INSIDE

Career: Supporting Physician Wellness: Health Care Organizations Seeking — and Piloting — Programs to Help Physicians Manage Their Work-Life Stressors. Pg. 1

Career: Finding Jobs as a Dual Physician Family. Pg. 7

Clinical: Obesity in Adolescents, as published in the New England Journal of Medicine. Pg. 9

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A career in medicine is exciting and challenging. On behalf of the entire New England Journal of Medicine staff, please accept my wishes for a rewarding career.

Sincerely,

Eric J. Rubin, MD, PhD

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Supporting Physician Wellness: Health Care Organizations Seeking — and Piloting — Programs to Help Physicians Manage Their Work-Life Stressors

By Bonnie Darves

Just when organizations were formally recognizing that many of their physicians were seriously struggling with burnout and had started to seek remedies to address the endemic problem, the pandemic hit. The timing could not have been worse, many experts on physician burnout agree, and yet, for the most part, the physician workforce navigated the added stressors of COVID-19 both admirably and competently. Physicians worked in highly functioning teams to save lives, mitigate the virus’ impact on patients, and offer the highest standard of care possible under the circumstances. Many physicians also helped their organizations chart a “survival path” to navigate the operational crises the pandemic unleashed.

Organizations that employ physicians, having witnessed the steep toll that the pandemic on top of burnout took, are understandably concerned about the state of their workforce. Many organizations are actively seeking, developing, and trying out wellbeing improvement programs to help bolster physicians and other clinicians. Health care leaders are recognizing, too, that physicians are hardly exempt from “the great resignation” our country is experiencing among workers.
Numerous approaches are being piloted or implemented, with varying degrees of success. These range from informal offerings such as hospital “wellness wagons” delivering a combination of snacks and cheering-up support and wellbeing days off for residents and fellows, to more structured programs. Examples of formal offerings include buddy systems mimicking military-type “battle buddy” practices, mental-health check-in offerings, and physician coaching resources.

The latter, when provided with anonymity guaranteed, appear to be somewhat effective for those who access them, according to Eileen Barrett, MD, MPH, a hospitalist and educator who formerly directed graduate wellness initiatives at the University of New Mexico (UNM). “Many physicians who have received coaching have benefited, and some organizations have been able to demonstrate real outcomes,” said Dr. Barrett, who now practices with the Indian Health Service and has published on and advocated for national clinician wellbeing improvement strategies. She said that UNM’s mental health check-ins, a “renewable” offering, were also relatively well received — 78 of the 109 physicians who booked appointments when the program launched kept those appointments.

Some organizations, such as Intermountain Healthcare in Salt Lake City, Utah, are trying several approaches simultaneously — developing a physician and advanced practice provider (APP) wellbeing center and dedicated portal and scheduling wellness-focused grand rounds and separate leadership rounds to celebrate successes and learn what clinicians are struggling with in their work. Intermountain also provides a range of peer-support forums and options for connecting caregivers, aimed at offering a confidential forum for sharing emotions.

“My task is to develop resources and learn from others around the country — and at Intermountain, we’re all working on this together to determine what works and what’s not helpful,” said Anne Pendo, MD, an internist who is senior medical director of Provider Experience and Wellbeing at Intermountain. “What we all recognize, I think, is that we as a profession weren’t well before the pandemic,” she said, and that the pandemic further eroded physician resiliency. “Now we have an opportunity to try to discover ways to improve wellbeing and then implement them.”

Peer-support programs taking hold

At Intermountain, of the initiatives piloted to date, the peer-support offerings have been among the most successful in terms of uptake. Peer supporters have trained nearly 100 physicians to serve in the role, and approximately 300 physicians and clinicians have participated. “I think it’s important to position this as ‘I can be a helper’ if you want physicians to get involved and to ensure you offer a safe space for sharing feelings — something physicians have historically struggled with,” she said, because of fear they’ll be perceived as weak.

