reviews

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Select committee castigated for citing death of 3 year old girl in obesity report

The House of Commons Select Committee's inquiry on obesity was published on 27 May. The press release, issued the previous day but embargoed till publication of the report, highlighted the rapidly rising rates of obesity, the potential health consequences, and the need to increase physical activity and focus on preventing obesity in children. However, Radio 4's *Today* programme on 26 May had been leaked a story that MPs would report the case of an obese child who died of heart failure. By the evening, the media was saying that the report was critical of both the government and the food industry, and called for the banning of food advertising aimed at children. The following morning, national newspapers carried headlines like "Obesity kills child of 3."

The report was officially available to the press for the first time on 27 May. Its second paragraph leaps out at the reader: "Over the last two years, [Dr Sheila McKenzie] had witnessed a child of three dying from heart failure where extreme obesity was a contributory factor. Four of the children in the care of her unit were being managed at home with non-invasive ventilatory assistance for sleep apnoea: as she put it, 'in other words, they are choking on their own fat.'" When questioned at the press conference, David Hinchliffe, chairman of the committee, said: "We were all shocked when we heard about the young girl. I see in my constituency children who are grossly obese, but to hear of a girl dying from heart failure was shocking." He added: "It was the first situation of its kind we had come across, but we feel it may become a more serious consequence of obesity in the future."

The evening papers ran the headlines "Choking our children on their fat" and "Food will carry fat warning." It was not long before journalists had tracked down the parents of the dead child in the Bangladeshi community in east London. One commentator remarked, "When a three year old girl who weighs 40 kilograms dies of heart failure brought on by obesity, you know her parents are guilty of gross child abuse."

There was a further flurry of media activity over the weekend, but by Tuesday there had been no corrections made by the select committee, who seemed pleased with the wide press coverage of the report. Investigative journalists became suspicious and, having talked to several experts, were told that it was very unlikely that such a young child would die from overeating unless there was some serious genetic defect such as leptin deficiency or Prader-Willi syndrome. It then emerged that a research group at Cambridge that specialises in the molecular genetics of precocious obesity had identified a serious genetic defect in the child, but the child had died before treatment could be offered. The story broke on the web (www.spiked-online.com) on 8 June and was more widely reported on the *Today* programme, which had been investigating the story for over a week, on 10 May.


DAILY EXPRESS

Coming to your town?

SMOKING BAN IN PUBLIC

CHILD, 3, DIES FROM BEING TOO FAT

The terrifying truth behind Britain's obesity epidemic

Princess Pushy 'insults' black diners

David Hinchliffe was incandescent on radio and television over the allegation that his committee had been duped: he denied that the committee intended to highlight the death of the child and blamed the press for misreporting her death. The following day the headlines ran that the committee had got it wrong on the death of the 3 year old and was guilty of telling a "Big Fat Lie."

What lessons can be learnt from this episode? Much of the problem stems from the overheated language used in the report, which seems to have been intentionally placed to garner headlines. Secondly, it was quite inappropriate to link severe precocious obesity to the problem of overweight and moderate obesity in children, which is related to lifestyle. Thirdly, it was unwise and unethical to refer to a child with such a rare condition in a public report, as it is hard to protect the anonymity of the family. According to one of the committee's defenders, the National Obesity Forum (which is funded by the pharmaceutical industry), the girl's story "was used to gain a bit of drama and it certainly worked, but in retrospect it should probably not have been used." The online publication *spiked* summed it up: "In this kind of climate it is not surprising that an isolated death can be turned into a modern morality tale, and that even bereaved parents, about whom we know nothing, can be accused of effectively killing their child."


A BIG FAT LIE

By PAUL GILFEATHER
Whitehall Editor

MPS who used the death of a three-year-old girl to highlight the dangers of obesity were slammed yesterday.

Scientists said the child was actually the victim of a genetic disorder, adding that her family had been caused huge distress.

They accused the Commons health committee of being "duped" by pressure groups.

The weight of the girl – whose condition meant she

TARGET: MP Hinchliffe

'Obese' girl, 3, had genetic disorder

constantly thought she was starving – was said to be about six stone instead of the normal 2st 4lb.

