Experts question the government’s delays in improving end of life care

Adrian O'Dowd LONDON

National efforts to improve care at the end of life should be speeded up to maintain the progress made in some parts of England, it has been claimed.

The health policy think tank the King’s Fund has warned against a loss of momentum on England’s end of life care programme in a new report published this week and has questioned the government’s intention to leave a review of this area until 2013.

Around 500 000 people die each year in England. More than half (55%) of deaths occur in hospital and only 20% at home. The government has said that several surveys have shown that most people’s preference is to die at home.

The government announced on 18 October in its consultation paper Liberating the NHS: Greater Choice and Control that it wanted to establish a national system for offering people at the end of life choice over place of death. The paper was a follow up to the government’s health reform white paper published in July (BMJ 2010;341:c3796).

The health department’s new document says, “A lot needs to be done to improve end of life care services to make this possible, so we will undertake a review in 2013 to decide when this national choice offer could be introduced.”

The King’s Fund, launching its report Implementing the End of Life Care Strategy: Lessons for Good Practice, said that waiting till 2013 risked loss of momentum in the drive to improve end of life care.

Its report gives examples of good practice in end of life care and highlights progress made in enabling patients to be cared for and to die in their place of choice. The report focuses on three of the charity Marie Curie Cancer Care’s projects under its “Delivering choice” programme in Leeds, Lincolnshire, and Somerset.

This programme aims to improve service planning and coordination and to ensure that comprehensive services are in place so that patients can choose how and where they are cared for at the end of their lives. It also aims to identify barriers to good care and to highlight good practice.

The King’s Fund report says, “The current financial pressures and reform of the health service should not be allowed to distract from the innovation and improvement in the quality of end-of-life care that is needed.”

Implementing the End of Life Care Strategy: Lessons for Good Practice is available at www.kingsfund.org.uk.

Cite this as: BMJ 2010;341:c6018

European regulators demand tighter rules on cross border working

Clare Dyer BMJ

Doctors’ regulators from 23 countries in Europe are pressing the European Commission to tighten the requirements for doctors who practise outside their home country, to protect patients.

They want more stringent safety requirements to be imposed when the commission reviews the 2005 European directive on the mutual recognition of medical qualifications in 2012.

The move comes after concerns about the language skills of foreign doctors employed by locum agencies in the United Kingdom and the reciprocal arrangements that allow doctors registered in another European Union country to be registered by the UK regulator, the General Medical Council, with exemption from the normal training requirements for general practice.

The worries were highlighted by the case of Daniel Ubani, a locum doctor from Germany who killed 70 year old David Gray, who had renal colic, with 10 times the recommended dose of diamorphine during his first out of hours session in the UK (BMJ 2010;340:c3326).

In a joint statement, called the Berlin statement, the regulators call on the commission to examine “the increasing occurrences of false documents and fraud and find means of combating these effectively.” They also want the provisions on language to be re-examined “to address the concerns of competent authorities in relation to language proficiency of migrant doctors in the interest of patient safety.”

At the moment there are voluntary agreements between regulators in the various European countries to share information about doctors on their registers and disciplinary action, but the information is not always shared.

The statement signatories call for it to be made mandatory for regulators to answer requests for information from their counterparts in other European countries.

Cite this as: BMJ 2010;341:c6016
Two in five doctors don’t think reforms will improve care

**Jo Carlowe LONDON**

Less than a quarter of doctors believe that the government’s health reforms will improve the care of patients. This is the finding of a survey commissioned by the health think tank the King’s Fund and undertaken just before last week’s spending review announcement.

The survey of 1,000 doctors (500 hospital doctors and 500 GPs), carried out by Doctors.net.uk, showed that 24% of doctors think that the proposed reforms in the white paper *Equity and Excellence: Liberating the NHS* would achieve one of its key goals: “to focus on continuously improving those things that really matter to patients—the outcome of their healthcare.”

Not only did 38% of those surveyed disagree that the reforms would achieve this aim but 15% disagreed strongly (with 23% “tending to disagree”). Almost a third of respondents (31%) neither agreed nor disagreed.

However, perhaps the most radical proposal in the white paper—that of giving GPs responsibility for commissioning healthcare—received a more mixed response.

Survey participants were asked whether they believed that their area had GPs with the capacity to lead the new commissioning consortiums. Some 62% of GPs said that they were confident of this, as against 31% of hospital doctors.

