LETTERS

Dealing With the Obesity Epidemic

In his discussion of comfort eating, there's no doubt that Dr. Robert Pretlow has identified one of many reasons for the obesity epidemic ("Why Do Kids Overeat?" July 2010, p. 18).

However, to narrowly point to one or two causes for the obesity epidemic is overly simplistic. With 66% of the U.S. population either overweight or obese (and growing), the new normal is to be on the high side of the body mass index charts. After thousands of hours of research, I have come to the conclusion that if you are overweight or obese, it is not your fault. This is not to absolve the individual from making better lifestyle choices.

The problem is that it's difficult to make good choices. To paraphrase former president Bill Clinton, "It's the environment, stupid." To state that our food environment is atrocious would certainly be an understatement. We've all heard it a million times; portions, sugar, salt, processed foods, calories, and more. There's too much of it.

Some of my heroes in the fight to get back to a normal food environment state it eloquently. Dr. Marion Nestle brought it to my attention when she said, "When did it become okay to eat in a bookstore?" Chew on that for a few moments. Yes, we can say "no" to eating at bookstores, hardware stores, pet stores, and other locations that peddle junk food at the cash register.

It's important to pay attention to Michael Pollan's observation, "You can leave the Western diet without leaving civilization." Millions have done it, and your patients can, too.

Ken Leebow
Marietta, Ga.

Mr. Leebow is the author of "Feed Your Head" (Atlanta: Feed Your Head, 2010)

Dr. Pretlow responds:

The food-rich environment is frequently blamed as the main cause of the childhood obesity epidemic. Kids are said to overeat simply "because the food is there." Presumably, this theory refers to highly pleasurable foods such as junk food and fast food. Nevertheless, if overweight kids don't see such foods in front of them, i.e., the food is no longer "there," do they stop overeating and lose weight? No, they still seek out such foods. They are hooked. In effect, the food-rich environment theory is like claiming that smoking and alcoholism are caused by a tobacco- and alcohol-rich environment, and teens become alcoholics or pack-a-day smokers simply "because alcohol and tobacco are there."

The overabundant food environment is certainly related to the childhood obesity epidemic. But the environment is the precipitant rather than the underlying cause. It may be that the comforting response to pleasurable food is actually an innate biological coping mechanism. Even so, increased stress in our kids, in conjunction with the overabundant, pleasurable, comfort food environment, has pushed that coping mechanism into overload. It is stressed kids, hooked on cheap, widely available "comfort food drugs," with which we need to deal.

Helping Overweight Kids

I just read the commentary by Dr. Robert Pretlow ("Why Do Kids Overeat?" July 2010, p. 18) and have been exploring the Web site weigh2rock.com. Thanks so much for creating this, Dr. Pretlow. I finally feel as though I have a place to send the unhappy, lonely, overweight kids who need help.

In addition to my private practice, I have a position as a school physician, and the nurses and I would like to attempt to make a change for the overweight and inactive kids. Your approach through stress management hits just the right tone. Has it been used in schools, and if so, how?

Ann Engelland, M.D.
White Plains, New York

Dr. Pretlow replies:

With regard to school intervention, we have worked closely with several school districts in Alaska that have used our Web-based schools program. The school nurses and physical education (PE) teachers acted as online mentors.

The kids use special wireless eScales to weigh in at school; the eScales are located in private areas of the nurses' offices or the PE departments, and automatically send the student's weight to his or her chart on the weigh2rock.com Web site. Each child or teen has a secure weight chart and "eRoom," to which they log in with a password. The nurses and PE teachers are able to log in as well, and view the weight charts of the kids in their individual schools. The nurses and PE teachers may post secure supportive messages, including predesigned weight control tips, to the kids in the personal eRooms. Each child or teen can post messages back to the nurse or PE teacher.

The kids learn about what causes overweight and the attendant health risks, and how to obtain a healthy weight in the "School Area" of the Web site by interacting with their mentor. They also are able to receive support and tips from the 100,000 overweight kids and teens who use the system from all over the world, on the bulletin boards and in the chat rooms.

