JOSEPH SKELTON: I think a lot of you guys-- I feel like I can't really lecture. You guys could give me a talk on something like this, so sort of the frustration of dealing with weight. And you've been dealing with this I think a lot longer with a lot of your patients than we have. And so hopefully, I can condense some of your experiences within this, and hopefully you can take away a couple of Chi squared and p values with that.

So here's our objectives. And actually, I'll go down these as we go through the talk. And I want to make a couple of suppositions first.

[LAUGHTER]

Each one of these-- again, I'm a GI doc. I can make these statements.

[LAUGHTER]

But I have some suppositions that I need you to sort of trust me on, because each one of these could be a separate talk sort of discussing somewhat is considered controversial things within pediatric obesity. And one is, of course we know, you have to put slides up like this when you give an obesity talk. But my main point with this slide is that the rise in childhood obesity, adult obesity, is because of a change in the environment.

I'm not taking away anything of our personal responsibility or how our behaviors, but I would have you look at this through the lens of we've had this severe increase in childhood obesity. It's the world that changed and we did not adapt to it very well. And so the ecological model where you look at the child's weight in the context of their own behaviors and personalities in their family, in the community, in the nation, it's very complicated.

It's very, very complicated. And it's not just about a child that is lazy, or a parent that is not doing something right. It's very complicated. Does anyone know why we started the school nutrition program in the 1940s? It was because one third to one half of kids were not qualifying for the military because they were malnourished.

So we started feeding kids in schools. What is our problem today? One third almost one half of kids are not qualifying for the military because they're overweight or obese. So there's different policies and different things that have changed in our environment and we need to figure out as people, as health care providers, as our society, how are we going to adapt to this unhealthy environment, change the environment, as well as change our own behavior.

So that's the first supposition. The second one is going to be obesity is not a moral failing. And I put up this slide because, in the context of kids, we tend to look at the parents a little bit. And being a pediatrician that ignored his kids broken leg and said it was sprained and had to come back here and have Matt Ravish and his crew diagnosis it as broken, you feel like a real heel.

And so when you look at the parents and say all this is your fault, it's not a moral failing. But because when we look at people who develop problems with their weight, in the conventional approaches that we have to obesity treatment in adults or in kids, long term treatment with the approach that we have today, some estimates are about 20% have long term weight loss and keep it off.

This is very hard to do. So it's not a moral failing. So when you look at a family that's struggling with this and they bring a soda into your office when you're there to talk about sugar sweetened beverages, which happens to us. I'm sure it happens to you guys. It's not a moral failing. There's something else deeper to that.

Finally, what works for you does not necessarily work for me and vice versa and all around that. Everyone has different challenges when it comes to their weight-- myself, my kids, my family, all of us. So when you see your patients, what might help one family be healthy might not work for another. And I think we fall victim to a lot of this with sort of fad approaches.

Oh, I did CrossFit. I did the pomegranate cleanse. That's what's going to help you. And that's not going to be the same issue. Everyone has their own challenges with that. And finally, and I know you've heard this, and I'm not scolding. I just went through this this week with one of my patients-- is scaring patients doesn't work.

Scaring parents doesn't work. As frustrated as we get-- and sometimes, to be honest, as angry as we get sometimes, it's not going to work. It's actually going to have a negative reaction. It's going to drive people to do things either against what you're trying to do with them-- change their habits, change from unhealthy habits to healthy habits-- or it's going to drive them to do something that might not be safe. And I'll talk a little bit more about that.

Just know scaring families, scaring patients doesn't work. So weight bias. I think this might be where we need to start about where we see weight bias. And I'm sure you've heard a lot of this. But really what it comes down to is having stereotypes-- stereotypes about the patient or about the patient's condition. It can be verbal, physical, relational of how you interact, and there's subtle and there's overt expressions of that.

This old study with medical students showed their perceptions of patients that are obese-- poor in self-control, less likely to adhere to treatment, sloppy, awkward-- comes home to roost here. David Miller in internal medicine and public health sciences actually did this study with medical students here a few years ago where he gave them overt and covert or unconscious and conscious tests for bias.

