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# Approval of historic US healthcare reform bill will extend coverage to 32 million more people

**Janice Hopkins Tanne** NEW YORK

Late on Sunday 21 March the US House of Representatives approved the healthcare reform bill passed by the Senate on Christmas Eve (*BMJ* 2010;339:b5671) and sent it to President Barack Obama to sign into law.

At midnight President Obama praised the legislators and said, "This is what change looks like." He called it a victory for the American people.

The bill's passage followed a year's effort by the president. If it had failed, his Democratic administration would have faced great difficulty in passing other legislation during his three remaining years in office.

The House vote, at 10.45 pm, was 219 to 212, with no Republicans supporting the bill and 34 Democrats voting against it.

Democrats who opposed the bill said that it permitted the federal funding of abortion, because some people would receive subsidies or tax credits to buy insurance covering it. Some were won over by Nancy Pelosi, speaker of the House, and by President Obama, who promised to issue an executive order preventing federal funding of abortion. That gained the support of Bart Stupak, a Michigan Democrat who had led Democrats opposing the bill because they believed it to be weak on abortion funding. Mr Stupak spoke forcefully in favour of the bill.

Healthcare reform is not yet complete. At 11.30 pm the House passed a reconciliation bill, a package of amendments to the Senate bill, which will go to the Senate this week. This bill eliminates provisions favouring certain states and increases subsidies to help people afford health insurance.

SAUL LOEB/AFP/GETTY IMAGES

**President Obama briefed doctors about his final proposals before taking them to the vote**

For a century US presidents have been trying to provide universal health care. The bill passed last night will provide health insurance to 32 million Americans who now lack it.

Health insurance companies will no longer be able to refuse to cover people with pre-existing conditions, to place caps on coverage, or to cancel insurance when they become ill.

All Americans will be required to have health insurance or else pay penalties, and most employers will be required to provide health insurance or pay penalties. However, subsidies and tax credits will help people on low or middle incomes to buy coverage.

The Congressional Budget Office last week estimated that the bill would cost $940bn (£630bn; €700bn) over 10 years.

Cite this as: *BMJ* 2010;340:c1635

**See EDITORIAL, p 663, FEATURE, p 680**

## US drug manufacturers will have to disclose payments to doctors

**Ray Moynihan** NSW, AUSTRALIA

New rules forcing drug and device manufacturers to disclose all payments to doctors look set to become law in the United States, after the historic healthcare reform bill was passed by the House of Representatives this weekend.

The "Sunshine Act" was first proposed as standalone legislation three years ago, but its provisions were incorporated into the wider reform bill now close to being signed into law. Under the new law all manufacturers of drugs, devices, and biologicals will have to provide details to the government of all payments they make to doctors and teaching hospitals, which will then be made publicly available.

The names of receiving doctors and how much they received will have to be made accessible on a searchable website in a "clear and understandable" format that can be easily downloaded.

Under the new rules companies will have to disclose consulting fees, honorariums, gifts, entertainment, food, travel, education, research, speaking fees, and grants. Payments of less than $10 (£7; €7.40) will be exempted, but once a doctor receives more than $100 in total in any given year from one company, all payments will have to be disclosed.

A previous version of the Sunshine Act would have forced the industry to disclose payments to a much wider group of recipients, including pharmacists, patient advocacy groups, medical schools, and providers of sponsored medical education. However, the language in the final bill means that only payments to doctors and teaching hospitals will have to be disclosed.

Cite this as: *BMJ* 2010;340:c1648

# Government's reply to alcohol report is "too complacent"

**Zosia Kmietowicz** LONDON

The Department of Health has rejected a call from MPs for tighter controls on advertising of alcohol, saying that its policy of self regulation and education is working well. But it has left open for the time being the decision on a minimum price for alcohol until more research on the strategy's effect on crime and disorder is published at the end of March.

The department was responding to a report on alcohol from the cross party health select committee published in January. In their report MPs made a raft of recommendations, including a minimum price for a unit of alcohol, better detection of people with alcohol problems, and improved treatment services (*BMJ* 2010;340:c136, 12 Jan).

Don Shenker, the chief executive of Alcohol Concern, said that the government's response was "too complacent" and "fails to acknowledge the actions needed to drive down these harms [from alcohol]."