Dr Sadaf Farooqi, who dealt with the case, said the implication was the child had been "overfed, with bad parents", resulting in obesity and death.

"I was very disappointed and, I must say, annoyed at the way this child's case was represented." Dr Farooqi, based at Addenbrooke's, Cambridge, said evidence taken by MPs on obesity was too narrow.

Prof Tom Sanders, a nutrition expert, said the committee was fed a lot of information by "vested interests".

The answer was to help children follow a balanced diet and not grow up with a "fat phobia".

Committee chairman David Hinchliffe, Labour MP for Wakefield, said its report had been misrepresented. It did not say or imply that the girl had died from poor diet. The report, he added, was based on evidence from "all sorts of people".

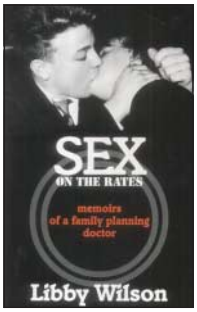
p.gilfeather@mirror.co.uk

Daily Mirror, 10 June 2004

Tom Sanders *professor of nutrition and dietetics, King's College London*
tom.sanders@kcl.ac.uk

Sex on the Rates: Memoirs of a Family Planning Doctor

Libby Wilson



Argyll Publishing, £7.99,
pp 224
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Email:
Argyll.publishing@virgin.net

Rating: ★★★★

This really is the sort of book that, once you start to turn the pages, you can't put down. If, like me, you have a fanatical interest in family planning and reproductive health you cannot help being seduced by it.

Wilson has achieved something very admirable in putting this account together. Not only has she detailed the shaky, haphazard emergence of family planning services over the last 50 years and their metamorphosis into the rather more robust set up we have today, but she has highlighted other political and social issues of great importance: the difficulties of women in medicine, balancing work and career, the lack of contraceptive choices before the arrival of the pill, and the slow evolution of recognition for vital contraceptive services. It was not until the government agreed in 1974 to make contraceptives freely available—and indeed to pay doctors for offering these services—that these cumulative efforts came to fruition.

Wilson herself was a pioneer of intrauterine contraception and was one of the first people in the United Kingdom to be trained and then to train other doctors in this excellent method of contraception, which has, happily, been gaining in popularity in Britain. She describes funny scenes of insertion of intrauterine devices in patients' homes. Once, for example, in the process of insertion she realised the patient's bed was occupied by more than just the patient when a large Alsatian dog stuck its head out from under the covers.

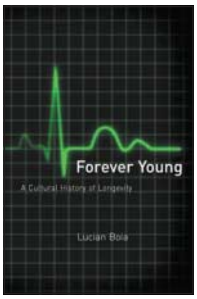
The book makes it clear that poverty and social inequality have an influence on public health. Wilson paints a colourful picture of life in the Glasgow slums, visiting women in need in appalling conditions, having her car vandalised, and at times fearing for her own safety. She also introduces the topic of what used to be referred to as venereal disease but which we have moulded into the now familiar term sexual health (perhaps the term was invented in Glasgow?).

The book conveys well the empathy Libby Wilson has had for her patients and the experience she has accrued over her career. With her title of "clinical coordinator" her status could not be pigeonholed by royal college certification or rubber stamped with a consultant grade, but her accomplishment speaks for itself. She is a forward thinking doctor of enormous valour, great skill, and compassion. It is time that reproductive health achieved the status it deserves, and this book will help. It will be relevant and of interest to anyone who works in the fields of sexual and reproductive community medicine and public health, as well as to those who need to understand more about the depth and breadth of our specialty.

Deborah J Lee *associate specialist in reproductive health, Southampton*
Debbie.Lee@scpct.nhs.uk

Forever Young: A Cultural History of Longevity

Lucian Boia



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Rating: ★★

The Romanian historian Lucian Boia sees the pursuit of longevity, even to the eventual status of immortality, as a natural strategy for humankind. He cites the decline in religious belief and the afterlife, as well as the failure of secular "religions" such as Progress and Science, as key factors in the present interest in the subject.

However, it seems a little odd to cite science's failure to provide solutions for humanity as one of the drivers of the quest for salvation through the prolongation of life—especially given medical science's record in providing many of the epidemiological explanations and treatments that have helped increase life expectancy dramatically in the 20th century. Additionally, the study of genetics has contributed greatly to our understanding of the ageing process.