Researchers and physicians involved in developing wellness-support programs and resources are finding that although it’s challenging to figure out exactly what physicians do need in support, there’s growing consensus on what physicians don’t want: tips and recommendations for improving their personal resilience. In other words, Dr. Barrett said, “Physicians don’t want to hear about another yoga class or meditation practice.”

Heather Farley, MD, chief wellness officer at ChristianaCare in Delaware, which rolled out the “wellbeing wagon” described earlier and created a Center for Worklife Wellbeing, concurred with Dr. Barrett. “What doesn’t work is focusing too much on the personal minutiae, such as sleep hygiene. Whatever you offer has to support physicians “in their work environment,” said Dr. Farley, an emergency medicine physician. Like Intermountain, ChristianaCare has seen a gradual but steady utilization uptake of peer-support offerings. “We’re shifting away from the culture of ‘shame and blame’ to one that says, ‘It’s OK not to be OK,’ and to reach out if you need help,” she said.

At the University of Minnesota, which created the buddy system a few months into the pandemic and rolled out the program in a matter of weeks, the model was predicated on the recognition that Dr. Farley cites: everyone needs help sometimes, and it’s important to know that someone has your back and is willing to help. In the university’s program, modeled in part on both the military-battlefield scenario and observations an anesthesiologist made in the operating room during the early weeks of the pandemic, when staff members were becoming more nervous, buddies are “paired” somewhat strategically. Ideally, they’re close in age, career length, and experience, so that they can both recognize and understand the stressors their buddy is experiencing — and identify when that buddy needs some extra support.

“We decided that the battle-buddy system was a brilliant idea and decided to give it a decent trial,” said Cristina Sophia Albott, MD, who heads the university’s division of adult mental health. “We wrote the protocol in one week, started the program in two weeks, and rolled it out across the
entire medical school.” By July 2020, more than 3,000 health care personnel, primarily physicians and nurses, had adopted and established the model.

Around the same time, the University of Minnesota implemented “listening groups” and established mental-health consultation services in each clinical department. The latter offering, however, despite the appointments being structured as confidential, wasn’t as well received as the buddy program. “Unfortunately, few physicians availed themselves of those offers,” she said.

On a positive note, even though the worst of the pandemic crises appear to have largely receded at the university, some departments have decided to continue with the buddy program, Dr. Albott reported. Although there’s been considerable variation in how individual departments set up or later retooled their buddy programs, the initiative’s early and ongoing success is a clear indicator of the offering’s value, she added.

**Desperately seeking on-the-ground support and remedies**

What physicians do want in the way of support from their organizations, Dr. Barrett and others interviewed for this article agreed, is operational load-lightening, however that can be achieved and institutionalized. Offerings such as onsite childcare and schedule flexibility to address family needs rank high on the wish list for many physicians, and there’s a growing consensus that the electronic health record (EHR) persists as a chief source of physician frustration and stress, despite years of organizations’ attempts to ameliorate the problem.

“What does appear to work is providing physicians protected time for EHR training or having dedicated information technology (IT) support for dealing with EHR-related issues,” Dr. Barrett said, or adding scribes to offload the bulk of EHR-data entry processes. In similar fashion, physicians would appreciate their institutions removing the burden of treatment prior-authorization management. And she noted that the incredibly complex and inordinately inefficient processes related to physician credentialing are ripe for fixing, as they’re unnecessarily burdensome for physicians. “If credentialing were centralized, at least for Medicare, that would go a long way in reducing the burden. Most people think that the system, as it stands, doesn’t really make anyone safer,” Dr. Barrett said.

Health care organizations, concerned about both their physicians’ wellbeing and their facilities’ ability to maintain adequate staffing levels at a time when many physicians are deciding to leave jobs where they don’t feel well enough supported, are taking note. They’re actively trying to figure out what physicians want and need to care for patients with fewer frustrations.

