

As uniquely trained holistic caregivers, DOs have duty to overweight patients

Now that we've discussed my diabetes, doctor, can we talk about my weight?"

Unfortunately, no comment sends most primary care physicians into a "change of subject" mode more quickly! Shrinking time allotments, lack of third-party reimbursement for weight management, and a general lack of training in bariatric medicine are among the many reasons for the discomfort. Beginning on page 358 of this issue of JAOA, Jeffrey E. Harris, DrPH, MPH, RD; Valerie Hamaday, BS, CHES; and Eugene Mochan, PhD, DO, report the results of a survey of osteopathic family physicians. The findings of their survey substantiate that general lack of training in the management of obesity.

The sad irony is that obesity—the second leading preventable cause of death, the root of the vast majority of cases of diabetes, and genesis for many other comorbid conditions—is our most *underrespected* and *undertreated* disease. The incidence of obesity is staggering and sharply on the increase! Fifteen years ago, the incidence was one in four adults. When then Surgeon General C. Everett Koop, MD, declared war on obesity in the early 1990s, the prevalence of overweight was a third of American adults. And more recently, that prevalence has climbed to fully half of adult Americans.¹ Pediatric and adolescent obesity has reached zenith proportions—an estimated 25% incidence in children aged 8 to 13 years.² Christina Holtz, DO; Troy M. Smith, DO; and Frank D. Winters, DO, examine the issues surrounding childhood obesity, beginning on page 366.

For years, multiple barriers have obstructed proper bariatric medicine, and many have been iatrogenic. Personal negative feelings and biases toward the obese patient, lack of formal training of physicians, failure to understand the multifactorial etiology of obesity as a disease state, lack of professional esteem among colleagues to the point of derision, and fear of retribution by licensing boards despite proper use of anorectic agents are but a few.

I have practiced family and bariatric medicine for 24 years and have personally treated more than 20,000 obese patients. Therefore, allow me to share key factors for success:

- Remove judgmental statements and attitudes from your dialogue with obese patients; no patient population requires more support.
- Develop informative and educational handout materials and be prepared to teach. (Remember, the word "doctor" means teacher.)
- Reinforce "maintenance" attitudes during every patient visit, including exercise prescriptions and life-long dietary change.

- Use food diaries and *review* them at each visit. (No greater behavior modification tool exists.)
- Foster "moderate" weight loss as success attitudes—attempt to remove perfectionist and unrealistic "ideal weight" concepts.
- Consider proper use of anorectic drugs and other modes of antiobesity therapy adjunctively in weight management programming.
- *Separate* weight medicine visits from routine care. This strategy allows proper focus and patient time, removes anxieties about false billing for uncovered managed care services, and allows for frequent supportive visits and accountability.
- Use your current staff as part of the support team, and encourage weekly no-charge "weight checks."
- Screen all obese patients for depression and substance abuse. A large proportion of new bariatric patients suffer from depression, and a substantial number of binge eaters have an accompanying substance abuse issue.
- Attend postgraduate CME courses in bariatric medicine, and consider joining specialty organizations. An excellent resource and the leading voice in physician-directed treatment is the American Society of Bariatric Physicians (ASBP). Founded in 1950 by several osteopathic medical pioneers, the ASBP boasts more than 1200 DO and MD members in all 50 states. The ASBP headquarters is currently at 5600 S Quebec St, Suite 109-A, Englewood, CO, 80111; (phone) 303-770-2526; (Fax) 303-779-4834.

As osteopathic physicians, we are uniquely trained holistic caregivers. No greater medical irony exists than for us to shun our duty to the overweight and eating-disordered patient. The time has come to rid ourselves of barriers and realize our potential. I will promise no greater practice reward, nor a more appreciative patient population. ♦

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References

1. Kuczmarski RJ, Carrol MD, Flegal KM, Troiano RP. Varying body mass index cutoff points to describe overweight prevalence among U.S. Adults: NHANES III (1988 to 1994). *Obes Res* 1997;5:542-548.
2. Klesges RC, Shelton ML, Klesges LM. Effects of television on metabolic rate: Potential implications for childhood obesity. *Pediatrics* 1993;91:281-286.