

Mission Impossible? Managing the American Academy of Pediatrics' Obesity Guideline

Eleanor R. Menzin, MD^{1,2,3}

¹Longwood Pediatrics, Boston, Massachusetts

²Children's Hospital, Division of General Pediatrics, Boston, Massachusetts

³Harvard Medical School, Boston, Massachusetts

ABSTRACT

A primary care pediatrician casts a skeptical eye at the American Academy of Pediatrics Obesity Guideline. Using back-of-the-envelope calculations, she explains that meeting the guidelines would swamp her office, hospital, and the country's clinicians in a manner that is unrealistic. Warning against the alienation that boots-on-the-ground clinicians experience when guidelines are too theoretical to be practical, she suggests alternative avenues for addressing this public health issue.

Ann Fam Med 2024;22:170-171. <https://doi.org/10.1370/afm.3069>

As the daughter of a mathematician and an engineer, I am acutely aware of the tension between theory and reality. For years, my mathematician mother planned elegant and efficient road trips to minimize mileage and distance. My mechanical engineer father countered with a few quick calculations explaining how meals, weather, and traffic could thwart her plans. When the American Academy of Pediatrics published a new guideline on obesity management in February 2023, I, a primary care pediatrician, read it through both lenses: the theorist's appreciation for solid science and the realist's need for practical solutions.

Media attention on the guideline centered on the wisdom of recommending long weight loss medications for children, but failed to consider (as did the guideline) the complete lack of pediatricians' training or insurance coverage for these medicines. Pediatricians worried that this increased attention to body mass index would stigmatize children and lead to restrictive eating disordered behaviors.

The guideline also recommends that children aged 6 to 18 years with a body mass index (BMI) over the 85th percentile participate in intensive health behavior and lifestyle treatment (IHBLT) programs. These programs, while challenging to deliver and not universally available, are the most effective known behavioral treatment for child obesity. Programs in this category provide at least 26 hours of face-to-face, family based, multicomponent treatment over 3 to 12 months.¹

I did my own back-of-the-envelope calculations just as my father taught me. My practice cares for 8,890 patients who are aged 18 years and younger, of whom 1,396 are aged 6 to 18 years and have a BMI greater than or equal to the 85th percentile. Providing each of those patients with 26 (the minimum) appointments over 1 year (the maximum) would be 36,296 appointments a year. In 2022, our practice did 34,529 medical visits, each with an average duration of 30 minutes, one-half of what IHBLT calls for. If we wanted to incorporate these IHBLT visits into our practice, assuming we could find trained clinicians, we would need to triple our staff, space, and administrative support.

We could refer to an academic pediatric center's program, like the tertiary care children's hospital across the street. The hospital's catchment area is 1 million children. If 15% of that population meets criteria for IHBLT, 150,000 children are eligible—an additional 3.9 million visits a year. Even if each clinician could see 40 patients a week for 48 weeks a year, the hospital would need to hire 2,031 new staff members to meet this need.

Regionally, with fewer pediatric providers per capita, this need would be even harder to meet. Nationally, as of 2021 there were 49.5 million children aged 6-17 years in the United States.² Using the same 15% estimate would yield 7.4 million children eligible for IHBLT, or 193 million annual visits requiring over 100,000

Conflicts of interest: author reports none.

CORRESPONDING AUTHOR

Eleanor R. Menzin
Longwood Pediatrics
319 Longwood Avenue
Boston, MA 02115
Eleanor.menzin@childrens.harvard.edu

clinicians. Limited resources favor those with privilege; with a shortage of clinicians, underserved communities will struggle to access their share of appointments, thus increasing health disparities.

Looking at real numbers moves this guideline from staggeringly improbable to totally impossible. I, like many physicians (and mathematicians' offspring), love data and evidence-based recommendations. But as a practicing pediatrician, I have the soul of an engineer; I need data I can use practically. This guideline is the equivalent of giving a stack of neat theoretical equations to a group of engineers and asking them to build an enormous bridge—without materials, money, time, or blueprints. Major ventures, whether construction projects or public health strategies, require large-scale solutions beyond the scope of what pediatricians and family medicine physicians can achieve alone.

Systems will need to be designed and funded to meet this need. Interventions could be planned through community-based organizations the way federal funds are used to provide services through early intervention. Since nearly all children attend school, school-based programs integrating exercise, nutrition, and intensive counseling might reach large numbers of children. A national health corps, like the Peace Corps, could train young community workers to do outreach and

teaching, perhaps in return for tuition reimbursement. To succeed, these programs must engage parents and caregivers without causing the hardship of missed work.

These ideas need more than published guidelines, physician training, and patient compliance. They require acknowledgement of the issue, political buy-in, massive funding, and outcomes research to determine efficacy. The American Academy of Pediatrics' guideline describes the scope of the problem and goals of treatment programs; implementation will require pediatricians and family medicine physicians to spearhead well-funded programs outside of offices, clinics, and hospitals.



[Read or post commentaries in response to this article.](#)

Key words: obesity; practice guidelines; evidence based medicine; pediatrics

Submitted April 18, 2023; Submitted, revised August 1, 2023, accepted November 16, 2023.

References

1. Hamal SE, Hassink SG, Skinner AC, et al. Clinical practice guideline for the evaluation and treatment of children and adolescents with obesity. *Pediatrics*. 2023;151(2). [10.1542/peds.2022-060640](https://doi.org/10.1542/peds.2022-060640)
2. POP1 Child population: number of children (in millions) ages 0–17 in the United States by age, 1950–2017 and projected 2018–2050. Childstats.gov. Published 2017. <https://www.childstats.gov/americaschildren/tables/pop1.asp>