Physician professional organizations are also stepping in to identify what’s needed now in institutional supports to help physicians mitigate burnout and regain resiliency. The American College of Physicians’ Patients Before Paperwork initiative, for example, has identified the most burdensome tasks and regulatory requirements that internists face and offered policy recommendations for reducing associated workload. The American Medical Association has also developed a multifaceted initiative to provide guidance and targeted solutions to health care organizations for many of the problems that threaten physician wellbeing.

In an article published in the *Annals of Internal Medicine* in September 2021, Dr. Barrett and her co-authors proposed a series of steps that organizations might take to reduce clinician burnout, keep physicians in the workforce as the health system continues to navigate COVID-19, and simply make physicians’ practice lives more tolerable. In addition to the COVID-related recommendations for improving physician safety and providing practical support as needed to address system-capacity constraints, the authors urged organizations to do the following:

- Help ensure more flexible scheduling for physicians who are parents or care for aging parents.
- Reduce, eradicate, or reassign administrative tasks and meetings that aren’t mission-critical and haven’t delivered improved patient outcomes.
- Provide no-cost and truly confidential mental-health support services, and also truly encourage physicians to use their available vacation and professional development time to nurture a healthier workplace. At the same time, organizations should update credentialing and employment applications to remove unnecessary questions related to mental and physical health diagnoses to reduce the associated stigma.

Dr. Barrett offers another recommendation to employer organizations. “If you offer resources that might support or improve physician wellbeing, make sure your physicians know about them. Physicians are so stretched and busy that they might not know what’s available,” she said.
Tips for structuring physician-wellness support offerings

All sources who participated in this article offered guidance for organizations trying to provide resources that might help improve physician well-being. Here are a few:

- Understand that each environment is different, which means that the problems and needs might vary widely from one health care organization to another. To develop appropriate solutions and resources, ensure that physicians are directly involved in creating them.

- Avoid focusing resources on individual-physician resilience and instead focus on system approaches that might have the added benefit of helping physicians support one another and reduce unnecessary workload. Keep in mind that some physicians have an innate distrust of “corporate-sponsored” initiatives that appear to be focused on the bottom line.

- Provide a safe forum for physicians to recommend institutional approaches that mitigate the burdens that contribute to burnout and also make their overall work lives more realistically manageable.

- If you try a wellness initiative and it doesn’t produce results that are valuable to physicians, be ready and willing to abandon it. Then be prepared to pilot something else — quickly.

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Finding Jobs as a Dual Physician Family

By Nisha Mehta, MD, a physician leader whose work focuses on physician empowerment, community building, and career longevity in medicine

I’m part of a dual physician family; my husband is a plastic and reconstructive surgeon, and I’m a musculoskeletal radiologist. We’ve been dating since college, and every few years, one of us has had to make accommodations for the other, whether it be regarding medical school, residency, or fellowship. Finding jobs has been no different.

Approaching the job market as a dual physician (or really, any dual working member) family is tricky because you have two members of a family who’ve invested a lot into their education and goals and are now trying to find a geographic location that can accommodate both of those things. Depending on what your interests are, it can feel next to impossible. Let’s say one person has always wanted to incorporate policy work while another really wants to be at an academic institution that has niche expertise in a particular area of research — the city that has both opportunities available may not exist. Incorporate other factors, such as family support or access to interests outside of medicine, and it becomes even more complicated.

Let’s say you’ve narrowed your list down to a few cities, though. How do you approach that job search?

1. **Cast your net as wide as possible.** Forget about the reasons a job won’t work; instead, believe in the reasons why it will. Sometimes jobs that
Obesity in Adolescents
Tamara S. Hannon, M.D., and Silva A. Arslanian, M.D.

