Diversity awareness must be embedded in all aspects of professional interactions

Sir,

The fundamental principles of 'equality and diversity' run a risk of being overlooked in the clinical setting and in medical education, as this mantra becomes a hackneyed expression in the context of mandatory training: all too often undertaken as a tick-box exercise.

The editorial by Dogra and Bansal (vol 77(12), 2016, p. 672), challenging doctors to adopt a patient-centred approach to diversity, is timely and important. Such an approach needs to be embedded in all aspects of clinical care and, as suggested in the editorial, should not require specific teaching in the undergraduate medical curriculum.

The difference between cultural expertise (information provision about different groups based on one characteristic, e.g. ethnicity) and cultural sensibility (understanding the complex interaction between internal and external factors in any one person) is an interesting aspect of the discussion. Two things strike me as a clinician working in an acute surgical specialty: the first is that we have to embed respect for the other in all aspects of our professional interactions (and preferably our personal ones too). Second, as clinical educators, we must lead by example, treating our colleagues, patients and students as we would wish to be treated ourselves.

Diversity is not a 'simple' matter of ethnicity, gender or sexuality, but rather about honouring the uniqueness of the individual. This can only be achieved through setting time aside for reflective practice, in order to understand more clearly our own cultural belonging and sense of self, and thereby enhancing our understanding of what we bring to each consultation or conversation. Such practice takes time, and this is in short supply.

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Multisystem examination is still a critical part of medicine

Sir,

It is at our own peril that we allow ourselves to be deskilled in multisystem examination. In the past half century the optimization of the diagnosis and management of single system disease entities may have come at the risk of losing skills in the recognition of clinical signs outside one's specialist area of expertise.

Specialist guidelines sometimes reinforce this trend, an example being the comment from the British Society of Gastroenterology guidelines for the management of iron deficiency anaemia which reads '[clinical] examination usually contributes little but may reveal a relevant abdominal mass or cutaneous signs of rare causes of GI [gastrointestinal] blood loss' (Goddard et al, 2011). This comment ignores the observation that, in a patient with iron deficiency anaemia, cardiac auscultation might reveal a systolic murmur attributable to aortic stenosis, the latter a potential cause of chronic blood loss as a result of the development of aortic stenosis-related gastrointestinal angiodysplasia and aortic stenosis-related coagulopathy (Otto and Bonow, 2015).

Conversely, although abdominal palpation might be well within the comfort zone of gastroenterologists, the same might not necessarily be true of other physicians, as shown by the example of an 85-year-old woman with intractable congestive heart failure. The underlying cause was missed by more than 25 physicians who had examined her but had failed to detect a thrill which would have been palpable with the benefit of a routine abdominal examination (Berry et al, 2015). In this instance the thrill was attributable to an arteriovenous fistula involving the right renal artery and right renal vein, and the arteriovenous malformation was the cause of intractable congestive heart failure (Berry et al, 2015).

An unfortunate consequence of the loss of skills in multisystem examination is that the opportunity may be missed to refer the patient to another specialty in order to optimize his or her management

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