and partners and in view of their vulnerable position, Genesis is a women's only service. Although an outreach service such as Genesis is important, access to health services are also essential. If healthcare professionals have a better understanding of the issues facing women working in prostitution, they will be able to facilitate better access to health services, particularly primary care and sexual health services.

What can primary care trusts (PCTs) do to improve primary care provision for women working in prostitution? A key problem is access to appropriate services. This could be tackled in two ways: either having a designated clinic for sex workers, or a mobile clinic. A designated clinic would ideally be held in the afternoon or early evening, when women had recovered from working during the night. It could be an open surgery to encourage attendance from those with chaotic lifestyles, where keeping appointments is difficult. It would have the advantage of access to appropriate facilities, but might not target the most vulnerable who do not make it to the clinic. A mobile service would meet this need better and would target those who are most vulnerable. If women had a positive experience of healthcare provision in this way, they would be encouraged to attend appropriate referrals. Services that could be provided in primary care include: cap fitting, sexual health screening, cervical smears, family planning, and flu vaccines, as well as queries about general health. Services can be developed to include hepatitis B immunisation and fast track services to specialist drug use workers.

Separate services for sex workers help target the health needs of this group more effectively; however, separation can stigmatise and discourage use of mainstream services. To ensure that this does not happen, especially in areas where no separate services exist, education and training for healthcare professionals is crucial. If those working in primary care and A&E departments are encouraged to be aware of the issues these women face, they will be able to facilitate better health care for women working in prostitution.

Few women working in the sex industry are happy hookers on a glamorous career path. Many are forced into sex work through issues beyond their control, to lead difficult and dangerous lives. They are plagued by stereotypes and degraded by the attitude of the general public. The health and social needs of women working in prostitution may be complex. Healthcare professionals should not join society in marginalising this group of women, but need to understand the issues sex workers face and prejudices they encounter. By doing this they will be better equipped to empathise with women and cater more effectively for their individual needs.

Charlotte Allan

mike fitzpatrick

The obesity time bomb

Oh no, not another 'time bomb waiting to go off' — this was my reaction to the House of Commons Health Select Committee report on obesity.[1] Surely not, after all these years, the Chief Medical Officer is resorting to the same tired metaphor that has heralded numerous past health scares. Remember the 'ticking time bombs' of HIV/Aids and BSE/CJD, both of which were projected to explode, taking up to the half the population with them, but which have continued to tick away quietly without ever causing the anticipated 'nightmare scenario'. We can only hope that the new time bomb doesn't hit one of those icebergs from the old Aids adverts; this might precipitate a tidal wave that sweeps over the Thames barrier and engulfs the mother of parliaments, together with its Health Select Committee.

Now obesity calls forth the metaphors of impending catastrophe. Nobody can accuse the media of hysterical reporting: the Committee report is itself seething with hysteria. It offers an apocalyptic vision of a future in which the streets are thronged with amputees and the blind, renal dialysis units are swamped, and parents are obliged to bury their prematurely dying children. It reports the case of an obese 3-year old child dying of heart failure and other cases of children who require 'non-invasive ventilatory assistance' to prevent them from 'choking on their own fat'. The obesity epidemic is the new plague and everybody, particularly of course, GPs, must take drastic measures to deal with it (although nobody has a clue what these measures should be).

The obesity panic that has recently taken off in Britain has been raging in the US for some years. A timely book by law professor Paul Campos, entitled *The Obesity Myth*, exposes the weakness of the evidence that being overweight is bad for health and the dangers of the current obsession with weight and weight loss in the US.[2] It is clear that the 'war on fat' declared by the Health Select Committee follows familiar scare-mongering tactics of grossly exaggerating the scale of obesity and the health problems associated with it, and presenting rare extreme cases as though they illustrate general trends. Alarmist projections — 'by 2020 between one third and a half of adults will be obese' — invite simplistic authoritarian solutions (such as bans on advertising certain foods to children).

It is fairly obvious why obesity — and health scares in general — appeal to politicians. At a time when they are generally held in low regard in society, and traditional forms of political activity are moribund, they are desperate to find some points of connection with a remote and atomised electorate. Politicians in government are particularly keen to find mechanisms through which they can establish some authority over the poorer and more marginalised sections of society (whether the issue is diet, exercise, smoking, binge drinking, teenage pregnancy, the same social groups are the target).

But why should doctors be so keen to get involved in obesity propaganda? It seems that the effect of being drawn into policy discussions about obesity is to turn normally sensible clinicians and scientists into ranting prophets of doom and evangelical preachers of virtuous living. No doubt, many senior doctors share the prejudices of the political establishment against the lower orders and are keen to suggest ways in which their hedonistic lifestyles might be regulated. Perhaps more significantly, leading doctors have recognised that current treatments for common conditions, such as coronary heart disease, stroke, diabetes and cancer, are not very effective and, having lost confidence in scientific medicine, believe that they must turn their efforts to changing individual behaviour in the cause of improving health.[3]

The problem is that, with the exception of stopping smoking, the evidence that any other lifestyle change has a significant effect on health is poor. This is particularly true in relation to obesity, which is not a disease and for which no intervention, whether medical, psychological or social, has been shown to be effective.

The overheated rhetoric of the Health Select Committee report reflects a wider problem. Like similar health scares, it stigmatises a significant section of society and treats the obese as pariahs to be pitied and scorned. As Professor Campos puts it, 'the war on fat is an outrage to values — of equality, of tolerance, of fairness, and indeed of fundamental decency towards those who are different'.[2]

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