He added, "Health professionals, police officers, and youth workers up and down the country will be very disappointed that another chance to take further action on reducing alcohol harms has gone missing, leaving them to clean up a mess the government is unwilling to tackle."


LENSCAP/ALAMY

Ian Gilmore, president of the Royal College of Physicians, agreed, saying that for "the government to say its current plans are sufficient flies in the face of the evidence."

He added: "While the secretary of state correctly recognises the huge and costly problems caused by excessive drinking, the [health] department's formal response then fails to countenance the actions needed to drive down these harms."

In its report the House of Commons Health Committee said that in 2003 the drinks industry spent an estimated £600m (€670m; $900m) to £700m on marketing and that the current system of controls on advertising and promotion was "failing young people." It recommended that the regulation of alcohol promotion should be independent of the alcohol and advertising industries.

*The Government Response to the Health Select Committee Report on Alcohol* is at www.official-documents.gov.uk/document/cm78/7832/7832.asp.

Cite this as: *BMJ* 2010;340:c1619

# British boy receives trachea transplant

**Jeremy Laurance**
THE INDEPENDENT

A 10 year old British boy has become the first child in the world to receive a transplanted organ that is being rebuilt inside his body using his own stem cells.

Doctors hailed the surgery as a milestone in the development of regenerative medicine, bringing closer the prospect of replacing damaged or worn-out organs with functioning replacements that are not rejected by the body or of treating damaged organs in situ with stem cells to stimulate self repair.

The nine hour operation was carried out at Great Ormond Street Hospital, London, last week by a British and Italian team of specialists. Doctors said that the boy, who has not been identified, was out of bed, breathing freely and speaking.

Martin Birchall, a specialist in regenerative medicine at University College London, who was part of the surgical team, said, "Only a few hundred children and adults will benefit directly from this operation, but we can immediately apply the technique in other settings. It will be many years before it replaces [conventional] transplants, but it is a serious step on the way."

The boy was born with congenital tracheal stenosis. His windpipe measured 1 mm across, and he could not breathe unaided. Over the past decade he had repeated operations but had a serious haemorrhage last November. Doctors said he had run out of options, and the revolutionary transplant was his only hope.

He was given a donor trachea that was stripped down by an enzymatic process to the fibrous collagen scaffold. The organ was injected with stem cells isolated from bone marrow taken from his hip, which were programmed with growth factors to turn into

# Two hospitals are granted conditional registration by CQC

**Jacqui Wise** LONDON

Two troubled NHS foundation trusts, Mid Staffordshire and Milton Keynes Hospital, have been granted registration by the Care Quality Commission but must fulfil strict conditions to protect patients. If the conditions are not met their NHS licence to operate may be withdrawn.

The independent regulator announced that a further 64 NHS trusts will be registered without conditions. This is the first wave of registrations under the new tougher system for regulating standards in the NHS. Legally all 381 NHS trusts in England have to be registered with the commission by 1 April. Over the next two weeks the commission will announce how the remaining trusts have fared.

Cynthia Bower, the commission's chief executive, said: "This is a tough new system, and we have stronger enforcement powers than ever before to make sure services improve." The new powers include warning notices, fines, prosecution, restrictions on activities, and, in extreme cases, closure.

"This initial registration process is just the start of the system. For a number of trusts registration will be conditional on them taking immediate action to improve. Others have identified specific areas they are addressing. We will be keeping a very close eye on them to make sure they do," she said.

Mid Staffordshire NHS Foundation Trust hit the headlines when the former regulator, the Healthcare Commission, found that a lack of staff and equipment had led to unnecessary deaths of patients (*BMJ* 2009;338:b1141). The Care Quality Commission found that the trust had not complied with six of the 16 essential standards of safety and quality. The inspectors noted that there was still an overall deficit in nursing staff of 11% at the end of January 2010.

Andrea Gordon, the commission's regional director for the West Midlands, said: "Few trusts have undergone the intense scrutiny that Mid Staffordshire has experienced, both from CQC and from other parts of the NHS system. The scale of change required was significant and was never going to happen overnight."

But she added: "We are seeing progress and evidence that patient care is improving."

