on the link between sugar and risk of type 2 diabetes,[1] we clearly acknowledged the key findings of the InterAct study in our media comment.[2 3] We stand by our view that this study does not provide definitive evidence that sugar increases the risk of type 2 diabetes independent of its effect on body fat. Dr Malhotra may think this is too cautious, but this is a single study showing a significant but small association between sugar and risk of diabetes after correcting for body mass index; a larger body of evidence is needed to show whether this finding is medically relevant. We are pleased that the Scientific Advisory Committee on Nutrition is currently considering all the available evidence.[4] Once that official assessment is available, we will all be better placed to reach an evidence based view.

We already know, however, that sugar is an energy dense food source which we are consuming far too much of and which contributes considerably to the obesity epidemic that is fuelling the current record rate of type 2 diabetes. This is why we are putting pressure on food companies and government and giving healthy lifestyle advice to those at high risk to try to reduce their consumption of sugar as part of a balanced and healthy diet. But sugar is not the only cause of obesity, and while debating the science openly we have a collective duty not to send confusing messages to the public. Healthcare advice must continue to reflect the body of evidence that shows that maintaining a healthy weight through a balanced diet is the most effective way to prevent type 2 diabetes.

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Competing interests: BY is chief executive of Diabetes UK.

1 Malhotra A. The dietary advice on added sugar needs emergency surgery. *BMJ* 2013;346:f3199. (21 May.)
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4 Scientific Advisory Committee on Nutrition website. www.sacn.gov.uk/meetings/working_groups/carbohydrate/index.html.

Cite this as: *BMJ* 2013;346:f3999