And if you look down at the bottom, 39% had moderate to strong unconscious anti-fat bias. And the last bullet point there, less than 25% were even aware of that. So I think a lot of us say, no, no. Of course I understand how tough this is. I don't have a bias. But when they did a test for sort of unconscious bias, it scored very high.

A lot of us have done this and it's sort of shocked ourselves at how much these stereotypes tend to persist. This extends really to all physicians, of how we view our patients-- non-compliant, weak-willed, unsuccessful, dishonest. This is shown actually in studies of what kids think of other kids who have weight problems, of describing them as dirty or lazy and things like that.

Nurses-- so even our nurses that provide care for these patients-- some of this research is old and needs to be updated. But in research that we're doing right now within the hospital, we're still finding this, that there's still a bias. And this goes to psychologists. It goes to dietitians. I'm not just picking on doctors and nurses.

But this bias does affect care. And they've looked at this very well. I guess this is some science I'm putting up now. They've looked at this very well about how it affects our interactions with patients-- spending less time, less discussion, more assignment of negative symptoms. A patient who is overweight complains of pain. Well, yeah, that's just because you're overweight, instead of addressing the pain and then how to care for it.

Less intervention. Sometimes they're saying, oh, that's because of their obesity. I'm not going to do this test or do that intervention. So it does affect the care that we provide to our patients. And if you ever seen me talk, you've probably seen me put up the slide-- not because I'm a big Tyra Banks, but because I found this very powerful.

She actually went through this experiment herself. Tyra Banks is a super model that has talk shows and stuff like that, for those of y'all who do not know who Tyra Banks is. And so she dressed in this suit that made her appear 350 pounds. And it profoundly affected her actually. And this was her quote. "I started walking down the street and within 10 seconds a trio of people looked at me, snickered, started pointing and laughing at my face."

And this is a super model that is used to people pointing and looking at her because she's a supermodel and she's famous. And it was just for her wearing this-- I hate to say, it's what they call a fat suit-- just for her wearing that. It's really kind of disturbing. How it's presented in the media. This is a great study, looking over 1,000 different characters across six major TV networks and find that overall, they're under-represented.

But when they are represented within a TV show, they're the targets of humor. Many were from Fat Albert, Norm-- Newman, I think is sort of the evil foil, evil comic foil, of the main character. And they're never pictured being in romantic relationships. Now I'm happy to say, it's changing a little bit. I mean, you'll start to see some of this come around. But the victories are few and far between when it comes to an accurate representation.

So the second objective-- discuss practical approaches to sensitively and effectively discussing weight with children and families. A lot of it has to do with language. And so this was actually a very well done series of studies out of the Rudd center. And if you're interested, if you look at the UConn, University of Connecticut Rudd Center, has a lot of great information, has videos about training and weight sensitivity and weight bias.

And they looked at both patients and providers at looking what was the preferred language when you talk about weight. This is not something-- and I'm not telling you to dance around the subject. Oftentimes, this is why the families are coming to see you for that. But what kind of language to use. And so the non-preferred language. What patients, kids, and parents both did not like hearing was the term fat or morbidly obese, or what we think might be a little more sensitive as chubby.

I had to be careful myself. I'm a GI doc by training. I talk about tummy's a lot, or let me feel your belly. Well, to someone who has a problem with their weight, hearing the term belly implies like Santa Claus, a bowl full of jelly. And they kind of winced when I said that. I kind of caught myself like, oh, I need be careful. I say that all the time and I don't mean it, but it actually was taken-- I don't want to say the wrong way. It hurt this kid's feelings, I believe, and so I've had to be very careful about that.

The least motivating terms. You know when you're talking about this, just really it's best to sort of get another arsenal of words that you use. So the least stigmatizing is talk about weight or unhealthy weight or excess weight. In this study, they said high BMI. Think sometimes we spend, even if you explain BMI to a family, it's just not a common term that you'll use around that.

What we found that has been very effective in Brenner Fit is we talk about having extra weight around our middle or extra weight around here, which is actually fairly technically correct when you're talking about the health complications of having extra weight. All the big chunky weight I have up here on my head does nothing but protect my noggin.