By 1 April the trust must:

- Demonstrate that procedures for managing patients admitted as emergencies are implemented
- Ensure that governance and audit systems to assess and monitor the quality of service provision are in place
- Ensure that equipment is properly maintained and that staff have been appropriately trained
- Ensure that nursing staff levels are adequate, and
- Ensure that systems are in place by 30 June for the supervision and appraisal of staff and for the keeping of proper records.

Antony Sumara, chief executive of the Mid Staffordshire trust, said that action plans to address the shortfalls were already under way.

Cite this as: *BMJ* 2010;340:c1608

# built with his own stem cells in pioneering surgery

the appropriate tissues to coat the trachea's inner and outer surfaces. The "seeded" organ was then implanted.

The operation follows pioneering surgery conducted by the same team in Spain 18 months ago on Claudia Castillo, 30, who became the first person to receive a transplant customised with her own stem cells. Her trachea, which had been damaged by tuberculosis, was replaced by one seeded with her stem cells and grown in a "bio-reactor" in the laboratory before being implanted. She remains well and has not needed immunosuppressant drugs.

In the case of the British boy the seeded trachea was transplanted immediately and will grow in the "bio-reactor" of his body, making the procedure simpler and cheaper and putting it within reach of more centres around the world, doctors said.

Paolo Macchiarini, of Careggi University Hospital, Florence, who led the team, said, "Rather than wait till an organ fails we may [in the future] be able to use stem cells to repair it—by trying to replace the function not the organ. The question is: can we avoid replacing the organ by just improving the function?"

Cite this as: *BMJ* 2010;340:c1633

KATIE COLLINS/PA

**The surgical team was led by Paolo Macchiarini (third from left) from Florence, and the boy's trachea was implanted by Martin Elliott (far right) with help from Martin Birchall (far left) and Mark Lowdell, all from London**

# Royal college calls for smoking ban in cars to protect children

**Jacqui Wise** LONDON

The Royal College of Physicians of London has called for a ban on smoking in all vehicles, parks, and other public places frequented by children, as part of a raft of initiatives designed to protect children from passive smoking.

A major report from the college's tobacco advisory group concludes that passive smoking is a serious hazard to the health of millions of children. New figures in the report show that every year passive smoking causes more than 20 000 cases of lower respiratory tract infection, 120 000 cases of middle ear disease, 22 000 new cases of wheeze and asthma, 200 cases of bacterial meningitis, and about 40 sudden infant deaths. Most of this additional burden of disease falls on the more disadvantaged children.

CHRIS ROUT/BUBBLES/ALAMY

**Passive smoking causes respiratory tract infections, asthma, and sudden infant death**

Launching the report, John Britton, chairman of the tobacco advisory group and director of the UK Centre for Tobacco Control Studies, said, "2010 is when the existing smoke free legislation comes up for review. It has proved highly effective in reducing exposure to smoke and resulted in marked improvements in health.

"We now have the opportunity to close the small number of gaps in the legislation. We have made massive progress, but there are still two million children living in a home where somebody smokes."

The report contains new research carried out by the UK Centre for Tobacco Control Studies in Nottingham and funded by Cancer Research UK. Jo Leonardi-Bee, lecturer in medical statistics at the University of Nottingham and one of the report's authors, said, "Passive smoking produces a threefold increase in sudden infant death syndrome and a 54% increase in lower respiratory infection, mainly bronchiolitis. It also results in a 35% increase in risk of middle ear infection."

The report states that the most important factor governing children's exposure to smoke is whether their parents or carers smoke and whether smoking is allowed in the home. Professor Britton said, "We would like to promote smoke free homes and get away from the belief that smoking in only one room or only after the children go to bed is sufficient."

The report calls for mass media campaigns and health warnings on smoking in homes. It also calls for the real cost of cigarettes to increase and further action to reduce illicit supply. Professor Britton said he believed that smoking should be banned in all vehicles, not just those carrying children, as this would be easier to enforce. He added: "We are looking for a change in public perception in what is acceptable behaviour."

The report states that children growing up with parents or siblings who smoke are around 90% more likely to become smokers themselves. Liam Donaldson, chief medical officer for England, says in a foreword to the report: "One of the biggest impacts of smoking around children is that adult smokers can be seen as role models, increasing the likelihood that the child will, in due course, also become a regular smoker."