Speaking to the BMJ, Richard Vautrey, deputy chairman of the British Medical Association’s General Practitioners Committee, said he was confident that although most GPs wouldn’t get directly involved in GP consortiums there would be enough interested GPs to ensure a good geographical spread of suitable candidates.

Nonetheless, he warned that most organisations take “a year or two” to “become robust and mature enough to make a difference”—a fact that may account for the survey’s finding that more than 40% of the doctors believed it would be more difficult to tackle health inequalities under GP commissioning.

Overall Dr Vautrey said he was not surprised that the survey showed a high level of scepticism among doctors.

“There is weariness over organisational changes,” he said.

Cite this as: BMJ 2010;341:c6032

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NHS budget rises slightly, but money “will have to stretch further than ever”

**Zosia Kmietowicz LONDON**

Spending on the NHS will rise by 0.4% in real terms over the next four years to reach a total of £111.4bn (£130bn; £180bn) a year in 2014, the chancellor of the exchequer, George Osborne, has announced in the first comprehensive spending review of the coalition government.

This is a fraction of the 6% annual increase in real terms spending that the NHS has enjoyed over the past decade and shows that the share of the gross domestic product allocated to the NHS will fall over the coming years.

Mr Osborne referred to the NHS as an “intrinsic part of the fabric of our country” and prioritised the health service for increased funds made available by savings in the welfare budget worth £7bn a year.

However, he said, “productivity in the NHS fell steadily in the past 10 years, and that must not continue.”

John Appleby, chief economist at the King’s Fund, said that the increase of 0.1% a year in the NHS budget would soon be swallowed up by pay increases and increases in VAT. “The net result will be a reduction in the NHS’s purchasing power,” he said.

The NHS is still expected to make £20bn of efficiency savings in the next four years. An estimated £2-£3bn of the health budget will also be used to pay for the cost of reorganising services in line with the proposals in the government’s health white paper, which will see the abolition of strategic health authorities and primary care trusts by 2013.

The only other department to be spared a cut in real terms was international development. All other departments will see average budget cuts of around 19% over the next four years.

The chancellor also guaranteed that the cash budget for science would stay at £4.6bn a year,
People would have died if government had been less “precautionary” during swine flu outbreak

Nigel Hawkes LONDON

Liam Donaldson, the former chief medical officer, has defended the last government’s handling of the swine flu pandemic, rebutting charges that GPs were overburdened with information or that their clinical judgment over the use of oseltamivir (Tamiflu) was over-ruled.

Giving evidence to the Select Committee on Science and Technology, which is investigating the scientific advice given during the pandemic, Professor Donaldson said the claim that GPs had been “bombed” with information was “a little unfair.” Decisions had to be taken quickly, he said, and often on poor or inadequate evidence.

“On antivirals, the evidence base didn’t exist,” he said. “There was some evidence for normal seasonal flu, but not for pandemic flu. The issue was whether to be very precautionary. We knew some patients without underlying conditions were dying—not many, but we’re in the 21st century and we don’t want people to die if we can prevent it.

“The BMA view was to leave it to the clinical judgment of GPs, but if we had been less precautionary, some people would have died. I strongly felt we should use antivirals, and I wasn’t prepared to see us take risks with children’s lives and with adults’ lives.”

Earlier, Peter Holden of the BMA General Practitioners Committee had told the committee that he felt there had been a real danger of information overload. Most doctors had gathered their information from the websites of the Health Protection Agency, the Department of Health, and the Royal College of General Practitioners, but he suggested that a single web portal might have been better.

“In a scenario like this, it’s about command and control,” he said. “There’s no time for discussion, you have to trust the expert, or you risk a tower of Babel. If there are arguments to have, let’s have them afterwards.”

Could money have been saved by better procurement of vaccines? Yes, said Professor Donaldson. “I couldn’t put a financial figure on it, but substantial sums of money could have been saved.” David Harper, chief scientist at the Department of Health, was more sceptical. The United Kingdom, he said, was part of the world market for vaccines and not in a privileged position to dictate its own terms.

Doctors can force woman to have lifesaving treatment, High Court says

Clare Dyer BMJ

A High Court judge in England has ordered that doctors can force a woman without the capacity to decide for herself to have lifesaving treatment for aplastic anaemia.