Down here is the inflammatory component of adipose tissue and what actually causes a lot of heart disease. So it's actually a fairly accurate term to use. Kind of some more science there, I think. So talking about having extra weight, having a weight challenge, weight issue. And again, you're not dancing around it. They know this. They're there to talk with you about it, but being very sensitive with the language that you use.

Feel free to steal that term-- weight around here. If you've ever trained in motivational interviewing, this is very familiar, sort of asking permission. You know, lots of times they might be coming to you for another issue. You want to talk with them about it, but it might be a sensitive subject. And so asking permission.

Would it be OK if we talk about Timmy's weight today? Can we talk about your weight today? I have some concerns. You know, that's showing of a caring approach to what you're trying to accomplish. How do you feel about their weight? This is a question that we've instituted over the past year. So what do you feel about your weight?

It's actually a quandary that in certain populations, their kid's self-esteem is not based upon their weight, which is actually a great thing. They're very confident in who they are. And we don't want to tear that down. And so oftentimes getting what their perspective is. Recognize that this is a point of conflict. I think you guys probably know this better than I do, that when you're in a room-- be it sort of a middle school age kid or a high school teenager-- and you bring this up, this can cause a lot of distress.

One of the biggest points of conflict between a child and their parent when it comes to issues around weight is not necessarily eating. It can be. Or physical activity. Oftentimes, it's clothes. I've had to check this with my 13, almost 14-year-old, who's growing. He's grown almost an inch in the past two months. You outgrew that again? That doesn't mean much to me.

That's just me frustrated I have to go spend $30, $40 on a pair of jeans. He hears something else. I don't know exactly, because he's a teenager and just sort of grunts at me, but he hears something else of, at the worst case, you don't like how I look. You don't love me. I mean, it's really hard to tell. But they hear something different. So oftentimes, we have these more sensitive discussions, as you often do with teenagers, is have some parnet-- meet with the parent by themselves for a little while.

Meet with the kid by itself. It's amazing of when I take a kid out of the room and my dietitian's talking with the parent of how the conversation changed, and what the parent-- parent may be trying to be very sensitive to the kids feelings and watching what they're saying, but really trying to unload the stress-- their own internal struggle-- they're having in dealing with this.

Oftentimes, the kids won't-- especially if it's a point of conflict around food, nutrition, activity, TV time-- get them by themselves, talk to them by themselves. Even if it doesn't give you anything you can do immediately there, you build a bond. You get a little bit deeper understanding of what that child and the parent is going through.

Some other things that we've added in our evaluation is, when did you first become concerned about their weight? When did the child's weight begin to really come on? Was there a point in time? Oftentimes the answer is, no, they've always been big. It's been so steady. But often times it's, when we moved here from California and we noticed that was a major change.

Well, your plan is not to send them back to California, but it does give you some insight into what's going on. Again, separately ask what conversations are going on in your house. Lots of families don't discuss issues around nutrition, physical activity at all. Some discuss it all the time. It allows you to identify a very sensitive point. It gives you a point of action later on if there's an issue with that relationship over weight, and I'll give you an example of that in a minute.

That's something to address, especially as you're trying to make a plan. Does this bother your child? Does it bother him or her? No, they're pretty confident with themselves. Or yes, this really bothers them. Again, it gives you a little bit more insight of how to deal with this. How do include-- and I think we all have experienced this of the parent looking at the 7-year-old kid.

Do you hear what he's saying? Do you hear him? Are you going to do what he says? That type of thing. And so we try to be very upfront, as I'm sure you guys are. We address that sort of head on. And we've actually even started doing this in our orientation. We find putting things up like I'm doing right now makes it looks that more scientific. There's some p values here.

[LAUGHTER]

And so we find presenting it as fact sometimes helps with us getting buy-in with the family instead of sitting there arguing, because we hear that a lot. No, he needs to learn. He needs to know this. No, your 7-year-old does not need to know how to prepare a healthy breakfast. So we do this very front of right from 2 to 7.

This is you as the parents. We have parent only visits. Parents are actually relieved when we say, they don't really need to come back to the second visit. This is all that's going to be working with you. The parents can include the child in some decision-making-- especially for some of these older kids, if you're meal planning or want to find fun activities.