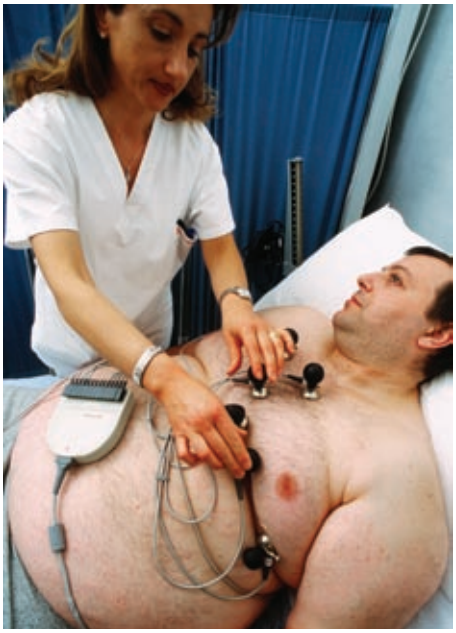
Richard Hubbard, professor of respiratory epidemiology at the University of Nottingham, said, "Passive smoking results in 303 000 excess consultations and about 9500 excess hospital admissions in the UK. The additional costs to the NHS are £9.7m [€10.8m; $14.6] a year in primary care costs and £13.6m in hospital costs."

Martin Dockrell, director of research and policy at Action on Smoking and Health, said, "There has been a shift in public opinion towards supporting smoke free legislation." He said that support was growing for a ban on smoking in children's play areas and in cars.

***Passive Smoking and Children*** **costs £20 and can be ordered from http://bookshop.rcplondon.ac.uk/.**

Cite this as: *BMJ* 2010;340:c1689

# NICE focuses on diagnosis to improve chest pain outcomes



MAURO FERMARIELLO/SPL

**An ECG can help differentiate between patients who need immediate help and those who can wait**

**Zosia Kmietowicz** LONDON

Anyone who might be having a heart attack or has unstable angina should undergo 12 lead electrocardiography as soon as possible, say new guidelines from the UK National Institute for Health and Clinical Excellence (NICE). If patients need to be referred to hospital the result of the ECG should be sent ahead so it is there when they arrive, although recording and sending the result should not delay transfer to hospital, they say.

The guideline on chest pain of recent onset has been jointly developed with the National Clinical Guidelines Centre for Acute and Chronic Conditions. Unlike many guidelines from NICE, the latest advice does not cover treatment for chest pain but focuses only on diagnosis, with the aim of reducing premature deaths by differentiating between people with acute coronary syndromes and those with stable angina.

Chest pain accounts for up to 1% of visits to GPs in England, about 700 000 visits (5%) to emergency departments, and up to 25% of emergency admissions to hospital.

The guideline says that doctors should not exclude acute coronary syndrome if the ECG result is normal but should check how current the pain is and the patient's symptoms and history. Oxygen should not be given; and men and women and people from different ethnic groups should all be assessed in the same way, as symptoms do not vary.

For people with intermittent, stable chest pain who may have stable angina the guideline recommends that diagnosis should be based on clinical assessment. Only where there is uncertainty should doctors perform tests, such as anatomical testing for obstructive coronary artery disease or functional testing for myocardial ischaemia.

In patients in whom a diagnosis of stable angina cannot be excluded after examination, doctors are advised to take a resting 12 lead ECG and to arrange further diagnostic testing according to the likelihood of coronary artery disease. Exercise ECGs should not be used to diagnose or exclude stable angina in people without known artery disease.

Adam Timmis, a consultant interventional cardiologist and chairman of the guideline development group, said, "This guideline emphasises the central role of the initial clinical assessment in diagnosing cardiac causes of chest pain. It provides objective clinical criteria for determining whether diagnostic testing is necessary and, if so, what test should be used. The guideline will improve clinical decision making in patients with suspected angina, identifying those who might benefit from treatment to reduce risk and improve outcomes."

A separate guideline covers the early management of unstable angina and non-ST elevation myocardial infarction (NSTEMI) from the time patients arrive at hospital to their discharge. This recommends that as soon as unstable angina or NSTEMI is diagnosed, and aspirin and other drugs that prevent blood clotting have been offered, the patient should be formally assessed for their individual risk of future adverse cardiovascular events, by use of an established risk scoring system that predicts six month mortality, such as the GRACE score.

