



VIEWPOINT

Too big to swallow

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Abstract: The failure of current treatment approaches to severe obesity has resulted in significant investment by the scientific community to develop new treatments for this challenging health problem. Any new treatment must be scientifically tested to determine its potential role and any innovation in healthcare can be associated with moral and ethical challenges. This reflective piece is based on the experience of running the first randomised controlled trial to compare laparoscopic adjustable gastric banding to an intensive behaviourally-based intervention in adolescents with severe obesity during which many moral and ethical concerns were articulated by other health professionals. Five different types of responses are described (preventers, druggies, deferrers, slippery slopers and simplifiers). While raising important concerns, these responses also deflect attention from the urgent need to develop and test new treatments for the most severely obese adolescents. The stigma of obesity is posed as an underlying yet unaddressed issue.

Key words: adolescent; ethics; obesity; RCT; surgery.

I was recently involved in the first trial of laparoscopic adjustable gastric banding in extremely obese adolescents. Funded by the Australian NH&MRC, we compared lapbanding to a highly intensive life-style intervention. Over the life of the trial, I was struck by the extent of negative comments from local and national colleagues, which I have grouped into five categories that helped me to explore what was being said – and what remained unspoken.

The first category, 'the preventers', dismissed any need to consider surgery because 'prevention is what matters'. I would have thought it obvious that population efforts to prevent the global obesity epidemic are critical. However, just like smoking and lung cancer, a focus on prevention should not preclude efforts to treat those most affected. Indeed, such an approach would be unethical.

The second category, 'the druggies', also discounted surgical options suggesting greater focus on behavioural interventions, especially pharmacological options. Currently, meta-analyses show only modest benefits of even the most intensive behavioural interventions. And despite substantial investment in drug

development, the recent withdrawal of various anti-obesity drugs is a cogent reminder of the importance of safety of any intervention.

'The deferrers' conceded that surgery has a role in extremely obese adults but discounted it for those under 18 years old. This group thus deftly avoided grappling with the risk of the death of a minor from non-urgent surgery. Yet, this approach fails to acknowledge the profound effect of extreme obesity on the social and emotional development of some adolescents, let alone the potential psychosocial benefits of weight loss in adolescence itself.

Rather than concerns of surgical risk, the 'slippery slopers' worried that a trial of surgery for extreme obesity would become the 'thin edge of the wedge' by which surgery would become acceptable for *any* overweight adolescent. I obviously have more confidence that clinical trials will help define the role of surgery.

Finally, 'the simplifiers' believed that obese individuals should simply 'eat less and exercise more'. The corollary is that obese adolescents must lack willpower as they have been unsuccessful. Lapbanding is then viewed as a quick fix that should not be made available to those who, having brought obesity upon themselves, don't deserve such effective, expensive interventions.

As an adolescent physician with little intrinsic belief in surgical solutions for complex problems, why was I supportive of this trial in the first place? First, having run a clinical obesity service for many years, I had become disillusioned with the lack of weight loss from behavioural interventions in extremely obese adolescents. Second, lapbanding was increasingly requested by my patients, some of whom had subsequently had surgery privately and were highly satisfied. At that time, the absence of any randomised controlled trial (RCT) in adolescents meant that there was no safety data I could draw on to inform my patients

Key Points

- 1 Current treatment approaches to severe obesity are largely ineffective.
- 2 New approaches are required.
- 3 Testing new approaches can raise ethical moral challenges

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and their families about the risks and benefits of the procedure. Third, I had world class bariatric surgeons on my doorstep who had led many of the trials that had helped define the risks and benefits of lapbanding in extremely obese adults.

I was also acutely aware of the short window of ethical equipoise in which we could undertake a randomised controlled trial. Growing awareness of lapbanding in the Australian community, largely fuelled by the media talking up its use in adolescents, would soon render a trial impossible because of the inability to recruit a cohort prepared to accept conservative management.

The trial showed that in 14–18-year-old extremely obese adolescents (the mean body mass index (BMI) was just over 40), lapbanding was superior to the intensive life-style intervention in achieving substantial weight loss.¹ It was not, however, without complications; a higher revision rate was required than in adult studies. Importantly, a recent position paper about the role of bariatric surgery in adolescents in Australia and New Zealand now recommends lapbanding be considered for those meeting severity criteria akin to our trial.²

So, why all the negative comments? One explanation may be ignorance about the different types of bariatric surgery. Lapbanding is reversible. Rather than a quick fix, it requires an ongoing commitment to small, well-chewed meals and regular monitoring for the life of the band.

Another explanation might be the lack of appreciation of the seriousness of the social consequences of extreme obesity in adolescence, that in addition to the medical consequences, are only starting to be defined as the juggernaut of extreme obesity rolls through the developmental years.

Such comments might also reflect ignorance about the social and emotional barriers to weight loss regardless of age. Without this knowledge, it is easy to resort to the victim-blaming of 'the simplifiers' and harder to appreciate how a powerful kick-start to weight loss from lapbanding might catalyse a series of changes around these social and emotional barriers to produce longer term changes.

This research also deeply challenges the very core of our long-held commitment to behavioural approaches to weight loss, which I believe is a substantial reason for my colleagues' difficulty in accepting the findings. This is not to deny that a

minority of adolescents in the trial's conservative arm lost a substantial amount of weight or that behavioural approaches are likely to be more successful for those less severely affected.

However, it seems that underpinning these explanations of ignorance and fear, about concerns of misplaced emphasis on treatment or the relative value of different treatments, lie judgemental attitudes about obesity that are held as much by clinicians as the community. Surely, this is what most explains how we can collectively tolerate the lack of comprehensive obesity clinics for children and young people and the lack of substantial investments in obesity prevention that continue to be a feature of most developed nations including Australia. Could it also be that these same judgemental attitudes underpin our discomfort with standard academic approaches that would seek to better understand how to treat obesity in the most severely affected, regardless of age?

Rather than fearing such research, the more we learn about obesity and weight loss, the more ammunition we generate for investment in the full suite of interventions that target communities as well as individuals.

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