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Assignment 4: Final Paper

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**How Do I Put This?**

*Physician Practices in the Face of America’s Greatest Epidemic*

For 20 years of my life I struggled with being overweight. It was a burden borne not by my belly alone, but one that influenced all aspects of my life and psyche; name calling and laughter at my expense was bullying that could be shaken off, but the daily ritual of peering into the mirror and hating what peered back was not so easily forgotten. However, none of this negativity ever provided me the compulsion to lose weight. No, it was not until my physician informed me that I was at a risk of developing diabetes and on the verge of pre-hypertension – a prognosis that made me feel like I was facing death – that I realized I needed to make a change. Upon leaving that consultation, I began eating responsibly and exercising diligently. At the time of this paper’s writing, since that fateful day of February 15, 2014, I have shed approximately 50 pounds, reduced my BMI from obese to normal, reduced my blood pressure to well within the normal range, and established a far healthier and happier life. However, this grand achievement is tinged with sadness, because for every happy ending like this one, there are more and more where nothing happens.

In fact, in a large-scale examination conducted for the Centers for Disease Control and Prevention, it was found that in the past 30 years, the incidence of overweight and obese children has tripled, and that obesity has doubled for children aged 6-11 and quadrupled for adolescents; the consequence of these trends is that as of 2012, one in three children are overweight or obese (Odgen, Carroll, Kit, and Flegal, 2012). Addressing the issue will become increasingly ubiquitous for primary care physicians as more and more overweight and obese children fill their clinics. It will be the duty of these caregivers to ensure that the roughly 18% of both teenagers and children that are obese do not grow up to join the 35.1% of American adults that are obese, or the 69% of American adults that are overweight (Odgen, Carroll, Kit, and Flegal, 2012). However, despite the gravity of the issue, primary care physicians cannot ethically tell their patients they are dying before they have even begun to live (as a way to compel them to lose weight). Thus, this retrospective research study examines not the etiology of obesity, but rather the attitudinal practices already in place to guide physicians in informing both children and parents about obesity and its consequences. In addition, this study analyzes current epistemology surrounding the characterization of the physician, and potential adaptation of that epistemology in order to best address this epidemic.

The manner in which consultation should be conducted with regard to overweight and obese children has been well established. According to Kuzel and Larson (2014), the underlying theme of the consultation should be to avoid blame. This concept should be applied from the very beginning of the conversation; rather than bluntly commenting on the nature of the child’s physical characteristics in order to initiate a weight conversation, the physician should ask permission so as to ease into a discussion. An insensitive opening to such a highly sensitive issue may alienate the child and cause them to shut out all the well-intentioned advice being given, as evidenced by the fact that children “…are more likely to engage in unhealthy eating behaviors, such as binging, and to avoid exercise and eat more if they’re stigmatized. That’s not unusual considering that overeating is a common coping strategy people use when they feel stressed” (Rochman, 2011). The sensitivity with which the consultation should be conducted influences not just the tone and language of the conversation, but also what content should be emphasized. Again, Kuzel and Larson (2014) suggest speaking more about the health issues associated with being overweight or obese rather than the physical characteristics. This avoids shaming the child by not focusing on weight or appearance, and also makes more medical sense given the fact that the health consequences of being overweight and obese are more significant than the numbers on the scale or externalities.

The content and conduction of the consultation are only half the battle – the physician must ensure that the conveyed information is translated into appropriate action. To this end, the American Academy of Pediatrics (2007) recommends that physicians offer “lifestyle prescriptions” to children. This can take the form of the “5-2-1-0 Rule”, a helpful metric for children to remember to – per day – eat five servings of fruits or vegetables, engage in no more than two hours with electronic media, play or exercise for one hour, and consume zero sugary drinks. However, while these tools are useful in motivating the child to follow through on losing weight, the ultimate guarantee of successful weight loss comes in the form of the parent.

Not just responsible for their child’s physical needs, the parent is also responsible for shaping the habits and lifestyle their child can carry for life. In a study conducted by Musher-Eizenman and Kiefner (2013), one older adolescent interviewed reported that “A lot of our meals were cooked with butter, so now I like butter on most of my food”, while another said “We always had easily accessible sweets in the house. Now I snack more than I should”. Given the significant effect parents have on determining their child’s health status, it is imperative that the physician address the parent as much as the child during consultation. Accordingly then, sensitivity is just as – if not even more – important in regards to the parent during this process. Many parents are unaware or in denial of their child’s health condition, but regardless, any insensitive approach to the topic may be taken as a slight against their parenting ability (Douglas, Clark, Craig, Campbell, and McNeill, 2014). The same mindfulness used for children – not assigning blame, asking permission, and emphasizing health over weight – should be applied in consultation with parents. These practices are especially useful in ensuring that the parent does not dismiss the consultation. Some parents may perceive a discussion regarding weight and lifestyle practices beyond what they believe the physician’s realm to be: simply treating sicknesses and providing medication.