The guideline then recommends treatments that are tailored according to whether the patient is at high, intermediate or low risk of future cardiovascular events.

Patients whose risk of further events is intermediate or higher (predicted six month mortality >3%) should be offered angiography with percutaneous coronary intervention within 96 hours of admission, provided that they have no contraindications. Patients who are clinically unstable or at high ischaemic risk should have the procedure as soon as possible.

**The two guidelines are at www.nice.org.uk.**

Cite this as: *BMJ* 2010;340:c1670

# Latest TB figures are a "wake-up call for all governments"

**Peter Moszynski** LONDON

The incidence of drug resistant tuberculosis has reached a record level, becoming a serious threat to global health, the World Health Organization has warned.

In 2008 there were an estimated 9.4 million new cases of tuberculosis and 1.8 million deaths. Of these, multidrug resistant tuberculosis was responsible for 440 000 cases and 150 000 deaths. However, only 7% of cases of tuberculosis are accurately diagnosed, says WHO's latest report on multidrug and extensively drug resistant tuberculosis (M/XDR-TB).

India and China account for half of all cases of multidrug resistant disease, while in parts of Russia almost a quarter of cases are now resistant to drugs.

No official estimates have been made of the number of extensively drug resistant cases, but the report says that the number may be around 25 000 a year, "with most cases fatal." Since XDR-TB was first defined in 2006 a total of 58 countries have reported at least one case.

Multidrug resistant tuberculosis is resistant to isoniazid and rifampicin, the most effective drugs. It either results from primary infection with resistant bacteria or may develop in the course of a patient's treatment. XDR-TB is resistant to isoniazid and rifampicin, any fluoroquinolone, and any of the second line injectable drugs (amikacin, kanamycin, and capreomycin).

While a course of standard treatments for tuberculosis costs around $20, drugs for multidrug resistant disease can cost up to $5000 (£3300; €3700), and treatment for XDR-TB is "far more expensive."

The report says: "Countries face enormous hurdles in accelerating access to diagnostic and treatment services . . .and previous efforts to address this epidemic have clearly been insufficient."

It notes that "greater political commitment by national health authorities" has given "reason to be optimistic" but that although "pledges have been made . . .translating these commitments into actual treatment. . . remains limited to a few thousand patients worldwide."

The Global Plan to Stop TB (www.stoptb.org/globalplan/) says that 1.3 million cases of multidrug resistant tuberculosis will need to be treated

# Poor countries must do more to reduce heart disease deaths

**Bob Roehr** WASHINGTON, DC

Cardiovascular disease is the leading cause of death in the world, and 80% of this mortality occurs in low and middle income countries. But a huge discrepancy exists between the burden of disease and efforts to reduce mortality.

A new report from the US Institute of Medicine aims to address those challenges in feasible and practical ways, said Valentine Fuster, a cardiovascular specialist at Mount Sinai Medical Center, New York, who chaired the committee that wrote the report, released on 22 March.

"It is important to recognise that there is no single strategy that will work everywhere, so it is critical to search for locally relevant solutions that will be feasible in the settings where they are needed," he said.

The growing prevalence of cardiovascular disease in low and middle income countries is in some ways testimony to the success of public health and the control of infectious disease, which has dramatically increased lifespans over the past 50 years.

But migration from the countryside to cities and better pay have led to behavioural changes that contribute to the rise of heart disease. These changes include reduced physical activity, less healthy diets, and greater use of tobacco.

The report's recommendations focus on practical interventions and outcomes. It recognises that major new funding is not likely to happen and that strategies must be tailored to individual countries. Efforts should focus on integrating cardiovascular disease into broader health and development concerns, it says, and chronic disease should be made a priority for programmes of development assistance.

National and lower level governments "should create and maintain health surveillance systems to monitor and more effectively control chronic diseases," says the report. Such systems should be part of efforts to strengthen and increase the capacity of health systems and healthcare delivery systems.

The World Health Organization, other non-governmental organisations, and stakeholders from the food and services industries should "develop collaborative strategies to reduce dietary intake of salt, sugar, saturated fat, and trans fats in both adults and children."

Dr Fuster said, "Leaders in the field of cardiovascular health need to think and act more globally . . . to do more to confront cardiovascular disease and other chronic diseases."

