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

experiences, I have found that fat persons do indeed eat much more than lean persons. In fact, most obese persons compulsively overeat *in secret*. A minority of normal and underweight persons also have periods of compulsive overeating. Because binge eating is generally always done secretly, accurate food intake is nearly impossible to determine by any of the methods mentioned in the article.

Various techniques that are used by compulsive overeaters to conceal actual food intake include eating normally in public followed by a binge in private afterward, eating several normal-sized public restaurant meals in a series, purchasing binge food from several different stores or restaurants so as to avoid buying an excessive amount of food at any one place, hiding binge foods in nonfood areas, such as under the bed or in the clothes closet, hoarding food in a cache to be used when the need for a binge occurs, stealing binge foods while working around food, eating leftovers and repositioning the remnants to conceal the portions taken, and lying about food intake when confronted by others. Compulsive overeaters will often prepare double the amount of binge food needed at any one time, such as two birthday cakes or two pizzas, and eat half in secret before the normal meal is eaten in public. Binge eaters will often dispose of food wrappers and remnants in public trash receptacles or conceal the extra wrappers inside the one legitimate wrapper so that neither family nor acquaintances will find all the packaging and become aware of the actual food intake. Occasionally, entire families will engage in binge eating. Self-report in the form of food diaries is notoriously inaccurate because compulsive overeaters are in denial about their excessive food intake. In my experience, a normal meal entered on a food diary will often be followed by a snack, such as a 1-pound bag of peanut chocolate candies accompanied by a half-gallon of ice cream, which will not be entered on the food diary.

Genetics plays a large role in determining body type but probably plays only a relatively small role in determining actual amount of body fat. This is obvious when one repeatedly observes, as I do in my area of the country, very slim Asian-born immigrant parents accompanied by their very plump American-born children. Using simple logic, food intake equals energy expenditure plus fat storage. Obese persons usually have increased calorie-dense food intake with or without decreased energy expenditure. Either must necessarily lead to increased storage in the form of excess body fat. Any sedentary society such as our own that encourages the consumption of large amounts of low-cost, easily available, highly palatable, calorie-dense foods will inevitably have a large obese population.

Compulsive overeaters often self-medicate by using binge foods for their mind-altering effects. Not all foods are used compulsively. Sugary or salty foods that are high in fat have tranquilizing, calming, and comforting properties and are the foods usually used in binges. Compulsive eating binges are often triggered by stress, depression, boredom, or loneliness. Chronic overeating provides a means to avoid confronting and solving other problems in a person's life. The emotional pain of compulsive overeating is great and generally leads to increasing isolation. The authors are indeed correct in maintaining that dieting is an ineffective treatment for obesity. Obesity can in fact be defined by compulsive seeking and continuing intake of certain foods despite increasing evidence of adverse effects. Obesity due to compulsive overeating has so many qualities in common with other addictions, such as alcohol, tobacco, and drug abuse, that it might be best characterized as a "binge food addiction." Although food abuse has been given very little attention in the medical literature, compulsive overeating would fulfill the diagnostic criteria for psychoactive substance dependence as outlined in the *DSM III-R*, 1987.[1]

In the health care field, we now refer those with alcohol abuse to rehabilitation programs coupled with Alcoholics Anonymous or other similar self-help groups. We avoid enabling them by confronting abusers with the truth about their excess use. We should do no less for those suffering from food abuse. We should refer compulsive overeaters to nutritional programs stressing a healthy lifestyle coupled with Overeaters Anonymous. Resistance to a referral to Overeaters Anonymous is to be expected because denial is so great; however, the benefits of abstinence from compulsive overeating are even greater.

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References

1. Diagnostic and statistical manual of mental disorders. 3rd ed, revised. Washington, DC: American Psychiatric Association, 1987.

The above letters were referred to the author of the article in question, who offers the following reply:

To the Editor: It is clear from the two responses to our article "Obesity: A Move From Traditional To More Patient-oriented Management" that the topic of obesity is a highly controversial issue that generates strong feelings in many physicians. While we by no means believe that the final word on the causes or treatment of obesity is in, we wanted to present an alternative perspective that we believe has gained increasing acceptance among many segments of the public and some segments of the medical and psychological communities.

Dr. DeFazio raises some challenging questions about the "reliance on multiple studies with flawed methodology" to prove that fat persons might not, as a group, overeat. While we agree that indeed these studies are flawed, most studies have flaws, but that does not mean they are wrong and useless. He correctly notes that an adequate (I would say flawless) study on persons' diets requires round-the-clock surveillance for years. Unfortunately, the cost of such a study would be prohibitive. The studies we reviewed used methodology in line with current practice for assessing eating and