But leave it on the parent. Empower the parent to do it. Make these very clear messages about you as a parent and what you're going to change in the home and not trying to lump blame on the kid. 8 to 11, that sort of in-between stage-- what we sort of surmised is that kids understand the information. You know, my kids can understand what a balanced plate is. My kids understand a banana's healthy and gummy bears aren't.

They will not take that information and put it in a behavior change. We know at that age and the stage that they're at in development, that they will not take that information necessarily and do something about it. You can make that case even for teenagers. That's more of a frontal lobe issue, I know. But what most research has shown is-- an actually it's old research and very new research-- is they need to do it independently.

What do adolescents want? They want autonomy. And so we'll do what we call parallel treatment is the term, is that we will do some things independently with the child. We'll do some things independently with the parent, typically letting them know what the child is wanting to do and how the parent can support them in doing that.

And so it can oftentimes be hard in a busy clinic to do this at the same time. But as you do your adolescent visits around weight, kid only, parent only, some together, you have to get your own routine with that. But we found that very powerful. So actually I just jumped ahead. This is essentially what I said. Let it be known right from the beginning, this is about you.

I'm not blaming you for your kid's weight problem, but to change this in the household, it's going to be about you making that change. It's up to you to model that behavior. It's up to you to-- one of the things that we always say is, when your kid graduates from high school, when they leave the home hopefully, that they're going to hold on to the behaviors and the habits that they were raised in. So that's our big goal.

So it's up to you to sort of build that within your home. You can include sort of the in-between 8 to 11's in some of these discussions, but make it very clear that the responsibility falls on the parent to institute some of this. And then the adolescents, really sort of pushing that parallel treatment. And one thing to think with doing the parallel treatment, spending time with both, is really showing empathy.

A very common thing we say in our clinic is we really live in an unhealthy world. Going back to that ecological model, the world around us has changed. We just haven't adapted to it very well. So we're here to help you guys navigate that. So the other things you can do in your office-- there's a much more complete list of this on the UConn Rudd Center-- is making your office accessible.

A comfortable office environment has to do with the steady chairs. Huge amount of embarrassment on broken chairs, getting stuck in chairs. We hear this happening a lot. We need to think about this actually across our entire hospital, because we have patients that have a lot of extra weight and may not hold up in regular chairs.

You'd be shocked at how certain chairs here may only be gauged to carry 250 pounds. Well, there's a lot of people that weigh more than 250 pounds in our hospital. Most football players weigh more than 250 pounds. And so looking at what you have in your office that can make people that have extra weight feel comfortable.

Weight sensitive reading materials-- we pulled out of our waiting room the other day a pregnancy magazine that had this woman just with pump and biceps. And it's like, is that something that we really want seen in people that are trying to struggle with weight? And the place that I did a special elective in residency in New York, their eating disorder clinic met at the same time as their obesity clinic.

[LAUGHTER]

And I kind or-- come on, are you kidding me?/ So medical equipment that can assess-- that's anywhere from blood pressure cuffs, the longer blood pressure cuffs, longer needles, things like that. Elizabeth Halverson just published a paper looking at some safety issues around hospitals. And that's one of the problems is actually having LP needles that are long enough.

And reduce patient fears about weight. One the most powerful things that we changed is before I'd come here, was we started doing the weights ourselves, because our MAs had told us the arguments, the things that are said when parents are looking over their shoulder, looking at the weight of the child, and the comments that are made.

And they're not made in front of us. It's almost like it's in private. So we thought the MAs were going to sort of revolt when we took that responsibility away from them. They're like, oh, thank god. The uncomfortable exchanges that we have over that. Because what do we want? Now, weight's important. I'm not saying that we ignore the weight. But what we want them to focus on is the habits behind the weight.

And so that's oftentimes what we do is we'll weigh them. We weight it kilograms. And we'll say, yeah, that number looks funny because it's kilograms. It's not in pounds. Some parents asks for the weight and we'll provide it. But we're really trying to take the focus off of that onto the habits behind it.

