LETTERS TO THE EDITOR

Identification and Management of Overweight and Obesity by Internal Medicine Residents:

Christopher B. Ruser, Lisa Sanders et al.

To the editor:—Similar to Ruser et al.,¹ our Internal Medicine residency has also been studying obesity identification and management. In addition to an ambulatory chart review, for 3 years incoming residents were surveyed. In our chart review of resident practices at the Norwalk Community Health Center, structured similarly to a federally qualified health center,² weight was documented in 63% of the charts reviewed and body mass index (BMI) in only 4%.³

There has been a trend of increasing awareness of obesity and its management among surveyed physicians in training. Over the last 3 years, 56 of 75 incoming residents (74.6%) completed a survey adapted from the literature using a 5-point Likert scale.³ Residents reported that maintenance of BMI in healthy range is important (98.2%) and that treatment for obese patients should be offered (67.8% when BMI > 25 compared with 32.1% when BMI > 30). Furthermore, 80.3% disagreed when asked whether treatment for overweight should be offered only when other risk factors such as Type II diabetes or hypertension are present.

Residents noted their lack of training in managing overweight and obesity (only 32.1% and 26.7% felt that they are professionally well trained to manage overweight and obese patients, respectively). Finally, residents compared self-rated importance of different approaches for weight management with their personal use of these approaches with their patients. As expected, self-reported practice fell short of self-rated importance: patient weight history (usually done 10.7% vs important 80.3%); dietary habits (usually done 10.7% vs important 48.2.1%); physical activity habits (usually done 12.5% vs important 85.7%); and readiness for change at first contact (usually done 5.35% vs important 80.3%). As seen with other physicians, it is challenging to integrate weight management into medical practice.⁴⁻⁶

These results expand on the study published recently in JGIM and reinforce the importance of improving practice among Internal Medicine residents toward obesity. It is critical that trainees become prepared to deal with what is one of the largest growing epidemics facing health care today and in the future.—**V. Adimoolam, MD,¹ and P. Charney, MD,^{1,2}**
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Letter to the Editor Regarding Sullivan et al.

To the Editor:—In their brief report "Training Internists in Shared Decision Making About Chronic Opioid Treatment for NonCancer Pain," Sullivan, Leigh, and Gaster reported on their training of Internal Medicine physicians (principally residents) in the prescribing of opioids, especially methadone, to patients with chronic noncancer pain.¹ They reported that their training resulted in "improvement," with physicians in the intervention group being 3 times more likely to prescribe opioids at 3 months posttraining than those in the control group.

The authors chose methadone "as the long-acting opioid least prone to abuse." Although it is debatable if methadone is actually the opioid least prone to abuse, what is certain is that methadone is causing many preventable deaths. A National Assessment by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration concluded that dramatically increasing methadone-associated mortality is from its use as an analgesic, not from its use in opioid addiction treatment.² In the most recent data from the Centers for Disease Control published on January 31, 2006, methadone was implicated in 2,376 deaths and other specified opioids were implicated in an additional 4,484 deaths (not including 2,101 deaths from heroin) in 2002 in the United States.³

In their reference to the editorial by Van Korff and Deyo,⁴ the authors acknowledged the belief by many that the efficacy of long-term opioid treatment of chronic nonmalignant pain remains unproven. The authors failed to mention the unacceptably high mortality that is resulting from this questionable practice. We should be training our residents in safe and effective treatments for chronic nonmalignant pain, not in those that are of questionable efficacy and are causing great harm.—**Catherine T. Baca, MD, Kenneth J. Grant, MD, Center on Alcoholism, Substance Abuse and Addiction (CASAA), University of New Mexico, 2650 Yale SE, MSC II 6280, Albuquerque, NM 87106, USA.**

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