This particular perception of the physician presents a major obstacle in treating overweight and obese patients because there is really no way for a physician to treat the issue outside of conversations addressing lifestyle behavior. However, that very fact may be the reason that physicians themselves harbor such perceptions, and therefore may not feel compelled to engage in conversations regarding weight. For example, researchers in the United Kingdom asserted that “Traditional medical training has placed a greater emphasis on the biological basis of disease rather than on the principles of behavioral science. As such, physicians may not feel fully equipped to address behavioral issues…or believe that treatment is futile” (Foster, Wadden, Makris, Davidson, Sanderson, Allison, and Kessler, 2003). For any of the effective counseling methods detailed in the prior two paragraphs to work, the physician has to be willing to counsel in the first place. The data suggesting that, largely, physicians are unwilling to provide treatment options for overweight and obese patients is indicative of the reactive, rather than preventative, medicine being practiced. Further evidence of this is given in a study by Kallem, Carroll-Scott, Gilstad-Hayden, Peters, McCaslin, and Ickovics (2013), where it was shown that the occurrence of weight, nutritional, or physical activity counseling given by physicians was dependent on the severity of the weight issue. For example, in their sample, 76.1% of obese patients received weight counseling while only 61.8% of overweight patients received the same. The disparity between these two groups – and the fact that none of the numbers are 100% – is alarming because it signifies that physicians are retroactively responding to health issues rather than taking action based on anticipation. This behavior on the part of physicians within the context of obesity is quite misguided given the fact that almost every single major disease that the healthcare community strives so hard to treat on a daily basis (diabetes, hyperlipidemia, stroke, heart attack, congestive heart failure, peripheral artery disease, hypertension, gout, ulcers, skin infections, infertility, liver failure, kidney failure, 13 different kinds of cancer at minimum, etc.) have all been traced back to the habits, decision, and lifestyles that lead to being overweight and obese. In this regard, the widespread weight issue plaguing this nation is not coined America’s Greatest Epidemic merely for its magnitude, but for the fact that it is implicated in such a diverse and impactful manner in the health of patients. Thus, at the heart of the very concept of preventative medicine lies the consultation physicians give concerning being overweight or obese. To neglect this consultation and fail to provide such lifestyle counseling is not only a disservice to the patient whose life-long health depends upon it, but ultimately also an action that will have consequences for the greater healthcare system and the nation.

With such an assertion, it is only logical that criticism should follow. Indeed, one major critique levied upon a presentation of this topic was the fact that physicians – limited to 15 to 20 minute consultations spread out intermittently through a patient’s life – have a very minute effect in the grand scheme of obesity’s prevalence. This certainly is true, for being overweight or obese is not developed through just a simple imbalance of inputs and outputs, but “a product of the interaction between genotype, dietary habits and levels of physical activity. No single factor can be identified as the primary cause and, for any individual, the balance of energy intake and expenditure will depend upon family circumstances (poverty, housing, education, food security, transport, leisure activity, balance of sedentary/active occupations)” (Langley-Evans and Moran, 2014). Clearly, it would be wrong to assign physicians the responsibility of curing a disease that has such a vast canvas, one rooted in socioeconomics as much as physiology. It would be incorrect to say that the absolute cure for obesity (and all those major diseases prevalently plaguing patients mentioned previously) is simply preventative medicine in the form of consultation. However, that does not excuse physicians from still doing the best they can do with what they have, even if that contribution does not have a significant impact on the magnitude of obesity: it does not excuse them from not providing every single patient some form of lifestyle counseling. As reported by Lowenstein, Perrin, Campbell, Tate, Cai, and Ammerman, 60% of overweight or obese adolescents given counseling regarding their weight attempted to lose weight. This shows that counseling does have an effect, it is not futile, and that with more widespread self-efficacy amongst physicians regarding the practice of preventative medicine, perhaps the effects physicians have in the grand scheme of obesity’s prevalence can be more than just minimal.

To reiterate, the overweight and obese epidemic is a multifaceted issue with no single cure. Within the effort to eradicate this public health concern, the physician’s role can only extend so far. However, the physician must be willing to acknowledge and inform patients of this issue, in a manner that is consistent with the sensitive nature of the condition. There are ideological and bureaucratic barriers in the way of the physician, and socioeconomic and perceptual barriers in the way of patients and parents; but with an acknowledgement of the gravity of the epidemic and by not trivializing the roles either side must play, this epidemic can be just one more to add to the history books. If I could suffer for twenty years of my life and then miraculously change it all within half a year, I wholeheartedly believe that this nation can find experience such a miracle as well.

Bekky’s notes:

* Overall great paper. You did a really nice job making your topic relatable, arguing your thesis, and addressing potential criticism.
* You are the English major, so I hesitate to criticize your use of punctuation. But I question your use of the semicolon in a few places (highlighted). To me, it would seem a period would make more sense and add clarity in these instances.

Megan M.’s notes:

Great job on both your paper and presentation! I agree with Bekky’s comments- the in text citations don’t need to list all authors, and there a few sentences that seem like they could be broken up instead of using a semicolon (however, I’m not an English major either!). Also, for your references, journal articles pulled from a clearinghouse should not be cited as a being retrieved from the internet. They should be cited as regular journal articles but with a Digital Object Identifier (doi) or PubMed number. Otherwise your paper is engaging, organized, and well-researched. Good job!

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