A 12-year-old boy with excessive weight gain that began when he was approximately 6 years of age presents for evaluation of obesity. He occasionally rides his bicycle but spends more than 6 hours per day engaging in screen-based activities (e.g., video games and social media). He drinks sugary beverages every day and eats mostly processed foods. His mother has obesity, and his maternal grandmother has type 2 diabetes. His body-mass index (BMI), the weight in kilograms divided by the square of the height in meters) is 41.9 (class 3 obesity, ≥140% of the 95th percentile for his age and sex). The fasting cholesterol level is 202 mg per deciliter (5.23 mmol per liter), low-density lipoprotein (LDL) cholesterol level 127 mg per deciliter (3.29 mmol per liter), triglyceride level 320 mg per deciliter (3.62 mmol per liter), and high-density lipoprotein (HDL) cholesterol level 43 mg per deciliter (1.11 mmol per liter). The glycated hemoglobin is 5.9% (6.8 mmol per liter), which is consistent with prediabetes. The alanine aminotransferase level is 80 U per liter, with hepatic steatosis shown on ultrasonography. How would you manage this case?

Once you’ve got some options that work for both lined up, make sure you both stay active in each other’s processes. It’s easy to get so caught up in your interview process that you both go on your job searches independently. However, your family’s happiness is going to rely on both of your jobs working well together, your significant other’s happiness, and your happiness with each other’s work environments. You presumably know each other better than anyone else, so having each other’s input when making these decisions will be invaluable. So many times at job interviews, I’ve pointed out something my husband didn’t pick up on that would’ve been problematic, and vice versa.

The jobs you pick together are going to shape what your life looks like, so approach this job search as a team. Together, you’ll have a much better shot at creating the life in medicine that you want for your family.
**OBESITY IN ADOLESCENTS**

- Adolescent patients with obesity benefit from evaluation and follow-up according to a long-term care model with attention to and understanding of the societal stigma and pervasive weight bias that exists around obesity.
- Obesity during adolescence is associated with a substantial increase in the risk of concurrent and later health consequences that should be evaluated and treated expeditiously.
- Intensive treatment with regard to health behavior and lifestyle, with at least 26 hours of face-to-face treatment over a period of at least 3 months, is a foundational aspect of the comprehensive treatment of obesity.
- The elimination of sugar-sweetened beverages from the patient’s diet is strongly recommended.
- The use of antirelapse medications or bariatric surgery (or both) along with intensive treatment with regard to health behavior and lifestyle results in a greater reduction in body-mass index than lifestyle treatment alone and should be discussed with families, along with the caveat that weight regain is common, data regarding long-term outcomes are lacking, and these treatments are expensive.

adolescence, as well as in adulthood, to reduce adverse health consequences. The prevalence of obesity in adolescents has increased since the 1980s, most markedly in low-income communities and communities of color, a difference that is at least in part attributable to structural racism and stigma (with negative attitudes creating social and economic obstacles to health). Among the social drivers of obesity is the marketing of unhealthy foods and drinks. In the United States, the prevalence of obesity in the 2015–2016 period was 20.6% among adolescents (as compared with 14.8% in the 1999–2000 period)—22.0% among non-Hispanic Black adolescents and 25.8% among Hispanic adolescents, prevalences that are higher than those among both non-Hispanic White adolescents (14.1%) and non-Hispanic Asian adolescents (11.9%).

Rates of weight gain accelerated during the coronavirus 2019 (COVID-19) pandemic; a retrospective cohort study in California showed an absolute increase in the prevalence of overweight or obesity of 5.2 percentage points among 12- to 15-year-olds and 3.1 percentage points among 16- to 17-year-olds during the first year of the pandemic. Moreover, obesity is among the most common underlying complications for COVID-19–associated death in persons younger than 21 years of age. Obesity interventions are needed to improve health in adolescence and beyond.

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**STRAATEGIES AND EVIDENCE**

**ASSESSMENT**

BMI is strongly associated with adiposity and is a useful clinical tool for assessing overweight and obesity, although its use has limitations. High BMI in some cases reflects increased lean body mass, and in Asian populations, adiposity is increased at lower BMI levels. In adolescents, a BMI at or above the 85th percentile but below the 95th percentile is diagnosed as overweight, and a BMI at or above the 95th percentile is diagnostic of obesity. Class 1 obesity is defined as a BMI at or above the 95th percentile up to 110% of the 95th percentile, class 2 obesity is a BMI at or above 120% of the 95th percentile up to 139% of the 95th percentile, and class 3 is a BMI at or above 140% of the 95th percentile. As an adolescent’s final height is reached, adult thresholds for overweight (BMI, 25) and obesity (BMI, 30) apply. Severe obesity in children is defined as class 2 or 3 obesity or a BMI of 35 or higher.