On the other hand, the list of treatments that scientists throughout history have proposed to counter ageing allows us today to have a good chuckle. For example, the 19th century British physiologist and neurologist Brown-Séquard injected himself with extract of rams' testes, while Russian transplant pioneer Serge Voronoff (1866-1951) believed that the same products from chimpanzees were far superior. The consumption of viper meat and the close proximity of healthy young people were part of the holistic approach of medieval experts.

Occasionally, however, the anti-ageist specialists were, probably by chance, correct. The 13th century English philosopher and scientist Roger Bacon advocated red wine, while the 14th century Venetian Cornaro, whose books were in print for several hundred years, extolled temperance and dietary restriction, which he believed were good for both spiritual and physical wellbeing.

The patients that geriatricians see have already tasted old age and its effects. Therefore, discussions tend to focus on their specific diseases and disabilities rather than on any extension of life for its own sake. The children of these patients also tend to focus on when their mother or father will die, rather than on for how long life will be prolonged. Indeed, the news that someone will live to be over 100 may be a cause for alarm rather than for celebration.

However, geriatricians cannot escape from issues that surround longevity. Clinical trials have shown that a number of interventions will extend life, and audits of national service frameworks and clinical guidelines will tell us how good we are at prescribing life prolonging medicines. The problem is that for very few conditions do we have robust evidence for the effectiveness of pharmacological interventions in the over 80s, or for those whose life expectancy is to be measured in months rather than years. Such patients have been excluded from clinical trials and extrapolation from studies in younger people is problematic.

While we must resist a nihilistic and ageist approach, a 10% or 20% prolongation of life may be statistically significant with a large number of zeros after the $p <$ sign but result in only a small quantum of benefit. Perhaps the solution lies in the burgeoning concept of concordance that allows patients to decline interventions legitimately if they assess any benefits to be of no or minimal importance.

However, we still have not resolved the issue of how to respond to requests for treatments that doctors consider to be of unproven value. Boia tells us that he has not sought to separate what is true from what is not. Should we be allowed such liberty?

Peter Crome *consultant geriatrician and professor of geriatric medicine, Staffordshire*
p.crome@keele.ac.uk

Items reviewed are rated on a 4 star scale (4=excellent)

PERSONAL VIEW

Treating our own

One advantage of being in the medical profession is that you can avoid the tedium and delays of seeing a doctor simply by hailing a colleague. Over the years I have been consulted by many members of the consultant staff and by many other professionals, medical and non-medical. A friend calls these "corridor consultations," and he always feels a little compromised by them. As a dermatologist he is particularly vulnerable: surely, they think, he just needs to have a quick glance to identify the problem? The funny thing is that many of the colleagues who approach you teach students the importance of a careful history and full examination before formulating a diagnosis and treatment plan. They would be horrified if you suggested that all they needed to do was have a quick glance at the problem and would rant on about Osler and Asher and the value of the clinical examination.

I dread the words "I know you're not on duty"

So, is it a question of "Do as I say, not as I do," or do we really believe that a glance is enough? Once, as a house officer attending a cardiac arrest, I was hugely impressed by the senior registrar who strolled up to watch our despairing efforts at resuscitation and commented from the end of the bed that the patient seemed to be in asystole and our efforts were likely to be in vain. Only a quick glance was needed. How often have you seen the main problem just after the patient has entered the consulting room, waving their clinodactylic fingers or their psoriatic distal interphalangeal joint? Another instance: a seasoned orthopaedic surgeon described how his neighbour called round after hurting her wrist in a fall a few days before. He could see that she had a fractured wrist, that it was impacted, and that the way she was waving it around suggested she didn't need treatment. So he kept quiet about the fracture and reassured her; the whole thing took a few minutes.

The phenomenon is not confined to colleagues. Friends often take an opportunity to confirm their own doctor's opinion or treatment or to seek advice on a problem they haven't discussed with anyone, like an unofficial and immediate NHS Direct. This is one reason I keep my medical defence subscriptions up to date, in case someone takes me to task for advising them to ignore the bloating in their stomach.

