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Bad Medicine

I enjoy Spence's monthly polemics on bad medicine.[1] There is a lot of it about and it concerns me as current trends would seem to rob patients of their resilience and responsibilities. In my work as a tribunal member assessing appeals over eligibility to Employment and Support Allowance and Personal Independence Payments, I frequently see appellants whose doctors seem to diagnose anxiety. Anxiety is an emotion that everyone experiences. Where anxiety is abnormal it is anxiety disorder. Your own journal falls into this trap on its front cover.[2] I frequently see what doctors describe as low mood being treated with antidepressants, especially as we know that depression is over-treated and, by inference, over-diagnosed.[3] Post-traumatic stress disorder is frequently mentioned but enquiry often fails to show evidence of the exposure criteria laid down as a requirement of the diagnosis.[4] These are examples of bad medicine that rob individuals of their resilience. It is small wonder that the press talk of a crisis in mental health if we as a profession make diagnoses on such a poor basis.

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Evidence–based physical examination and point-of-care testing to improve patient care and avoid unnecessary hospital admission

I very much appreciate the article by Cals and Ebell.[1] Evidence–based physical examination and an accurate history taking can lead in up to 77–90% of cases to a patient's diagnosis,[2] but there are limitations to history taking and clinical signs on physical examination. The clinical assessment of renal failure is limited and two-thirds of acute kidney injury identified in hospital started in the community with a high mortality.[3] Identifying renal impairment by an eGFR analyser or urgent blood test (biomarker) via a domiciliary phlebotomist or specimen transport can potentially reduce disease progression and hospital admission, which applies to abdominal pain as well.[4]

The clinical evaluation of abdominal pain can be limited, as no finding on clinical examination can effectively rule out appendicitis.[5] The Alvarado clinical decision model is recommended as the most user-friendly while being among the most powerful, but it incorporates biomarkers.[6] Further research has to be undertaken into the value of biomarkers in the diagnostic reasoning process and its application and availability in the GP setting.[7,8] Knowledge of the accuracy and limitations of the physical examination in the diagnostic process by introducing teaching of evidence-based physical examination in the undergraduate curriculum and postgraduate education and introducing point-of-care testing in the future are needed, in order to improve patient care and make it more cost-effective and patient friendly.[9]

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