Mrs Justice Hogg made the ruling in the Court of Protection after an unnamed NHS trust applied to the court with the backing of the Official Solicitor, who looks after the interests of those lacking capacity.

The judge said that the 30 year old woman, named only as SB, who is detained under the Mental Health Act, has a serious psychiatric disorder and lacks the capacity to decide for herself whether or not to have the potentially lifesaving treatment.

The court heard that SB “dislikes being touched or having any physical intervention. She dislikes being touched by men. She gets very distressed on being touched, and indeed a senior sister described a very distressing scene,” the judge said.

When doctors attempted to treat her, she screamed for 40 minutes and two nurses were needed to hold her down.

The judge gave permission for doctors to restrain SB and force her to undergo the treatment, which is given over five days. Mrs Justice Hogg said that treatment would be in the patient’s best interests and “would give her the opportunity of life.”

The Court of Protection was reconstituted three years ago to take financial and welfare decisions on behalf of those without capacity. Cases concerning medical treatment of adults, including abortion and sterilisation, used to be heard in public—though with anonymity guaranteed—in the High Court’s family division and were widely reported by the media.

Cite this as: BMJ 2010;341:c5950

Cite this as: BMJ 2010;341:c5951
Haiti’s cholera outbreak could spread to other countries as number infected passes 3000

Sophie Arie LONDON
Haiti’s cholera outbreak is likely to spread to neighbouring Dominican Republic and may reach the rest of the Americas, the Pan American Health Organization has warned.

“Now that cholera has established itself with a strong foothold in Haiti it’s probably clear to us that this will not go away for several years,” said the organisation’s deputy director, Jon Andrus, days after the first cases were reported.

“During the last epidemic in the Americas, which broke out in Peru in 1991, there were more than 500 000 cases reported over a two year period,” he said. From Argentina to Canada, almost every country in the Americas was affected, apart from some Caribbean islands, including Hispaniola, which is shared by Haiti and the Dominican Republic. Haiti has not seen cholera for more than a century.

The Pan American Health Organization and other international health organisations are working closely with the Haitian government to control the outbreak. After an initial surge of reported deaths—which reached 250 in the first few days—the number of new fatalities reported each day dropped significantly. The numbers infected continued to rise though, passing 3000 within days.

Health services were able to reduce the number of deaths by using oral rehydration salts, intravenous fluids, and water purification tablets stored in anticipation of such an outbreak after the January 2010 earthquake. And additional supplies and expertise arrived within days. Brazil has sent large supplies of powdered chlorine, and the strain seems to respond to antibiotics, said the US Centers for Disease Control and Prevention.

The largest problem for Haiti, which has no living experience of cholera, is to mount a nationwide education campaign among the population and in the medical profession.

In addition to providing medical supplies and assisting the sick, non-governmental organisations such as the International Medical Corps are training local health workers and even the Boy Scouts to identify new cases early and teach local populations about good health and hygiene practice.

Many people had been washing, playing, and drinking in the major Artibonite river, which is now thought to be contaminated.

Cite this as: BMJ 2010;341:c6057

Drug companies are accused of using unsuitable doctors for promotion

Jeanne Lenzer NEW YORK
Hundreds of doctors who have been disciplined for ethical breaches or had their medical licences revoked are on drug companies’ payrolls as speakers and consultants, an investigative report released on 18 October says.

The wide ranging investigation took months and was the product of a collaboration between the investigative news organisation ProPublica, a non-profit group based in New York, and five other news outlets: National Public Radio, the Chicago Tribune, the Boston Globe, Consumer Reports, and the US Public Broadcasting Service’s Nightly Business Report.

Doctors cited in the report include a pain physician who had performed “unnecessary” nerve tests on 20 patients and an anaesthetist who had admitted giving female patients rectal and vaginal exams without documenting why.

The reporters created a searchable database of payments to doctors since 2009. The database includes $258m (£163m; €185m) in payments to 17 700 individuals by seven drug companies: Pfizer, GlaxoSmithKline, Merck & Co, Johnson & Johnson, Eli Lilly, AstraZeneca, and Cephalon.

Sixty three drug companies that operate in the US but do not publicly disclose their payments to doctor consultants and speakers were not included in the investigative report.

Five of the seven companies that do disclose payments told ProPublica that they don’t routinely search state medical board records before contracting with doctors as speakers and consultants. The companies said that they relied on self reporting and checks of federal databases. Only Johnson & Johnson and Cephalon said they reviewed the states’ sites.