**The report is at www.iom.edu/.**

Cite this as: *BMJ* 2010;340:c1658

STEFAN BONESS/PANOS

**Adoption of Western habits has increased cardiovascular disease in developing countries**

# Surgeon's mistakes revive issue of regulation of European locums

**Clare Dyer** BMJ

A botched operation by a surgeon flown in from Germany to provide holiday cover at an English hospital has been blamed for hastening the death of a 94 year old woman.

Coroner Stuart Fisher said he had been "deeply shocked" by the case of Ena Dickinson, who died eight weeks after what should have been a routine hip operation but which left her bedbound.

The surgeon, Werner Kolb, who is based in Stuttgart but was on a six week holiday cover placement, made a catalogue of errors during the hemiarthroplasty operation at Grantham Hospital in Lincolnshire in August 2008. Mrs Dickinson, a former nurse, died eight weeks later from pneumonia.

Angus Wallace, the expert witness at the inquest, told the coroner it was the worst case of negligence he had come across in his career.

The case highlights again the dangers of using foreign locum doctors, often recruited through agencies, who may lack the necessary experience and language skills. Rules on the free movement of workers between member states in the European Economic Area oblige employers and regulators to accept medical qualifications at face value and prevent checks on competence and ability to speak English.

In another case, a locum GP from Germany, Daniel Ubani, killed 70 year old David Gray by giving him 10 times the recommended dose of diamorphine (*BMJ* 2010;340:c286).

Cite this as: *BMJ* 2010;340:c1584

DAVID BRUNETTI

**This picture of 3 year old Moneesha Kumari receiving treatment via a Target TB project in India is part of a Westminster exhibition. See www.targettb.org.uk**

in 27 high burden countries between 2010 and 2015, at an estimated total cost of $16.2bn.

WHO's report says, "Mobilization of both national and international resources is urgently required to meet the current and future need." The funding required in 2015 "will be 16 times higher" than that available in 2010.

Asking all UK political parties to commit themselves to increasing the fight against the disease, Desmond Tutu, speaking for the UK Coalition to Stop TB, said, "In 2010 two million people will die from TB—that is 5000 people every day. It remains one of the top three killer diseases in the world, of a similar magnitude to HIV and AIDS. Even in developed countries like the UK it is on the rise, with rates in parts of London rivalling that of some countries in Africa."

Archbishop Tutu lamented, "This ancient killer, traced back thousands of years, should have been conquered last century. Yet even with all the technology and advances of the 21st century it remains with us today—more lethal, increasingly drug resistant, and forming a deadly combination with HIV."

***Multidrug and Extensively Drug-Resistant TB (M/XDR-TB): 2010* is at http://whqlibdoc.who.int/publications/2010/9789241599191_eng.pdf.**

Cite this as: *BMJ* 2010;340:c1614

## IN BRIEF

**Soldiers remove patients from hospital in Democratic Republic of the Congo:** Médecins Sans Frontières has condemned as deplorable a serious incident in which armed soldiers from the Congolese army entered a hospital in Katanga on 11 March while emergency care was being provided. MSF said that the soldiers left the hospital a day later with four patients. MSF's head in the region, Philippe Havet, called on all armed personnel "to respect medical establishments."

**Condom advertisements can appear before 9 pm in UK:** Relaxation of advertising codes in the United Kingdom after a review and public consultation means that condoms can be advertised on television before the 9 pm watershed after 1 September. Advertisements must not be shown around programmes aimed at children under 10 years old and must comply with strict rules on taste and decency.

**Website captures patients' thoughts on leukaemia:** Patients' experiences of leukaemia have been captured on a new section of the Healthtalkonline website run by the charity DIPEx (www.healthtalkonline.org), which uses interviews from qualitative research to illustrate the real life experiences of patients. Leukaemia is the 50th group of conditions to feature on the website since its launch in 2001.

**Use of abortion pill in Italy will be restricted to hospitals:** The abortion pill mifepristone (also known as RU486) will be administered only in hospitals when it finally becomes available in Italy within the next few weeks. The Italian health ministry's technical advisory board said that the restriction was needed for users' safety. But critics, including the former centre left health minister Livia Turco, said that the stipulation was designed to limit use of the pill.