Again, we don't ignore it. The weight is why they're come to see us. But really taking that focus, making them fee comfortable, not dreading that going to get weighed at the doctor's office. And the final objective is to discuss how to manage weight loss failures in family, because as I said, we oftentimes fail more than we succeed in trying to get weight loss.

And there's a lot of contradictions with this, I think, can be very difficult. I saw kids last week-- they've got to do something about their habits. That's the first thing I would say. And the second thing is their weight is causing a lot of health problems. You know, hypertension, pre-diabetes, both that-- I mean, stuff that I went into pediatrics for.

That's internal medicine docs and family docs that do that, not me. But I was getting that frustration with it. And so I wanted to get some weight loss. But but then again, did what they were-- the things that get them to lose weight quickly would not be sustainable. It probably wouldn't be safe. So it's a contradiction that we do need some weight loss in these kids, especially as we're working with them and their weight gets worse.

But on the other hand, we don't want to do something that's unhealthy, or we don't want to destroy self-esteem. We want to empower parents to make changes, but we don't want them to get restrictive. That's one the worst things is you're going to go eat your salad while I feed your normal weight kids something else. It's one of the worst things to do.

So we want them to not have this very authoritarian approach to that. We want to be authoritative. But then again, we're putting a lot of pressure to lose weight. So there's a lot of contradictions when we get to these weight loss failures that can be quite difficult. I'll remind you again, do not yell, do not scare your patients. Your patients love you, and they want to come back to you to provide their care, but often times they get scared.

They get scared of getting in trouble. We hear that oftentimes. They're terrified to go back and be weighed because he wanted me to lose weight and I'm going to-- we know our weight's gone up. What are we going to do? And the message here is we need to keep pursuing weight management. We need to keep pursuing behavior change with children and with families.

But we don't want to drive them to treatment that doesn't work. Unfortunately, our present state of treatment of things that do work does not give us rapid weight loss. But we don't want to drive them to things that may work in the short term, but may have more damage associated with them in the long term-- I gotta go back-- because we've been there.

And we seem to be on a cycle of about every 5 to 10 years now of trying to fall back on fads, trying to fall back on things that are going to get us sort of rapid weight loss that we know is not sustainable, we know it's not going to last. I'm 43 years old. I've already lived through the low carb and Atkins craze. And within just within weight management.

Within pediatric weight management, we have that. It's starting to come back again even. So if we don't remember that these things didn't work before, we need to remember that they're not going to work again, and may even do damage. First of all, this patient said we could show these pictures. I just feel like I'm just going to cover up his face anyway.

And this is a big changing point for me. He started with us, on your left, when he was about 12 years old, and was with us for about two years and continued to gain weight, continued to not get long-term behavior change. The family really struggled with it. Two years. Brenner Fit, as of December 31st, was a one year long program. We're switching to a six month program.

But it was a one year program. Well, he stayed with us a whole extra year. And to be honest, the reason we sort of kept-- we loved the family. They were a very sweet family. Very nice. They loved seeing-- and they tried. They really tried. And then finally, something clicked. Something about the parent and the child's relationship clicked. Something about the child wanting-- getting a little bit of interest in some of this stuff.

And it was us being patient. And I learned a big lesson out of that, because at some point we're saying, why are we wasting our time? We'll send them out. Let it come back. But they wanted to keep coming back. And they persisted. And we persisted. And it clicked. And it's still clicking. There's been no rebound. He looks like that on your right today. He's doing really well with that in a very safe way.

And he recognizes that. Every time I see him, I screen for eating disorders. And he's like, nah, I'm good. I just really like this. It's important to me. And I'll be honest-- we kept seeing them just because we liked them. I feel really bad saying that, but it really changed our approach. This was another. I'm sorry. The print is really small. I'll sort of read out loud.

These are obviously redacted and names changed and stuff like that. And forgive the poor grammar. This is my typing in week one, in epic. Gloria and her mother started when she was eight years old. And after a year, her and her mother, they continued to struggle. The kid's weight continued to go up. We had those moments of, are we making this worse? Is her weight going up quicker than before we saw her?

And they wanted rapid weight loss. And they were very frustrated. And it was causing some stress between Gloria and her mother. And mother was quite disappointed and wouldn't talk about this openly in front of her kid. So Gloria felt-- and this is what broke or heart-- my mom doesn't love me as much as my brother.