When ProPublica approached Eli Lilly and asked the company about several of its speakers who had received warnings from the Food and Drug Agency, a spokesman said that the company was unaware of the cases “and is now investigating them.”

Even doctors with spotless records weren’t necessarily well qualified to serve as “experts” or critical reviewers, the report said. Of the 384 doctors who were paid more than $100 000 a year, 45 did not have board certification in any specialty.

Cite this as: BMJ 2010;341:c6026
Spain takes tough stance on smoking with new legislation

Aser García Rada MADRID

A total ban on smoking in enclosed public places, outside health centres and schools, and in children’s playgrounds could take effect in Spain early next year if draft legislation becomes law.

The passing of the legislation by Spain’s lower house of parliament, the Congress of Deputies, on 20 October is seen as a victory for antismoking campaigners, who have had to fight off strong pressure from Spain’s tobacco lobby. The ruling party, the centre left Socialist Workers’ Party (PSOE), also resisted pressure from the opposition conservative Popular Party, which has opposed a full ban because of the alleged economic effects on the hotel and catering industry.

A loophole in the present law, which was introduced in 2006, exempts certain bars and restaurants from adopting a smoking ban. It has meant that 90% of bars and restaurants in Spain have continued to allow smoking.

The draft legislation will now move to the upper house, the Senate, where it can be modified, and will return to Congress before the end of the year for final amendments. If there are no major obstacles the new law will come into force on 2 January 2011.

Gaspar Llamazares, president of the Congress’s cross party health commission and who has campaigned for a change in the law, said that 50 000 Spaniards die each year from tobacco related illness. Between 3% and 5% of these deaths are the result of passive smoking, and around 1000 of those who die are people who worked in bars or restaurants.

Although the 2006 antismoking law was “a milestone in the history of Spanish public health,” pressure from the tobacco lobby has so far managed to water down antitobacco legislation and restrictions on smoking in public.

But a new proposal adopted by Prime Minister Vladimir Putin’s government says that all advertising and promotion of cigarettes will be illegal from 2012 and that a complete ban on smoking in enclosed public spaces and in all “medical, sports, and cultural institutions” will be introduced by 2015.

Antitobacco campaigners cautiously welcomed the measures but called for them to be implemented more quickly.

Speaking at a government meeting in Moscow, Mr Putin, who doesn’t drink or smoke, emphasised the importance of the new strategy document and told ministers present that they should quit smoking themselves. “How are you going to fight [this problem]? You must lead by example,” he said. When one official sniggered at the suggestion he went on: “You are laughing? You smoke too; you should also give up.”

The health minister, Tatyana Golikova, told Mr Putin that 43.8 million people smoke in Russia, about 39% of the population. “It’s a huge number,” she said, adding that a packet of 20 cigarettes costs less than a loaf of bread.

Ms Golikova said that a rise in excise taxes, new restrictions on advertising, and more aggressive measures against underage smoking should cut use of tobacco by 10-15% “in the long term.”

Advertising of tobacco products in magazines and newspapers, the only media where it is currently allowed, will be phased out over the next two years.

Russia joined the World Health Organization’s framework convention on tobacco control in April 2008 after a long campaign by antismoking activists.

However, MPs came under fire eight months later when they passed a new “tobacco regulation,” which contradicted the framework convention by allowing the terms “light” and “mild” to be used on packs, albeit with a warning that such terms make cigarettes no less harmful (BMJ 2008; 337:a2837).

Gennady Onishchenko, Russia’s top public health official, labelled the regulation “a shameful compromise between medical professionals and the criminal tobacco industry.”

Cite this as: BMJ 2010;341:c6010

Baby P doctor’s case must be heard, GMC says

Clare Dyer BMJ

Sahabh Al-Zayyat, the paediatrician accused of failing to spot Baby P’s injuries two days before he died, should not be allowed to avoid a public hearing by voluntarily removing herself from the medical register, a General Medical Council fitness to practise panel has decided.

Her lawyers immediately sought and won a 48 hour stay of proceedings to allow them to ask the High Court for permission to apply for a judicial review of the decision.

The panel will reconvene on 28 October to learn the outcome of the High Court’s application and to decide how to proceed. If the High Court declines to intervene, the hearing of the misconduct charges is expected to go ahead in the absence of Dr Al-Zayyat.

