
Commentary - The Critical Challenge of Obesity

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A modern-day Rip Van Winkle might question whether his 20 year slumber had affected his vision, making his fellow Americans appear larger individually and as a group than he remembered prior to his dropping off to sleep. Alas, his vision would not be to blame; the proportion of Americans who are overweight (34%) or obese (27%) has increased dramatically over the past 20 years. This epidemic affects all ages and regions of the country, but obesity is more common in women while men are more likely to be overweight. As well as being a medical condition in its own right, obesity contributes to morbidity and mortality for many other diseases including osteoarthritis, heart disease, type II diabetes, hypertension and cancer, and is a major cause of decreased quality of life. One particularly striking aspect of this epidemic is the increased prevalence of overweight and obesity in children, with a parallel increase in type II diabetes. Obesity is especially common in African Americans, Native Americans, Native Hawaiians and some Hispanic populations.

In early 2003 the Institute of Medicine, part of the National Academy of Sciences, identified 20 priority areas for national action for transforming the quality and delivery of health care. (1) These priority areas were identified based on criteria that included impact (how big is the problem?), improvability (gap between evidence-based and actual practice), and inclusiveness (improvement requires changes in multiple parts of the healthcare delivery system). Obesity was selected as an “emerging area”, based on the criteria of impact and inclusiveness, recognizing that evidence needed to inform practice is still emerging. The Institute of Medicine committee clearly recognized that addressing this critical health challenge will require engagement of all aspects of healthcare delivery, including acute, chronic and preventive care. Moreover, the report explicitly notes that concurrent changes well beyond health care, including such spheres as housing, schools, exercise opportunities, the food supply and work patterns, are likely to be required in addressing all factors contributing to the growing prevalence of overweight and obesity.

The U.S. Preventive Services Task Force, sponsored by the Agency for Healthcare Research and Quality, is the leading independent panel of private sector experts in prevention, and conducts rigorous, impartial assessments of the scientific evidence for a broad range of preventive services. In December 2003, the Task Force recommended that clinicians screen all adults for obesity by assessing body mass index (BMI) and offering obese patients intensive counseling and behavioral interventions to promote sustained weight loss or refer them to other clinicians for these services (<http://www.ahrq.gov/clinic/uspstf/uspsobes.htm>). The Task Force defined intensive counseling to include two or more individual or group diet and exercise counseling sessions per month for at least three months. Moreover, the Task Force noted that counseling is more effective in helping people lose weight if combined with behavioral interventions that assist people in developing skills, motivation and support systems. For obese adults, the Task Force found insufficient evidence to recommend for or against the use of moderate or low-intensity counseling, defined as monthly or less frequently, to promote sustained weight loss. For adults who are overweight but not obese, the Task Force found insufficient evidence to recommend for or against the use of counseling of any intensity and behavioral interventions to promote sustained weight loss. It is important to note that the conclusion that

there is insufficient evidence to inform a recommendation is not equivalent to saying that these interventions are ineffective. Rather, this finding underscores the urgency of studies to identify practical strategies and tools for clinicians to assist as many patients as possible. The topic of screening for obesity in children is currently under review by the Task Force; a recommendation is expected in June 2004. (2)

In short, the problem of overweight and obesity confronts all practicing physicians. While evidence to inform best practice is still emerging and treatment options are thus limited, physicians have an important opportunity to serve as catalysts for change. However, effective practice with respect to helping patients make requisite changes in health behaviors differs from other areas of evidence-based practice. In contrast to providing evidence-based recommendations for diagnostic or therapeutic options, physicians must collaborate closely with other healthcare professionals in their organizations and local communities and develop effective strategies for identifying the “teachable moment” with individual patients, when information about the importance of the problem is most likely to have an impact. Metrics for success in this endeavor are challenging and sometimes elusive, but Dana Safran’s research has shown that patients who trust their primary care physician are far more likely to report making a serious effort to attempt such changes, underscoring the importance of the physician’s contribution. (3)

The way in which the Task Force recommendations are operationalized will differ by practice setting. While some healthcare organizations employ professionals trained to help patients modify health behaviors, physicians in smaller settings will need to be familiar with resources in the community. Understanding which resources are most useful to individual patients is likely to amplify the power of counseling and behavioral interventions, and represents a unique opportunity for collaboration among clinicians and other health professionals. Establishing stronger links between the healthcare system and the community is an essential component of the Department of Health and Human Services’s initiative, *Steps to a Healthier US* (www.healthierus.gov). Existing evidence currently provides limited insight regarding how recommendations could be tailored to patients who are members of racial or ethnic minority groups, but the prevalence of overweight or obesity in some subpopulations warrants clinical vigilance as well as additional scientific inquiry. Other interventions, including pharmaceutical and surgical treatments, are also options for selected patients, though we have much to learn about which individuals are most likely to benefit.

A focus on evidence-based practice, i.e., matching care to the best science, with close attention to assuring that current practice incorporates recent advances, is the overarching theme of *Clinical Evidence*. That the evidence base to inform our efforts to address the critical challenge of obesity remains underdeveloped should not deter us from applying what is known to be effective now.

1. Adams K, Corrigan JM, eds., Committee on Identifying Priority Areas for Quality Improvement. *Priority areas for national action: transforming health care quality*. Washington, D.C.: The National Academies Press, 2003.
 2. U.S. Preventive Services Task Force. Screening for obesity in adults: recommendations and rationale. *Ann Intern Med* 2003;139:930–932.
 3. Safran DG, Taira DA, Rogers WH, Kosinski M, Ware JE, Tarlov AR. Linking primary care performance to outcomes of care. *J Fam Pract* 1998;47:213–220.
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