**Andalusia approves Spain's first law on death with dignity:** Andalusia became the first region in Spain to pass a law establishing the right of patients with terminal illness to palliative sedation, even if this shortens life. Under national law "active" euthanasia carries a prison sentence, but judicial experts agreed that "passive" euthanasia (interrupting or not beginning a treatment, such as ventilation, that the patient would need to continue living) and giving sedative treatments that shorten a patient's life are not a crime if patients ask for them.

Cite this as: *BMJ* 2010;340:c1625

# Extreme obesity affects 12% of black teen girls in US, study says

**Bob Roehr** WASHINGTON, DC

The prevalence of extreme obesity in young people has reached 6.4%, a large study in southern California has found—nearly 1.5 times the percentage found in a roughly similar study a few years earlier.

The study analysed electronic medical records of 710 949 children and adolescents aged 2 to 19 years who were enrolled in the large health maintenance organisation Kaiser Permanente Southern California (*Journal of Pediatrics* doi:10.1016/j.jpeds.2010.01.025). The children and teenagers had an average of 2.6 medical visits a year over the study period of 2007 and 2008. The study defined extreme obesity as a body mass index (BMI) of ≥35.

The prevalence of extreme obesity differed between boys (7.3%) and girls (5.5%). Obesity in boys tended to peak at age 10 and then dip slightly, while girls had two peaks at ages 12 and 18. Both groups converged around age 18 and continued on an upward trend.

Ethnic differences were marked. Black Americans had the highest rate of extreme obesity (8.2%), with 12% of black teenage girls achieving this dubious distinction. Hispanic white young people were close behind (7.9%). Asians (3.4%) and non-Hispanic white people (3.8%) had rates that were less than half those of the other two groups.

"The percent of extreme obesity was higher than we thought it would be. That is scary," said Corinna Koebnick, lead author of the study. Although the rate of overall obesity seems to have levelled off, that of extreme obesity hasn't.

"Our focus and concern is all about health and not about appearance," said Amy Porter, a coauthor of the study.

"Children who are morbidly obese can do anything they want: they can be judges, lawyers, doctors—but the one thing they cannot be is healthy," she said.

The consequences of obesity are a higher risk and earlier onset of diabetes and cardiovascular

# Paediatrician David Southall launches new bid for reinstatement to medical register

**Clare Dyer** BMJ

David Southall, the child protection paediatrician who was struck off the medical register for accusing a mother of murdering her son, launched a fresh bid for reinstatement at the Court of Appeal in London this week.

Dr Southall, described as a paediatrician "of international repute," is appealing against a High Court ruling last year that upheld the General Medical Council's decision to strike him off for serious professional misconduct (*BMJ* 2009;338:b1360).

Dismissing his original appeal last May, Mr Justice Blake said that the paediatrician's conduct was "truly shocking" and "an abuse of the role of consultant and expert instructed in ongoing litigation."

Dr Southall's counsel, Mary O'Rourke QC, told Lords Justices Waller, Dyson, and Leveson at the appeal court in London that the GMC's fitness to practise panel had given no reasons for finding against him.

Dr Southall did not know why they had accepted the mother's evidence that he had accused her of killing her elder son and rejected evidence from him and from a social worker who was present, both of whom took contemporaneous notes, that he had not made the accusation.

REX

**David Southall**

The panel found in December 2007 that Dr Southall had accused Mandy Morris, whose 10 year old son Lee was found hanged, of drugging him and hanging him herself. Dr Southall, then a consultant paediatrician and expert in fabricated or induced illness, was instructed by a county council in 1998 to prepare a report in care proceedings involving her younger son and was interviewing her in the presence of a senior social worker, Francine Salem.

His case is that he had not accused her of murder but was outlining a range of possible scenarios. Her belief that she had been accused was a misperception, he argued.

A doctor "of international repute with a long and distinguished career" had lost his medical registration, but he did not know why his evidence was not accepted, Ms O'Rourke said.

The appeal, if successful, could put GMC panels under a stronger obligation to give reasons for their decisions.

Cite this as: *BMJ* 2010;340:c1684

LIONSGATE

**One in eight black teenage girls falls into the same category of extreme obesity as the fictitious character Precious, played here by Gabourey Sidibe, in the film of the same name**

disease. "Childhood obesity does decrease overall lifespan," Dr Koebnick said.

She believes that the size and diversity of the study population "gives us a pretty good view of what is going on here and most likely everywhere else in the US."