So I sort of pulled the kid out. Tears started flowing everywhere. And the mother was equally upset to even hear her say something like that. Mother expected this now nine-year-old to begin making all these changes. Mom was changing things in the home. Mom was putting a lot of pressure, I think, and had a lot of expectations for this child to change their behavior, too, at 9 years of age.

And it was killing this kid. This kid was quite upset. My mom doesn't love me because I'm the reason we have to come here. I'm the reason mom has to spend extra money on healthy food, all the things that you guys hear. And so we sort of stopped and said, whoa, wait. We need to stop this. We need to really not focus on that, because this focus on the weight-- the kid was healthy.

The kid did not have a pressing medical issue, but obviously had extra weight, which was causing concerns for the future. So we had to put pause and just say, wait, what are we doing here? And we really focused a while on their relationship about that, saying, listen-- we can take a time out from that. We need to focus on how you guys are talking about it, focus on the communication in the relationship, which is actually a very understudied area in this with kids, even outside of weight, just looking at nutrition, physical activity. It's very under-studying.

So after a period of time-- and actually not very long, just a few visits-- started to repair that a little bit, sort of gave them a pass to not work on these things for a while. We withdrew our pressure on the family. And I just saw them back recently. They still come to see us once or twice a year. Gloria said that her mother and her have a much better relationship and that her mother's no longer making comments about food. They do not fight over food, and therefore, weight.

I wish I had the growth chart to show you, but this kid has steadily started to decrease her BMI and is now actually starting to lose weight a little bit and is about to cross the 95th percentile. Actually, I think maybe she did. It's doing exactly what you want to see a growth chart type do. Not focusing on nutrition. They knew a lot. They'd learned a lot with us. But really focusing on how they interacted and relieving that pressure.

Now, the kid was getting to that point that was starting to want some autonomy. But the main thing we changed here was just their relationship and that pressure between them. Some other stories-- what we called the "Just do South Beach" story. We had a family. We'd worked with them for eight months. Finally, started to get a little bit of traction of changing some behaviors, changing some eating out behaviors-- sugar sweetened beverages.

Made really good changes. They went to see another doctor who saw the weight going up. Now this kid's BMI started to stabilize a little bit, but saw the weight going up and said, you need to do South Beach. That's how I lost weight. You need to do South Beach. Eight months of work thrown out the window. Came back to us confused, not quite upset, but very confused about, well, why didn't you all tell me to do South Beach.

This is another doctor who seems know a lot about this stuff. Very confused about that. Literally ruined about eight months of work with them. They need to hear this. This is that parent that says-- kid's very sensitive about the weight. They know that they have weight that they need to lose. They know that they're overweight.

This parent went in and asked the doctor ahead of time, can we not talk about weight? We're here for another medical reason. We're working on this. We see Brenner Fit. Your child needs to hear. They need to hear this. They need hear how this is affecting their health. That's the scaring technique. Again, not a good outcome that came from that.

And that's sort of that desperation. The doctor cared and the doctor wanted to do something, but was using a heavier hand that really sort of backfired. Any one a Lucinda Williams fan? I see someone smiling over there maybe. Both my children were born to Lucinda Williams albums, so-- born to Lucinda Williams albums.

Big singer-songwriter. She's fantastic. This is one of her latest song. It's based on a poem her dad wrote. "You do not know what wars are going on down where the spirit meets the bone." Oftentimes peeling back that layer to see what's behind a family that's struggling to make changes and see the other issues that are going on.

With Gloria and her family, it was an issue of mom and daughter's relationship. A lot of these families are going through a lot of things. Focusing on health might not be their top priority. We want them to. We absolutely want them to. I'm not saying that they shouldn't. But a lot of other stresses, a lot of other struggles that are going on that maybe they can't prioritize that right now.

So my main message is, continue to support the family, no matter how frustrating the eternal soda family is. And you've had them. I've had them. I mean, I look at their last care plan. They've been working on eliminating sugar sweetened beverages. Big Gulp still exists. Big Gulps have not gone away. They're still out there-- of walking in with this huge, regular soda.

