Ark. Childhood Obesity Prevention Law Reaps Some Benefits

BY MICHELE G. SULLIVAN Mid-Atlantic Bureau

SAN FRANCISCO — The first state effort to address childhood obesity through changes in public schools has met with some success, according to researchers who spoke at the annual meeting of the Society of Behavioral Medicine.

Arkansas Act 1220 passed into law in 2003, said James Raczynski, Ph.D. The product of a "remarkable confluence of political, private, and institutional support," the law requires schools to monitor every student’s weight annually, remove vending machines from elementary and middle schools, and disclose all vending contracts. It also mandates the creation of state and local advisory committees to examine nutrition and physical activity programs in schools and to advise legislators on future childhood health policies.

Concerns about the number of obese and overweight children in Arkansas spurred legislators, physicians, and communities to work together on the law, said Dr. Raczynski of the University of Arkansas. Little Rock: 36% of children in the state are either overweight or at risk for being overweight.

Initially, he said, public support for any aspect of the legislation was very high. Concerns arose during the first year, however. "The biggest issue was parental worry about the annual body mass index (BMI) measurement," he said. "Parents feared that having their child identified as overweight or at risk would stigmatize the child."

Although spearheaded by a small group of vocal parents, the debate became heated and garnered lots of public visibility.

Physicians also expressed concern. The law requires schools to send home letters about the annual BMI measurement; whose children were identified as overweight or at risk are advised to take the child to the pediatrician. "We heard from some physicians that they were concerned they’d be overwhelmed with visits from worried parents," Dr. Raczynski said. He and his colleagues presented information from a 1-year evaluation of the law, which included interviews with parents, children, and physicians and visits to schools. Baseline data from spring 2004—when the law went into effect—were compared with data collected during 2000.

The annual BMI measurements appear to be having a positive impact on parents, said Delia West, Ph.D. After the school BMI screening, parents were significantly better at accurately identifying whether their child was overweight, said Dr. West of the University of Arkansas.

The baseline survey asked parents of children in kindergarten through grade 10 to assess their child’s weight status. The follow-up survey asked the same after the child had undergone an annual screening.

"The change is important because family identification of weight problems can be the foundation for intervention and dation of behavior change," Dr. West said. "Parents who identify their child as overweight are more likely to institute or support appropriate health behaviors.”

The parental concern of an increase in stigmatization of overweight children was not an issue, said Nadia Siddiqui of the University of Arkansas. Data from both the baseline and 1-year follow-up surveys found no increase in weight-based teasing among any age group after the annual BMI measurement was instituted.

Physicians’ concerns about being overwhelmed by unnecessarily worried parents were unfounded as well, said Jada Walker, also of the university. More than half of the 481 physicians surveyed (57%) reported that at least one family had brought in a BMI report to discuss. "They were not as overwhelmed as some had feared, and they also reported being very supportive of the legislation,” Ms. Walker said. However, added Dr. Raczynski, it is somewhat worrisome that only 57% of physicians had dealt with a BMI concern prompted by the act. "We’d like to see more letters going to physicians.”

Fostering the Pediatrician-Oncologist Partnership

BY DEEANA FRANKLIN Associate Editor

Baltimore — From the outside, pediatric oncology treatment may look like a puzzling maze for patients, their families, and even primary care providers.

"One question that tends to come up is, 'How exact is that black box of pediatric oncology organized?' From the pediatrician’s perspective, often it’s hard to know who are the best people to get in touch with to get the best information,” said Dr. Patrick Brown, of the pediatric oncology department at Johns Hopkins University School of Medicine in Baltimore.

At his institution, a pediatric oncology fellow is usually designated as the first contact for a patient and this fellow is "at the center of delivering care."

"The fellow works closely with the attending on service at the time. Together this pair will become the primary oncology team for the patient,” he said at a meeting on pediatric trends sponsored by Johns Hopkins University.

This team devises a treatment plan that’s carried out by a large team of pediatric residents and physician extenders. Another important component is the multidisciplinary team, composed of surgeons, radiology oncologists, bone marrow transplant specialists, pediatric ICU staff, nurses, and social workers—all working closely with the fellow.

"We recognize the diagnosis of cancer is almost always the unexpected result of a series of rational diagnostic procedures, and that true cases where cues have been missed that cause a delay in diagnosis and negatively impact prognosis are exceedingly rare,” he said. While it often seems to parents that something should have been picked up earlier, “we do everything we can to assuage that notion, because in the vast majority of cases that is not true. I think it’s our job to help the parents understand that and to help you understand that."

During treatment the oncology team takes responsibility for all medical issues, including primary care issues, but they may ask a pediatrician for assistance with blood work, referrals, and urgent care matters, especially for patients who live far from the cancer center. The oncologist then needs to be a transplant center, he urged physicians to “find a place that’s a member of a clinical trials network for children with cancer. It’s been documented over the years that children with cancer who are treated within a clinical context have better outcomes.”

"This pediatrician plays a key role in communicating many of the elements of the diagnosis, prognosis, and treatment plan to the child, parents, and any siblings and—most importantly—offers them emotional support. The pediatrician also provides essential background information on the patient to the oncology team."

Dr. Brown stressed it is the job of the pediatric oncologist to “open lines of communication with the pediatrician early and sustain them throughout the treatment plan that’s carried out by a large team of pediatric residents and physician extenders. Another important component is the multidisciplinary team, composed of surgeons, radiology oncologists, bone marrow transplant specialists, pediatric ICU staff, nurses, and social workers—all working closely with the fellow.

Each patient is assigned a primary team of oncologists who have longitudinal responsibility for the patient’s care. “These providers are your primary point of contact. You should be hearing from either the attending or the fellow while the patient is being treated, and you should know how to get in touch with one or both of these individuals,” he said.

As with all good relationships, communication is a two-way street, and Dr. Brown suggested pediatricians initially try to refer patients to a medical center that can offer a multidisciplinary approach. While it’s not necessary that a center be a transplant center, he recommended “for a small group of patients who are being treated, you should try to find a place that’s a member of a clinical trials network for children with cancer.”

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