Madam Chairwoman and Members of the Committee:

I am Dr. Doina Kulick, Assistant Professor of Medicine at the Univ. of Nevada School of Medicine, Board Certified in Nutrition and Internal Medicine.

Thank you for giving me the opportunity to participate in this important discussion.

It is well known that obesity has reached an epidemic proportion in the last 15 years. As physicians we have already begun to see in our practice the impact of the obesity epidemic on other diseases. For example, type 2 diabetes, a major consequence of obesity, has also reached epidemic proportions over the last 10 years. During the 1990’s, the prevalence of diabetes increased by 50 percent in U.S. adults. This trend is expected to continue unless there is substantial public health intervention.

The obese patients also make up the majority of the cases of high blood pressure, coronary artery disease, high cholesterol, acid reflux disease, gallstones, urinary incontinence, low back pain, hip and knee arthritis, depression and different types of cancers.

Current scientific and clinical data show that successful treatment of obesity would eliminate at least 75% of all case of diabetes, 21-28% of all cases of coronary artery disease, 25-28% of all cases of hypertension, and 14-20% of all cancers cases.

Obesity is a complex, multifactorial, chronic disease that develops from the interaction of genes and the environment. We do not have yet a full understanding of how and why obesity develops, but we know that it involves the integration of social, behavioral, cultural, physiological, metabolic and genetic factors. Thus a successful battle against this epidemic would require the active participation of multiple levels and structures beginning with the individual and family, and continuing with schools, medical institutions and society as a whole.

Physicians as health care providers and educators clearly have the opportunity to make an impact on this issue, as the average American makes 3 office visits per year, and 60% of office visits are made to the primary care physician. The physician advice is usually sought out and respected, and there is evidence that clinician advice can motivate patients to change unhealthy behaviors. The advice and interventions physicians could offer to help their obese patients are based on scientific data and clinical trials.

Thousand of pages of medical literature have been written about obesity, but I would like to specifically mention two very important papers. These were published by prestigious scientific and medical organizations in order to guide and help practicing physicians in assessing, screening and treating obesity.

Most recently, in Dec 2003 the U.S. Preventive Services Task Force published Screening for Obesity in Adults: Recommendations and Rationale. These guidelines state that physicians should screen patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. The US Preventive Services Task Force defined intense counseling as more than 1 person-to-person (individual or group) session per month for at least the first 3 months of the intervention.

Despite public and medical awareness of the problem, obesity is still not routinely addressed in a meaningful fashion in the primary care setting. Many clinicians do not routinely assess weight, nutrition and physical activity or offer advice on these factors. In 2 studies using data from the Behavioral Risk Factor Surveillance System, fewer than half of obese individuals reported receiving advice to lose weight. In both studies, those who received such advice were significantly more likely to try losing weight than those who did not. Rates of counseling about physical activity may be even lower, with only 34% of adults who had seen a physician in the prior year reporting being counseled about physical activity at their last physician visit. The low rates of clinician intervention in obesity are generally attributed to lack of training, lack of time for counseling in practice settings, and little or no reimbursement for these activities.

Fortunately all these are surmountable causes.

The reason the majority of practicing physicians lack formal training in obesity is because only recently has obesity been recognized as a disease and thus only recently has this topic made its way into medical school curriculum and into residency training programs.

There are many opportunities for physicians in Nevada to bridge the gap in their knowledge on this issue. There is a plethora of medical literature on this subject, with more than 500 medical articles published each month; there are national workshops and conferences; but most importantly there are state level opportunities.

The Center for Nutrition and Metabolic Disorders at the University of Nevada School of Medicine is a very good resource in this sense. This center is the first integrated physician/dietician clinic in the management of obesity in our state. As a medical director in the first year of existence of this center, I was very happy to see that in spite of lack of any financial support this center has thrived, proving not only the stringent need for such a center in our community but also demonstrating its high quality of professionalism and expertise in the field of obesity. Besides being a state of the art weight management clinic, the center does clinical research and teaching. We teach nutrition for medical students, and internal medicine residents and we take an active role in educating health professionals and the public on the issue of obesity. This year we have provided two CME lectures on obesity for the physicians in Reno and these lectures have been received very well. If we are able to secure some financial resources we could
train and mentor the medical personnel in our community in establishing satellite clinics, especially in the areas serving populations with higher prevalence of obesity like the uninsured, Medicare, and Medicaid, and minorities.

One way this subcommittee can address the issue of caring for the obese patient is to require physicians in Nevada to obtain continuing medical education credits in the screening, assessment, and management of obesity. I respectfully ask you to consider adopting this recommendation.

I appreciate the opportunity to testify before this committee. I hope we can work together to improve the health of all Nevadans by creating and implementing a coherent state wide program to stop and reverse the obesity epidemic. Physicians have an important and well defined role in this plan, and the prerequisite for successful physician participation is solid medical knowledge.

References:


Berry L. Where to invest healthcare dollars. Diabetes an example of how spending on prevention can save lives, costs. Mod Healthc. 2004 Jan 19;34(3):25.