Voluntary erasure would not address two elements of the case: the maintenance and promotion of public confidence in the medical profession and the maintenance and promotion of public confidence in the GMC’s performance, the panel says.

Cite this as: BMJ 2010;341:c6042
Doctors fight for Kelly inquest despite release of report

Clare Dyer BMJ

Several doctors pushing for a full inquest into the death of the government weapons inspector David Kelly have vowed to continue their campaign after the release of the postmortem report outlining the pathologist’s reasons for concluding that he died by his own hand.

The government published the report more than seven years after Dr Kelly was found dead in woods near his home in Oxfordshire. The report, published with results of toxicology tests on Dr Kelly’s body, backs up the conclusion by Lord Hutton, the former law lord who carried out a public inquiry into the death, that Dr Kelly committed suicide.

The inquiry concluded that the scientist had killed himself in July 2003 after he was revealed as the source of a BBC report accusing the then Labour government of “sexing up” a report saying that Iraq had weapons of mass destruction.

The postmortem report by the Home Office forensic pathologist Nicholas Hunt found that the main factor in the death was bleeding from incised wounds to the left wrist, which completely severed the ulnar artery. “Had this not occurred, he may well not have died at this time,” he concludes.

Michael Powers QC, a barrister and former hospital doctor who is pressing for an inquest, said the reports “don’t take the matter any further forward.”


Cite this as: BMJ 2010;341:c6013

US health insurer begins shift from fee for service payments

Bob Roehr WASHINGTON, DC

A major health insurance company in the United States is piloting a programme for breast, colon, and lung cancer treatment that shifts away from the traditional fee for service system to a bundled payment for the entire treatment regimen. UnitedHealthcare, which serves about 25 million individual consumers through its employer sponsored benefits plans, announced the initiative on 20 October.

“By paying medical oncologists for a patient’s total cycle of treatment, rather than the number of visits and the amount of chemotherapy drugs given, this programme promotes better, more patient-centric, evidence based care with no loss of revenue for the physician,” said Lee Newcomer, the company’s senior vice president for oncology.

More than 40 cancer clinics expressed interest in participating in the pilot programme. Five in mid-sized markets were selected, Dr Newcomer told the BMJ. Each “dominates the market they are in” and has 12 or more oncologists in the practice, strong leadership interested in the programme, and “talented and flexible business managers” who were able to incorporate the changes into their operations.

The company has two principal goals in creating the pilot programme. One is to separate the selection of drugs from payment issues while maintaining the oncologists’ level of income. This eliminates any potential financial incentive to use one particular product over another.

The second is the desire to elucidate best practice. Each of the groups has agreed to internally standardise its treatment regimens for 19 specific stages or categories of breast, colon, and lung cancers. They will meet annually to compare methods and outcomes so as to better define best practices. They estimate that 1500 patients with cancer will be treated in the pilot’s first year.

The payment structure for cancer treatment

German MPs are to vote on preimplantation genetic diagnosis

Annette Tuffs HEIDELBERG

The German chancellor, Angela Merkel, announced her objection to preimplantation genetic diagnosis at a recent party conference. However, she has agreed to a free parliamentary vote on whether to allow pre-screening of fertilised embryos in Germany.

The leader of the ruling Christian Democratic Union announced the conscience vote after admitting that she opposed the procedure, which identifies possible genetic disorders. “We should ban preimplantation diagnostics,” said Chancellor Merkel, reflecting her party’s conservative stance.

Meanwhile her coalition partner has replied that his party would not tolerate a complete ban. Christian Lindner, general secretary of the liberal Free Democratic Party, expressed his “regret that this chancellor, as a scientist, hasn’t given greater recognition to the method.” Opposition parties suggested that Chancellor Merkel was using the disagreement to boost her popularity among conservatives in her own party and the public.

Officially Germany, in contrast to other European countries, has forbidden preimplantation genetic diagnosis since 1990, under the Embryo Protection Law, but some legal uncertainty remained. In July 2010 the Federal Supreme Court in Leipzig had ruled in support of a Berlin gynaecologist who had carried out screening on embryos for three different couples and implanted only those that were healthy (BMJ 2010; 341:c3741).
in the US is unusual in that almost all the drugs used are bought directly by the doctor or group practice and a significant mark up, often 30% to 60%, is added to the patient’s bill. “Those margins drive a lot of the income of the oncologist; the office visit itself brings very little income,” Dr Newcomer said.