They're out there, and it just blows your mind. How can this still be going on? Oftentimes, dive deep. See what else is going on. But oftentimes, it's going to be, let's work on something else. They may not be ready to give that up. There's a complex family system going on there that is obviously preventing that family from making that change.

Try something else. That might not be something that they want to change. Obviously they need to, and it's absolutely acceptable to share that. It's absolutely acceptable to say, one day we need to think about changing from sugar containing drinks to sugar free drinks. It's OK to say that. But it's also OK to drop that and move on to something else that's going to impact their health.

Leverage your relationship. I've really come a long way of seeing how that relationship can make a difference. You want to be the one they go to. You don't want them to pursue a fad diet. You don't want them watching Dr. Oz. I said it. I said it. You don't want them watching Dr. Oz, except for his attention to the poop chart. I think that's very helpful.

But you want them coming to you, because you're not going to do something silly. You're not going to do something that could be potentially be unsafe, or could be harmful in a biopsychosocial way to that child and that family. I'm not saying give them a pass. I'm not saying blow something off. But be the one that they want to come to.

And keep your eyes on the prize. I heard a colleague of mine say this one time. I'm not as concerned about that number on the scale as I am about your child's long-term health. We'll talk about the scale. The scale will come. But I'm more concerned about making the changes that are going to improve your child's health.

Because we look at this as an iceberg. We see obesity as that 10% of the iceberg that's above the water. But the complex systems that are interacting below the water that affects their nutrition and affects their physical activity, that affects the habits that impact their nutrition and physical activity, the family dynamics that impact that. There's a lot beneath there.

You can't always go beneath the water, but recognize there's a lot beneath there that's contributing to that family bringing soda in. And obviously we're influenced by the media around us. And whereas we see a little bit of sensitivity coming, you know-- what's that girl's name? Jennifer-- Jessica Simpson had an issue with weight, and how she was bullied and she wanted to stop that.

She did not do this until she got done and she lost a lot of weight. So it was I overcame bullying and lost weight. No. The message should be, bullying around weight is wrong and we should be against that. Jennifer Hudson, I think she was an *American Idol* person maybe, or an actress. Her struggles with weight was after she signed with either Nutrisystem or stuff like that and was really making a lot of bank shilling for them.

But her message was, I'm happy and healthy now. No. We should be happy. We should be healthy. The two necessarily don't have to intertwine. And so these are the messages they get of, oh, if my child is going to be happy and healthy, they need to be at a normal weight. And what we say matters. It's very, very hard. This is more of a message to parents of the comments that we do.

Me as a parent, I struggle with this, realizing that me teasing my son saying that he's being lazy, again, he might hear it in a different way, and that so much of what we say can have profound impact on kids and we don't realize that. That's a fake picture, obviously, so--

[LAUGHTER]

So measures of success. And these are actually-- these come from the AAP. Obviously I think a very lofty goal for a lot of our families of little kids trying to maintain their weight, the 6, 11. Maybe up to a pound a month. Teenagers, up what would consider adult weight loss of a pound a week. We don't see these very often.

I am guessing that you guys don't either. And actually, these numbers are not based on science. This was sort of a general consensus from the AAP. This was not based on what is considered a safe weight loss. It was sort of extrapolation of adult data. Because really, even in our program, about 2/3 of our kids have success.

And it doesn't look like big success. So this is our average patient in Brenner Fit. So these are very, very overweight-- the kids are very, very overweight. Again, I'm making that transition to the person first language-- person with obesity, childhood obesity, instead of obese child. So these kids are very much on the top of the growth chart.

If you look at our population as a whole, that's the change that we see. It's not a very big change. That's our population as a whole-- the 2/3 that have success and 1/3 that don't. If you look at the ones, the 2/3 that have success, this is a change you see.

Again, that's not remarkable, Biggest Loser type of numbers. But you've got to consider, this has been these children's growth trajectory. And sometimes that incline is steeper. Sometimes it's not so steep. And recognizing that small changes, a one pound weight gain with a two inch growth, is a major change. And when we sort of make up these numbers, but oftentimes if they'll maintain their BMI, we'll sort of draw the lines out and say, you know what? This is sort of like losing five pounds as an adult.

