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## Religious cliché and COVID-19 management: a barrier for physicians

The COVID-19 pandemic is a global crisis and efforts are focused concomitantly on limiting the transmission and reducing the impact of the virus.<sup>1</sup> From hand hygiene to vaccine development, physicians around the globe are trying to explore an effective and efficient disease management protocol. However, as with every other disease, COVID-19 has developed a religious cliché that has created a barrier for physicians in disease management. Especially in the developing world, practices are observed that are resulting in avoidance of precautionary measures as proposed by physicians. One example is the attitude of some Islamic faith believers who are not following the recommended precautions against COVID-19.<sup>2</sup> On being questioned, it has been quoted that, *'Allah is sufficient for us; and what an excellent guardian He is.'*<sup>3</sup> Additionally, the prevailing belief of life and death being controlled by the Almighty<sup>4</sup> is also becoming a religious stigma in adopting precautionary measures. Moreover, drinking cow urine and hosting cow urine drinking parties to cure Corona-related illness is also reported.<sup>5,6</sup> Combining and consuming water and sacred soil found at the grave of Maronite monk Mar Charbel (Mount Lebanon) is also practised against COVID-19.<sup>7</sup> We agree that religion is part of the human make-up and faith healing exists in societies as a prime philosophy. Today, people are looking to religion for COVID-19 protection but by doing so are not following the basic precautionary measures, and that is a barrier faced by the frontliners against COVID-19.

One possible solution to this religious cliché is to engage the religious leaders of the respective societies. These leaders are the most respected figures in communities and the influence on their followers can greatly benefit the efforts against COVID-19. As community members listen to their religious leaders, physicians should take them on board while handling and managing COVID-19, both in hospitals and at a communal level. Because religious

leaders influence social values, practices, and beliefs with their faith-based teachings, we strongly believe that their role in preventing COVID-19 will augment the efforts of the physicians. COVID-19 is a pandemic catastrophe and it is high time to overcome the religious cliché that is becoming a barrier for physicians in the optimal management of COVID-19.

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## Pandemic preparedness starts in properly coded electronic health records

The current COVID-19 pandemic situation, similar to the increased incidence of Kaposi's sarcoma in the 1980s, exposes the relevance of surveillance of new clinical pictures, and the fact that every clinician must share the responsibility, adequately documenting consultations, and recognising that their entries will be used beyond the clinician-patient relationship.<sup>1</sup>

Clinicians' preferred use of free text to store information is inadequate. There is a need to use clinical coding extensively, not just diagnoses, but symptoms and examination findings. Otherwise electronic health records are no more than digital papers. Processing a large amount of consultations can only be made through informatics, and software works much better with coded clinical entries.

Clinicians have been using electronic records for decades but they are still infrequent coders,<sup>2,3</sup> there is considerable data quality variation, and furthermore it is often suboptimal.<sup>4</sup> Additional training and improving systems design are needed,<sup>5,6</sup> but it is time to reconsider the clinical nomenclature itself? SNOMED-CT was expected to be the solution to facilitate coding,<sup>7</sup> but clinicians are still not engaging enough with it.<sup>6</sup> Frontline clinicians require an effortless, easy-to-use entry system that facilitates the interaction with the patient and the computer rather than the current complex and hard-to-find code nomenclature with less-than-helpful software that, combined, fail to facilitate coding consultations adequately.

The future use of clinical coding will not improve by implementing more complex nomenclatures. Currently there is more free text than code, and information will be partial, insufficient to improve health care, detrimental for research, and inefficient to alert about increases in particular symptoms or conditions.

Future generations of patients will be better served by a profound analysis of current clinical nomenclature and software,

and a resulting real change to clinicians' use of electronic health records.

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## Clinical scores in primary care

A clinical prediction rule represents a distillation of measurable features, usually by regression modelling. It helps standardise the approach to diagnosis and, in theory, should reduce variation in diagnosis and inappropriate prescribing.

Our review compared Centor's score with McIsaac's score.<sup>1</sup> These are the two most recommended prediction rules used for diagnosing GABHS-related pharyngitis in different national guidance.<sup>2,3</sup> Although other scores such as Walsh's score exist, they tend not to feature in international guidance.<sup>2,3</sup>

FeverPAIN does appear in UK guidance and was developed in the UK by one of the co-authors of the editorial.<sup>4</sup> However, the derivation study is still the only study that has evaluated the rule and so meta-analysis was not possible.

Our review demonstrates for both scores that there is substantial variation in performance across different settings.<sup>1</sup> Furthermore, the two studies that reported the most favourable receiver operating characteristic (ROC) curves for McIsaac's score have McIsaac as first author. Both of these points reinforce the need for multiple independent validation studies of FeverPAIN before we conclude on its accuracy.

Clinical features, in whichever combination or weighting, are unlikely to be sufficient to rule in GABHS pharyngitis. Point-of-care (POC) tests vary in shape and form, with some more disruptive to the consultation than others. But this should be weighed against the likely benefit they can bring — we don't hesitate in sending a patient to the loo to produce a urine sample if a subsequent dipstick test helps diagnose a urinary tract infection. So it may be in the future that a POC test augments one of the scores sufficiently to reduce diagnostic errors and the inappropriate prescribing of antibiotics.

Otherwise we may use clinical gestalt, which allows for less measurable, intangible features to be included in the diagnostic process. This is not without merits, but it is also more likely to vary between practitioners and be open to cognitive biases.

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## Competing interests

We are the authors of the meta-analysis that compared Centor's score with McIsaac's score.

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## Sarcopenia: hand grip dynamometers, the latest addition to the doctor's bag

The debate article highlights the importance of identifying sarcopenia, and the impact it has on reducing 'physical performance'.<sup>1</sup> It is also worth identifying that skeletal muscle is a 'metabolic organ', and that many of the associated adverse health outcomes may be potentiated by an endocrine mechanism. In order to screen for this, we propose the use of hand grip strength as a clinically relevant screening tool in general practice.

There is growing evidence that low hand grip strength is associated with an increased risk of developing diabetes.<sup>2,3</sup> One study from the UK Biobank demonstrated that high-risk 'South Asian' populations have on average a 5–6 kg lower grip strength than 'white European' counterparts. When the relative prevalence of diabetes was taken into account, low grip strength in the 'South Asian' population was associated with an attributable risk of 3.9 (male) and 4.2 cases (female) per 100, as opposed to 2.0 (male) and 0.6 (female) in 'white Europeans'.<sup>4</sup>

These studies support an interesting theory that there may be ethnicity-specific grip strength cut-offs, and one reason why there is no clear consensus on screening recommendations. Despite these drawbacks, it is clear that low hand grip strength is inversely proportional to disease-specific and all-cause mortality.<sup>5</sup> Specific dietary and exercise interventions to improve muscle strength may reduce this risk significantly and help in the management of long-term conditions (LTCs).

We propose that enough evidence has accumulated over the last decade to support the use of hand grip strength as a clinically relevant screening tool in primary care. It allows for objective measurement of grip strength in a number of seconds; we hope that hand grip dynamometers find their common place in general practice in the near future.