About five years ago Medicare, the federal insurance programme for senior citizens, which covers about half of all oncology services in the US, changed its reimbursement system for cancer treatment. It allows doctors to charge only 6% more than the average cost of the drugs used. Dr Newcomer said, “If a physician were sloppy shopping for drugs, he would lose money.”

Robert Berenson, who follows medical payment issues at the think tank the Urban Institute, said, “I give UnitedHealthcare credit for focusing on cancer. It gets ignored.”

He told the BMJ, “This payment model has a lot of merit” because “it gets away from cross subsidisation” inherent in oncologists making most of their income through mark ups on drugs.

Cancer is particularly amenable to this approach because diagnosis generally is based on pathology and “should be more objective than something like back pain,” he said.

However, Dr Berenson also worries that misdiagnosis is all too common. He said that misdiagnosis had been found in up to a quarter of cases where a patient with cancer was referred for further treatment at another location. Misdiagnosis of the cancer and its staging can affect treatment selection.

He believes the biggest gap in medical performance is at the stage of diagnosis. A second independent diagnosis should be made routine for cases involving non-emergency, high cost treatment such as that for cancer where “you don’t get a chance for do-overs.”

Cite this as: BMJ 2010;341:c6015

The embryos with hereditary genetic defects were left to die. In all three cases one of the partners carried the risk of a congenital genetic illness that would have “very likely led to a miscarriage, the death of the newborn right after the delivery, or the birth of a critically ill child,” the court wrote. The court’s decision revealed a legislative gap that has to be closed by a new or revised bill.

The debate has divided German society. Doctors have called for clear rules and limited preimplantation genetic diagnosis, the Catholic Church opposes the procedure entirely, while the main Protestant church has no clear opinion.

The German Medical Association (Bundesärztekammer) has asked for a temporary moratorium while the new law is prepared.

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Obesity related illness consumes a sixth of the US healthcare budget

Jeanne Lenzer NEW YORK

The medical costs of obesity in the United States may be double previous estimates, a new study concludes.

As much as 17% of medical expenditure in the US goes towards the treatment of illnesses caused by obesity, says the study (www.nber.org/papers/w16467), from the National Bureau of Economics Research, an independent, nonprofit organisation that is based in Cambridge, Massachusetts.

The authors, John Cawley, associate professor of policy analysis and management at Cornell University, Ithaca, New York, and Chad Meyerhoefer, assistant professor of economics at Lehigh University, Bethlehem, Pennsylvania, analysed data concerning nearly 14 000 non-elderly adults for 2000 to 2005.

They concluded that the annual medical expenditure for obesity related illnesses in the US among adults aged 18 or older was $168bn (£110bn; €120bn) (in 2005 dollars), which constitutes 16.5% of the $1.02 trillion in medical expenses for adults in 2005.

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A previous study found that obesity accounted for 9.1% of annual medical spending and that average medical spending for obese people was 42% higher than that for people of a healthy weight (Health Affairs doi:10.1377/hlthaff.28.5.w822).

The authors of the new study say that previous studies may have yielded less accurate results for two reasons: firstly, they estimated the costs associated with obesity rather than the costs of treating conditions caused by obesity; secondly, the data on weight and height were self reported, something that tends to result in substantial reporting error.

Including data about the subjects’ children allowed the researchers to examine genetic components of obesity (only adults with children were included in the study). If children were also obese, medical expenses were treated as being associated with obesity. The authors say this helped to distinguish the true burden of obesity from other problems, such as depression or injuries, that could result in obesity.

Genes rather than environmental factors, say the authors, play the most important role in obesity. Their review included selected literature on the topic, and they concluded that “contrary to conventional wisdom” environmental factors have little relevance when it comes to obesity. They acknowledge that some studies do report environmental correlation, but “the preponderance of evidence” is that “any such effects are so small as to be undetectable and ignorable.”

Dr Crawley told the BMJ that finding an illness not related to or exacerbated by obesity proved to be no easy task. Research has established biological pathways connecting obesity to type 2 diabetes, sleep apnoea, hypertension, myocardial infarction, stroke, gallstones, gout, cancer, osteoarthritis, asthma, and gastrooesophageal reflux.

Among the few conditions not apparently related to obesity, the authors say, were some conditions related to the central nervous system, such as epilepsy and brain damage.

Cite this as: BMJ 2010;341:c6014

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