Alternative Viewpoint on National Institutes of Health Clinical Guidelines

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ABSTRACT The use of the National Institutes of Health (NIH) Clinical Guidelines to guide assessment and treatment of overweight and obese patients is the source of considerable debate. The guidelines rely, in part, on research with methodological problems. The standard treatments for obesity outlined in the Guidelines have not proven to be successful long term. Evidence suggests obesity may be a result of biochemical defects, not eating and exercise patterns. Dieting, one of the recommended treatments, is a known risk factor for development of an eating disorder. Further, there is no conclusive evidence that weight loss improves health outcomes. Nutrition education professionals need to develop approaches that improve health independently of weight loss for Americans seeking to lose weight.

The Clinical Guidelines recommend standard, widely used treatments (i.e., diet therapy, physical activity, behavior modification, pharmacologic therapy, and surgery). Although standard treatments may be successful initially, it is well documented that most people who lose weight regain that weight within 5 years. A growing body of evidence suggests that most forms of obesity are more likely the result of biochemical defects rather than due to consumption of excess calories. Furthermore, the very references cited by the Guidelines to support the recommended initial weight loss goal of 10% of body weight actually show that less than half of the participants of those trials could meet this goal. In other words, we have no effective long-term treatments for obesity, and none are on the horizon.

We are also concerned that the Clinical Guidelines ignore what NEJM editors described as “the dark side to this national preoccupation” (i.e., body dissatisfaction among women and teenagers, the negative consequences of dieting, and the prevalence of eating disorders among adolescents and young women). Dieting is a recognized risk factor for the development of an eating disorder. A number of researchers have concluded that dieting is strongly associated with the development of bulimia. Furthermore, caloric restriction leads to bingeing behavior. The Guidelines, in recommending that weight maintenance therapy be continued indefinitely, will escalate our national preoccupation with weight and will exacerbate its “dark side.”

The association between overweight and morbidity or mortality is far from certain. Epidemiologic studies have indicated that higher body weights were neutral or positively associated with longevity. Of particular concern to us is that the Guidelines target Body Mass Indices (BMIs) of 25 and above as being associated with “high” relative risk. We agree that increasing weight and mortality are related at very high weights, but for BMIs below 28, the relative risk of mortality increases only slightly. We lack evidence that losing the 6 or 7 pounds that would result in a change in BMI from 26 to 25 actually reduces risk. Even at higher BMIs, there is no conclusive evidence that weight loss reduces risk. In a comprehensive review of epidemiologic

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studies, no support was found for the commonly held notion that weight loss, even among the overweight, leads to improved health and increased longevity. Furthermore, weight loss may increase mortality.25,26 Barnard et al. reported that obese men and women significantly reduced blood pressure and serum lipid, insulin, and glucose levels by changing diet and exercise habits with little, if any, change in body weight. Barlow et al. have shown that, in fact, lower risk of mortality has been found to be positively associated with fitness, but not with fatness. These researchers found that moderate- and high-fit men in BMI categories greater than or equal to 27 had lower death rates than their low-fit counterparts. Low-fit men with BMIs less than 27 were three times more likely to die young than the fitter men who exercised regularly.

Are the Clinical Guidelines an appropriate prescription for treating overweight and obese patients? We think not. First, health benefits can be achieved without weight loss. Second, encouraging weight loss, especially through dieting, is not likely to be effective and may result in a host of additional physical and psychological problems.29 We encourage our professional colleagues to join us in developing and testing "approaches that can produce health benefits independently of weight loss [which] may be the best way to improve the physical and psychological health of Americans seeking to lose weight."30 We conclude that weight loss is not necessarily the answer to "How can fat people be healthy?"

The Division of Nutrition and Weight Realities endorses the New Weight Paradigm.31 This paradigm has evolved through recognition of the limited success of weight loss interventions. It challenges the medicalization of obesity as demonstrated in the NIH Guidelines. We advocate acceptance of one's self, as well as one's body size and shape, and we urge direct pursuit of health and happiness, rather than viewing slenderness as a prerequisite for these goals.

REFERENCES