The National Health and Nutrition Examination Survey 1999 to 2004 found that 3.8% of children had a BMI that put them above the 99th percentile, roughly equivalent to extreme obesity. This Kaiser study found a rate of extreme obesity that was half again as large.

Ethnic information was available in 52% of the children's medical records. Surname and census tract information were used to assign children to an ethnic group where the information was not listed. Separate analysis of the recorded racial and ethnic information showed no differences from the larger dataset.

Cite this as: *BMJ* 2010;340:c1631

# Global Fund will eliminate vertical spread of HIV by 2015 if funding continues, report says

**Rory Watson** BRUSSELS

The Global Fund to Fight Aids, Tuberculosis and Malaria is on target to meet its major aim of reducing the incidence of the three diseases by 2015, according to projections in its latest results report.

However, the Geneva based organisation, which will this week start the formal process of trying to secure international funding for the next three years, warns that progress will depend on its current scale of health funding being at least maintained or, ideally, increased.

Presenting the fund's latest assessment, its executive director, Michel Kazatchkine, said, "No other area of development has seen such a direct and rapid correlation between donor investments and life saving impact as these investments in fighting AIDS, TB, and malaria."

He predicted that elimination of transmission of HIV from mothers to children was "within reach" by 2015 if the progress made by programmes supported by the Global Fund and others continues at the present rate.

These activities, he added, could lead to malaria being eliminated within a decade as a public health problem in most countries where it is endemic and to a halving in the prevalence of tuberculosis within the next five years.

The fund's latest report says that the programmes it supports saved at least 3600 lives a day last year and that, since the fund was created in 2002, 4.9 million people have survived who would otherwise be dead without help from its various programmes.

By the end of 2009, activities financed by the fund had provided antiretroviral treatment to 2.5 million people, treated six million people with active tuberculosis, and distributed more than one million insecticide treated nets to prevent malaria.

The fund, a public-private partnership, has distributed $10bn (£6.7bn; €7.4bn) to tackle the three global epidemics of HIV, tuberculosis, and malaria. Its impact is likely to be even greater over the next 20 months, because much of the $5.4bn pledged during the last two financing rounds will reach beneficiary countries this year and next.

The scale of new funding that the fund can expect between 2011 and 2013 will become clear at the replenishment conference in October in New York.

**The report is at www.theglobalfund.org/.**

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# Researchers say patent on BRCA1 gene was too broad

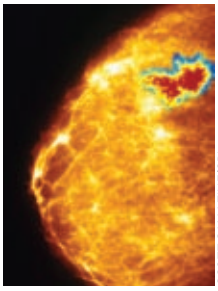
**Clare Dyer** BMJ

The controversial 1998 patent that gave Myriad Genetics a US monopoly over genetic testing for risk of breast and ovarian cancer contains a claim so "surprisingly broad" that it should never have been granted, says an article in the journal *Genomics*.

Three researchers from the Institute for Genome Sciences and Policy at Duke University, North Carolina, found that stretches of DNA claimed in the BRCA1 patent are common throughout the human genome and could be found in 80% of the gene sequences placed in the publicly accessible GenBank, the genetic sequence database of the National Institutes of Health, the year before Myriad sought patent protection (*Genomics* doi:10.1016/j.ygeno.2010.03.003).

"We find that, through this claim, the patent extends to portions of most genes in the human genome and likely to most genes in nature as well," say Thomas Kepler, Colin Crossman, and Robert Cook-Deegan.

They say that almost all research on the BRCA1 gene in the United States since 1998 has infringed patents held by Myriad and that research has gone ahead only because the company has voluntarily refrained from taking action against those doing basic research.



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**Myriad has refrained from taking action against scientists doing basic research**

But if the patent was enforced in the future it could have "substantial implications for medical practice and scientific research."

The paper coincides with a lawsuit filed by the American Civil Liberties Union in the Southern District Federal Court of New York, which challenges patents held on the BRCA1 and BRCA2 genes. The organisation argues that patents on human genes are unconstitutional and unlawful because genes are "products of nature" that cannot be patented.

The case, which had a first hearing in February, challenges whether genes in general can be patented and could have far reaching effects. Around 20% of all human genes are patented.

The authors say that many are watching the case closely for its implications.

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