I do that for the parent, not necessarily for the kid. So small changes in the concept of this kid's life and what their future trajectory is can be a huge change. So looking at other measures of success-- the fact that they're actually doing a lot of this stuff. They're practicing some of these goals. And they're changing habits. You cannot convince me that my family that gave up sodas, but the child's weight did not improve at all, you cannot convince me that that child is not healthier now than they were before.

We know the impact, aside from weight, that high fructose corn syrup and excess sugar has on someone's weight. So these changes, even if they don't see a change in the weight, are still positive health changes. And so it's good to cheer that on. Our family that got put on South Beach at eight months had made a lot of changes.

And again, I'm not trying to poo-poo and trying to find success where there's none, but when these families make a change, they need to know that is an important outcome measure. And pro-family relationships. We're seeing this come out in some of our research now, our qualitative research that we're doing, to find families and kids are saying their favorite thing in coming to Brenner Fit is they're getting to do stuff with their family.

You know, parents sort of-- cooking meals with the family. The biggest way that we have to get families that didn't cook to now cook is through the child. The child wants to spend time with the family. And that's a big thing that we're hearing as an outcome from both children and our parents. There's always the blood work that you can see improvement in.

And oftentimes down to that relationship, the child being less focused on food and more focused on other activities. Oftentimes, a child that they're really focusing on trying to change what they're eating, sometimes removing that pressure can be victory enough. That's really small font. I'll sum this up, since I'm running out of time.

The top one, the top couple of studies, are very interesting, showing that physicians who have a normal BMI or normal weight oftentimes feel more empowered to do something about it. They feel more confident. They feel like families will look to them and they feel very confident. One thing I'll note is that last one-- PCPs, primary care physicians, belief about the diet-related cause of obesity typically focus on that cause.

And that's where sometimes in an era where we're still looking for effective treatment-- if for me I love cooking meals with my family, I love cooking at home, and that's what I'm comfortable with. So when it comes to me giving nutrition advice, that's what I'm going to focus on. That might not be that family's biggest need. That family's biggest need might be something else.

And that might not even be what the family wants to work on. But oftentimes, we tend to focus on the things that we believe are the key causes of obesity and we'll focus on that. So the main point of that is the second one. Patients actually are very open to care providers that have issues with their weight. They appreciate the honesty if you then share it.

I've struggled with this. That's a joke I tend to do a lot. I love food. If I knew there's deviled eggs in this building, I will find them and I will cut you to get them.

[LAUGHTER]

And so admitting that you're human-- you like food, too. You like to sit and watch movies, too. They actually appreciate that. You don't have to go all personal and go too in-depth. But they actually appreciate when you can share your own experiences with them. There is something they're looking at now called the no-cebo response-- a lack of understanding and acceptance or invalidation has a strong negative impact on health.

Not negative impact on physician patient relationship-- impact on health. It actually drives patient noncompliance, patient non-adherence of when they don't feel validated and that you're really listening to them. And finally, I've always loved this quote. It's questionable whether it was really Theodore Roosevelt, but that's what the best guess by historians is.

"Nobody cares how much you know until they know how much you care." Everything you're doing, obviously when your care-- what you do with these family show that you care. Make sure that you're doing it in a way that they know that you care. I say to people all the time, I could tell my kids all day how much I love them. I need to show them that I love them.

So even though you're trying to provide care, sometimes the frustration you're having with families not changing behaviors can sometimes make them feel like you're not caring. So really quick summary-- weight bias exists. It's implicit and explicit. In discussions about weight, you need to be upfront. But be sensitive and supportive of the family.

And weight loss failures, make it about the health. The weight-- you've got to focus on the health habits that are going to impact the weight before you impact the weight. And that's it. This is my kids' and I's favorite hobby. My son has it on his Instagram, is we like to make up breakfast. I recommend the breakfast banana split-- a split banana with Greek yogurt, granola and fruit, and about a teaspoon of honey.

It's a lot of fun kids. Go ape-- nuts about it. It's a really good breakfast.

[LAUGHTER]

So thank you. I think I went over a little bit, but I have time for some questions.

[APPLAUSE]