Nearly all of the participating Alaska students liked the online schools program, and some were able to attain healthier weights. The drawbacks of the Alaska schools program were: 1) little time was allotted in the students' busy school schedules to use the school computers to access the Web site, view the information, and interact on the site, 2) many of the students did not have computers at home, and 3) the schools' administrators were only lukewarm to the idea of intervening for the sake of their students' weight; thus the school nurses and PE teachers were not allotted time for this.

Nevertheless, I believe that school is the opportune place to intervene for overweight kids. Kids spend 180 days a year there, the school has a relationship with them, and stress management and developing coping skills that don't involve eating are essentially an educational process. In addition, data show that student test performance (the priority of school administrators), as well as absenteeism and school health care costs, are all directly related to student healthy weights.

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LETTERS FROM MAINE

Decisions, Decisions

BY WILLIAM G. WILKOFF, M.D.

Let me begin by saying that I agree with those who feel our decision-making habits could use some spiffing up. We should not be choosing medications based on what our local pharmaceutical representatives tell us over a sumptuous meal at a nice little French restaurant. Nor should we be ordering lab tests out of fear that we will be sued for missing a rare and extremely unlikely disease. Nor should we continue to recommend a certain therapy because that's the way we've been doing it since we finished our residencies.

I agree that medical decisions (and probably all of our decisions) should reflect the best evidence available. However, I am having trouble wrapping my mind and my heart around many of the strategies that I encounter in articles about how I might practice evidence-based medicine. For the most part, they seem unrealistic and impractical.

Let's start with the initial premise that there is enough good evidence out there to support my decisions. New studies are being performed at such a rate that what seems to be correct information today may well be hogwash tomorrow. Yes, there are statistical manipulations that can help sort out the wheat from the chaff, none with a clear advantage. But I don't think that someone can reasonably expect most primary care pediatricians to carry these kinds of analytical skills in our decision-making "tool boxes."

It's not that we are stupid. It's just that we don't have the time to stop the merry-go-round long enough to do the footwork to perform these analyses. A computer can help, but I'm sure you have discovered that once you open up the Internet, time flies. An extra click here or there and before you know it a half an hour has zipped by.

So how can we make more rational decisions? First, many of the good evidence-based studies I have read (and trust) often suggest that what we've been doing out of habit and tradition isn't achieving our goals. The authors usually suggest further studies, but for the moment doing nothing sounds like the better course of action for those of us in the trenches. Therefore, I recommend we begin teaching medical students how to do nothing.

This isn't as crazy as it sounds. The therapeutic nihilists who trained me are long gone, so this will mean a new core curriculum that teaches young doctors how to just stand there instead of doing something for which there is no good evidence. One must learn the best body language to adopt while standing inert, and some comforting and reassuring words to say that can help parents understand and accept our inaction. Nihilism also can save money and lives by minimizing expensive tests and risky interventions.

A second and related strategy involves learning how to stop the clock. A recent article posed a scenario in which a primary care physician is consulted by an ENT specialist about the safety of doing elective surgery on a child with both a personal and family history that suggests a bleeding disorder (Pediatr. Rev. 2009;30:317-22).

The recommended approach included searching for several articles and then applying a formula to determine probability and likelihood ratios. The issue of time was never raised in the article, but in my experience, the real scenario would have to include the fact that the call from the ENT came at 4:30 in the afternoon and surgery was scheduled for 7:30 the next morning. Why? Because that's the way it always is.

Good decisions can take time and searching for evidence can take even more time. A shortage of time can contribute to bad decisions. Sometimes we need to be bolder about asking for more time to make our decisions. If I were faced with this scenario I would have picked up the phone and asked Ann, my saintly hematologist friend down in Portland, what she would do. ■

DR. WILKOFF *practices general pediatrics in a multispecialty group practice in Brunswick, Maine.*