Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in a bimonthly journal where continuity of comment and redress are difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Management of Obesity

To the Editor: I agree with the conclusion of Drs. Robinson, Gjerdingen, and Houge[1] that we, as physicians, have been very unsuccessful at helping obese patients lose weight, that being overly aggressive and disrespectful are not the answers to treating obesity, and that encouraging a healthy lifestyle in all patients should be our concern. I would question, however, whether those who are overweight are victims of their genes or cannot control their weight because of a change in their metabolic rate. It seems that if we cannot explain or treat a disease-producing lifestyle, we attempt to deny that patients might just make choices for themselves that are temporarily gratifying but harmful to their health. Perhaps we need to rid ourselves of the guilt that is being dumped on us by the public (and by our academic colleagues) to be everything to everyone and stop taking our frustration out on our patients.

The reliance on multiple studies with "flawed methodology" does not seem to be a reason to accept that obese persons eat the same as normal-weight persons. Studies of those who eat normally in public, who eat normal amounts in short-term observational situations (regardless whether being told not to limit calories), and who keep short-term diet diaries or studies that use similar methodologies just do not define the issue that to maintain a normal weight requires a lifelong commitment and struggle against the gratification of taste or some need other than calories. If "most" overweight people eat normal amounts, why can so many of them define exactly what it was that they gave up to lose the weight and tell you when they "cheated" or "stopped watching their diet as closely" or stopped their regular exercise program; then the weight "came back"? If their bodies' "thermostats" become reset, then their bodies should require fewer calories to maintain their weight. One would think that if obesity is not a behavior disorder, then the body's "thermostat" would tell the hunger center when maintenance calories have been met. Why should a person who drops from 210 lb down to 170 lb have a sudden change between 175 lb and 170 lb? If one is losing weight at 175 lb and gets to 170 lb during a 6-month period, 96 calories (+/−) per day less than maintenance are eaten. Even if the person added a soft drink per day to his or her diet, that person would be on the way back up. Once a patient who told me, "But I don't eat anything," was taking in 2000 calories per day in soft drinks. (By the way, she, not I, brought up the weight problem, as so often happens.) Two (very) small chocolate chip cookies add up to 120 cal/d, 1 pound per month, 12 pounds per year, 60 pounds in 5 years. You can just imagine what "Dave's Double Bacon Cheeseburger" does. To do adequate studies on obese person's diets would require round-the-clock surveillance for years. Perhaps the persons we should study are the 5 percent who keep the weight off permanently. What are they doing correctly? Or are they just freaks of nature?

It seems that our role should be to educate and encourage without passing judgment. It also seems that a major public health campaign should be started, not to condemn obese people, but, just as we have done with cigarette smoking, to warn people of the health risks. Certainly our traditional approach toward treating obesity has failed, as America continues its trend toward increasing obesity. Maybe we should move the battle out of physician offices and into public health departments and corporate health programs. The recent review of weight cycling by the National Task Force on the Prevention and Treatment of Obesity concluded that the risks of weight cycling are unproved.[2] Thus, it appears that we will do more good than harm by encouraging weight loss.

Finally, I have some questions for the authors. If we really cannot prove that physician intervention affects obesity, is there evidence that doing a "brief dietary and exercise history" is beneficial for the patient? Has physician-recommended exercise proved any more effective than physician-recommended weight loss? Likewise, has screening for eating disorders in all obese persons been proved effective? Are we moving from the failed traditional method to equally unproved screening recommendations? Should any unproved intervention be patient-initiated and therefore patient-motivated?

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References

1. Robinson BE, Gjerdingen DK, Houge DR. Obesity: a move from more traditional to more patient-oriented management. J Am Board Fam Pract 1995; 8:99-108.
2. Review: weight cycling. National Task Force on the Prevention and Treatment of Obesity. JAMA 1994; 272:1196-2020.

To the Editor: I must take issue with many of the statements and conclusions outlined in the article "Obesity: A Move From Traditional to More Patient-oriented Management" (J Am Board Fam Pract 1995; 8:99-108). From both extensive personal and professional