Giving the "right" answer can enhance your kudos

The only person not to make such impromptu consultations is my mother, who seems to find it difficult to believe that anything learned and medical can emanate from her son. She will often tell me that her friend Hilda has recommended a new powerful cure for a cold, as advertised on television, and refuses to believe that there is no evidence base for such treatments. Perhaps it's the way I tell her, or perhaps it is a willingness to believe that there really is something out there that can cure the common cold.

The phenomenon also extends to people you have just met, especially if you have been introduced as an "expert." I dread the words "I know you're not on duty, but . . ." Sometimes—and this is why we keep doing it—giving the "right" answer can enhance your kudos immensely, though quite unjustifiably.

I remember advising a childhood friend who asked whether he should go through with the laminectomy recommended for his sciatica. Because it was a recent problem, and because he clearly didn't have a footdrop (although I hadn't examined him, and I had no idea what his magnetic resonance image looked like), I advised him to hang in there, pointing out that one study had shown that at 12 months surgery conferred no advantage over conservative treatment for sciatica. His sciatica gradually improved and has not recurred, although his back pain still gives him trouble occasionally, as you would expect.

So, when a friend brought up the problem of his septic finger over dinner one night I wondered how I could give some insight into a problem that had been going on for some weeks, been seen by at least two doctors, and been treated with three courses of antibiotics. Desperately looking for clever options—I am a "specialist," after all—I suggested chronic paronychia caused by candidiasis, adding the nugget of possible underlying hypoparathyroidism. We discussed all this with some jocularity, but at the end of the evening we arranged that he would call round the next week and I would swab and take some blood. I should add that this visit was something of a trial for both of us, as he is the head of a school some miles away, and neither of us arrives home much before 8 pm. He duly called, I took the samples, but just as he was leaving I noticed that he had a nervous habit of picking at the offending finger with the long and slightly grimy fingernails of his other hand. This pointed out, he promised to cut his nails and stop the habit, of which he had been quite unaware. Now when we meet he regularly extends his pristine digit in my direction. The tests? Normal, of course.

Philip Helliwell *senior lecturer in rheumatology, University of Leeds*
p.helliwell@leeds.ac.uk

SOUNDINGS

Judgment day

Conference centre in Amsterdam. I'm in the press room, being briefed by an attractive hostess in a sash. She hands me a map marked with a cross. You will find the treasure *here*. Outside, 4000 delegates are networking in a purpose built informal space with endless corridors of glossy posters. They are vying, variously, for Best Oral Presentation, Best Poster, Most Innovative Quality Improvement Project, and Patient Communication Award. I'm here to judge Young Researcher of the Year.

Regular readers of this column will know that I can't read maps. I'm one floor too high but don't know it. I blunder into the pharmaceutical industry corner and start judging. The lad beside the poster—he's young all right—offers me a freshly squeezed raspberry juice and starts a spiel about a new contraceptive. The poster is surreal—lovers entwined, bound by a rubbery halo. So small you don't know it's there, he explains. But no cost effectiveness studies that he knows of. We exchange business cards.

The next guy—bald and wrinkled, but I presume he has a syndrome—offers a plate of petits fours and a free first aid kit for my car. We admire his poster. I note creative use of imagery and sexual innuendo, but sadly the small print is unreadable. Have I ever prescribed Something-o-sartan, he asks. I rack my brain. Yes, once, against my better judgment, and the patient developed mouth ulcers. I talk him through my Yellow Card report.

The next "poster" is a free medical check from a company selling an anti-obesity drug. I'm game. I complete a questionnaire about my personal habits, stand on the scales, and have my fat content estimated by an infra-red machine. Reassuringly, I fail to qualify for a free sample pack, but am awarded an apple in a takeaway bag.

Eventually, I am rescued and escorted to the lift. The real Young Researcher of the Year display stands proud in a draughty hall, conspicuous by the absence of freebies, sales pitch, and delegates. These shortlisted dozen are the names—mostly unpronounceable and double barrelled—to watch for the future. Their posters, comprising simple printouts glued on to card, present solid, original research with direct messages for patient care. I struggle to pick a winner, and slink guiltily back upstairs to queue for my free lunch.

Trisha Greenhalgh *professor of primary health care, University College London*