understanding has led to widely different views within it. Jewell suggests that doctors should inform the debate but not be involved in fundamental decision making, and this then raises the issue of who will, in fact, take on this responsibility. Jewell's suggestion that 'the public' will do so is disingenuous, given the obvious lack of unanimity of opinion within it. In any case, it seems curious to me for doctors to be urged to take such a passive role, when it is they who will be charged, quite literally, with the responsibility of delivering assisted suicide if it is introduced.

The risk here is that the voices of the politically powerful and influential will prevail. If they really want to safeguard the interests of their more vulnerable patients, doctors would do well to remember that there is a world of difference between being a public servant and a slave to majority public opinion.

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Editor's comment

Dr Alberti raises an important question, about the role of editors in setting the policy for journals. Mostly I have restrained myself from commenting: in 10 years this was, I think, only the third editorial I have published (there was a fourth that a trusted colleague persuaded me not to publish). But influence is exerted by the decisions on what to publish, which editorials are commissioned, and who is invited to write them. On this occasion I invited someone else, but when he declined I realised that I knew what content I wanted so decided not to hide behind someone else but to sign it myself — *Ed*

Obesity guidance

Mercer's discussion paper[1] on the usefulness of clinical guidelines for the management of obesity in general practice is commendable and yet raises serious concerns.

It is misleading that the NICE obesity guidelines focus so much attention on drugs and bariatric surgery, neglecting the only true treatment (and prevention) options of lifestyle modification through increased physical activity and improved diet. In the summary NICE clinical guideline 43, these get a single feeble line and this is a grossly misleading representation. One might also wonder how well equipped GPs currently are to, 'offering multi-component interventions to increase physical activity, increase healthy eating, and improve eating behaviour' during the average 9-minute consultation and when many GPs are not aware of the importance of physical activity.[2]

This persistent focus away from physical activity and diet as the main primary and secondary prevention options are a worry and reflect educational needs and faults within modern medicine, where the true causes of chronic disease are neglected and forgotten, to an extent, to have been largely self-inflicted. Perhaps this is commercially driven by the pharmaceutical industry and the relative simplicity of researching drugs by RCTs with dichotomous outcomes (it works or it doesn't) against more complex long-term studies assessing physical activity and diet with numerous multi-end point outcomes. There are not much promising long-term data for obesity treatment with drugs, plenty of side effects, and none of the collateral benefits of regular physical activity, including the potential to treat and prevent over a dozen chronic conditions.[3]

NICE guideline 43 is also unjustified in promoting negative attitudes towards lifestyle improvements in primary care when these have not been researched. Evidence shows that even brief consultations (3–10 minutes) or simple pedometer-based programmes delivered through health professionals can lead to substantial increases in patients' activity levels (by approximately 30%).[4]

There is a lot of convincing evidence from exercise medicine alone to suggest that physical inactivity is the causal factor for most western chronic diseases (including obesity) rather than obesity *per se*.[5] So, is it time to focus our resources on finding the best ways to achieve and sustain increased levels of physical activity and improvements in diet within primary care, rather than focusing on the unproductive symptom of obesity and increasing its societal stigma?

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Familial hypercholesterolaemia

Humphries *et al* report that a practice of 10 000 patients is likely to have around 20 patients with familial hypercholesterolaemia who are at risk of premature coronary heart disease.[1] They emphasise the importance of primary care in supporting adherence to lipid lowering treatment and lifestyle advice including exercise. Exercise is highly topical in view of the 2012 London Olympics and two recent UK government initiatives 'Be