confident that the posts obtained will necessarily be those with the highest relevance to our speciality. To add to this, we've also been informed that there will be no obligation for hospital-based trainees to attend their VTS educational programmes as the expectation is that their teaching will be provided within their specialist departments. Apparently this arrangement has the backing of the RCGP following their consultation with sister colleges.

We now have the frankly bewildering proposal that doctors specialising in general practice will receive the vast majority of their education and training delivered by colleagues in other specialities. Will such schemes be attractive to high calibre doctors? I very much doubt it. We might have to explain to prospective applicants that, as far as general practice training is concerned, 'fit for purpose' only makes sense if they accept that their purpose in life is to bide their time staffing hospitals.

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The good lie?

Dr Fitzpatrick wrote an interesting piece in the *BJGP* in Nov 2006,[1] making a good point about honesty being the best policy in the public health arena.

In the second part of his article, he then selectively quotes, twice, from a BHF spokesperson, Dr Mike Knapton. I could not see the source of Dr Fitzpatrick's complaints about Dr Knapton's remarks.

Firstly, in relation to a review article about eating oily fish and fish oils,[2] Dr Knapton is quoted as saying, 'people should not stop consuming omega 3 fats or eating oily fish as a result of this study'.

That seems precisely accurate to me. Dr Knapton doesn't seem to be saying that people should START consuming more of these items.

Secondly, in relation to an interventional study[3] that hoped to increase the exercise of young children and thus, produce a lower BMI, Dr Knapton is quoted as saying, 'we know it's crucial to encourage good exercise habits from an early age'.

I would point out that this DOES appear to be good support for this viewpoint — see for example this systematic review by Sallis *et al.*[4] Additionally, in Dr Fitzpatrick's original source for Dr Knapton's quotation,[5] there is the following remark, 'The British Heart Foundation, which part-funded the study, accepted the research was solid'.

I conclude that it is very easy to create a selective impression with quotations and evidence and that there is evidence that Dr Fitzpatrick may have fallen into the very trap about which he warns us.

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Competing interests

I am a friend of Dr Mike Knapton (and he can, in fact, fight his own battles!)

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Author's response

As any quotation is selective, the question is — did my selection of Dr Knapton's statements misrepresent him? I do not believe it did, he has not — to my knowledge — claimed that it did, and nor does Dr Thomas substantiate his implication that it did.

The quotations I used indicate that, in response to specific studies failing to confirm the health benefits of these interventions, Dr Knapton, in his capacity as health advisor to the British Heart Foundation, continues to promote the consumption of omega 3 fats and exercise among schoolchildren. I believe that this accurately represents Dr Knapton's position. It seems from Dr Thomas's letter that he agrees with Dr Knapton's position.

Both Dr Knapton and Dr Thomas are entitled to their prejudices, but my point is that there is no justification for foisting them on the public when they are not supported by scientific evidence.

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The support of obese patients in primary care

The Editorial and two articles[1,2,3] in the September issue of the Journal highlight the current difficulties in encouraging and supporting patients with obesity to reduce weight and maintain the achieved weight. One paper highlighted the effectiveness of a 'fourth level' of support, comparing it to other less supportive levels which were ineffective, but recorded only four out of 28 patients receiving this support.

'Fourth level' support had the characteristics:

- Non-judgemental and sensitive
- Direct and unambiguous
- Provision of personal information
- Provision of explanation and practical advice
- Provision of psychological support
- Group support.

The Thakur practice is an urban practice with a list size of approximately 3500. For the last 2 years patients with BMI >30 or BMI>27 with comorbidity have been offered during consultations with the GP or practice nurse or by publicity in the practice leaflet, free attendance at an

evening support group led by a non-clinical member of the practice staff (SH) who has previous experience in the conduct and process of self-help groups and personal experience of successful weight reduction. During the initial half of each session the patient is weighed alone by the therapist and given individual feedback and advice. During the second session there is a group interactive discussion referring to a relevant topic. Each cycle lasts 12 weeks and we have completed three cycles.

Patient questionnaires indicated a high level of patient satisfaction. Throughout the 12 weeks there is a minimal regular attendance of 76%. The age–sex distribution was 16–29 years = 1 female; 30–39 years = 10 females; 40–49 years = 12 females; 50–59 years = 1 male, 9 females; and ≥60 years = four males, 17 females.

At the end of the three 12-week cycles the total weight loss was 207.5kg with an average weight loss of 4.0kg for those starting and 9.1kg for those completing the 12 weeks. The maximum weight loss was 11kg (9%) and the minimum was 2 kg (4%).

Participation in this group removes responsibility from the healthcare professional referring the patient and encourages patients in their belief that reducing their obesity is their responsibility. We believe this type of group offers effective support and encouragement to obese patients, which may reduce the frustration described by everyone in their management, and also that a more detailed evaluation is indicated, ideally taking into account the recorded difficulties of such evaluation.[3]

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Acknowlegement
On behalf of the patients, we acknowlege the support given by the Leeds NW PCT.

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Childhood obesity

Scott Brown is right to draw attention to the absence of primary care involvement in the problem of childhood obesity.[1] In our flagship university-linked research & teaching practice, awarded Beacon status for clinical excellence, we are barely registering the extent and seriousness of obesity in children, let alone responding to it. In August 2006 we had 2748 patients aged 0–16 years, with BMI measurements recorded for just 128 (4.6%). In 2005 13 children had obesity documented in their records as an active problem, of whom five were brought by parents because of their weight, and four others presented with problems potentially linked to their weight — asthma, joint pains, snoring. Five were referred to a paediatrician or a dietician, and nine were followed up during the year by their usual doctor. Nine had one parent with a BMI over 25 (three were obese), and in six both parents were overweight.

While GPs are described as having 'a pivotal role' in tackling an epidemic that, on conservative estimates, will result in a fifth of boys and a third of girls in this country being obese by 2020,[2] there is little evidence that interventions based in primary care work.[3] The SIGN guidelines recommend that weight maintenance is the most realistic goal for most obese children (rather than weight reduction), and that weight management programmes for those not ready to change are likely to be time consuming, futile and possibly even harmful. Our apparent unawareness of obesity in children may not be so negligent after all.

One problem is that obesity is not as easy to understand as a risk factor as, say, smoking or hypertension. Its epidemiology varies according to socioeconomic and cultural conditions, with obesity a feature of the rich in poor countries and the poor in rich countries, while in many middle-ranking economies almost half of all households have both obese and thin members.[4] Obesity looks set to be one aspect of the polarisation of UK society, with the potential for interventions (however complex, multifaceted and social) being ineffectual or possibly even counterproductive. Before QOF targets are set in stone for childhood obesity, we must be sure that we are not being set up to fail.

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Correction

Malignancy and deep vein thrombosis [letter]. *Br J Gen Pract* 2006; **56:** 886. The first author of the letter is Jacqueline Barrett. She is a researcher at Caper Research Unit, now based at The Dairy, Stoke Hill Farm, Exeter EX4 5BW.

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