An evaluation of obesity in an adolescent includes complete medical and medication histories and a family history. The evaluation should include an assessment of obesity-related diseases and lifestyle factors as well as environmental and social factors, a psychosocial assessment that includes screening for depression (with the use of the Patient Health Questionnaire-9 for Teens), and a physical examination (Table 1). Eliding a family history of obesity-related conditions, including premature deaths due to cardiovascular disease or stroke, is important for assessment and discussion of familial risk.

**LABORATORY ASSESSMENT**

Table 2 shows recommendations for laboratory tests in adolescents with obesity, including screening for dyslipidemia and fatty liver disease. Com-
sistent with guidelines of the Pediatric Endocrine Society and the American Diabetes Association, screening for type 2 diabetes is recommended in adolescents who have BMI at or above the 85th percentile and one additional risk factor: family history of type 2 diabetes in a first- or second-degree relative, non-White race or ethnic group, physical signs or conditions associated with insulin resistance (e.g., acanthosis nigricans, hypertension, dyslipidemia characterized by low levels of HDL cholesterol and high levels of triglycerides, and PCOS), gestation complicated by diabetes, or intrauterine growth restriction.21–23 The possibility of autoimmune type 1 diabetes against the backdrop of obesity should be considered, and measurement of diabetes-associated antibodies against glutamic acid decarboxylase, insulinoma-associated protein 2, and zinc transporter 8 is recommended.23 Criteria for the diagnosis of diabetes and prediabetes are shown in Table 2. Glycated hemoglobin testing is a poor predictor of elevated fasting glucose levels and 2-hour results of an oral glucose-tolerance test and may be insufficient to diagnose early type 2 diabetes or accurately reflect prediabetes.2 In patients with multiple risk factors for type 2 diabetes and a glycated hemoglobin level of 5.7% to less than 6.5% (6.5 to <7.8 mmol per liter), an oral glucose-tolerance test is useful for detection of early type 2 diabetes.22 Additional evaluations rely on clinical findings (Table 2).23 Persistently elevated levels of liver enzymes (for >3 months) may prompt further evaluation for nonalcoholic fatty liver disease.24 Laboratory evaluations for endocrine disorders that are associated with increased adiposity, including hypothyroidism and Cush- ing’s syndrome, are not recommended unless there is growth attenuation or other clinical indications. In addition, the measurement of insulin concentrations to evaluate insulin resistance adds no diagnostic value and is not recommended. The diagnosis of suspected genetic obesity syndromes requires medical genetics evaluation and often additional workup, including karyotype analysis and DNA methylation studies.25 Although only a small percentage of cases of pediatric obesity are attributable to a mono- genic cause, testing for monogenic causes of obesity is indicated in cases of insatiable appetite and severe obesity in children younger than 5 years of age.

** MANAGEMENT **

Management of obesity in adolescents should use a multidisciplinary long-term care model that includes attention to lifestyle modification and consideration of pharmacologic and bariatric surgical therapies (Tables 3 and 4).26 Communication should be considerate of the stigma associated with the term “obesity,” and the use of person-first language (i.e., “person with obesity” rather than “obese person”) and preferred terms such as “too much weight for age (or health or height)” is important.27 Motivational interviewing may be useful as part of a multidisciplinary approach; a meta-analysis of 11 randomized trials assessing the use of this technique in adolescents with obesity indicated some positive effects on nutrition, physical activity, and quality of life, although with no significant reductions in BMI or cardiometabolic outcomes.28 Patients with symptoms of depression or other mental health disorders should be referred to a behavioral health provider.

** Lifestyle interventions **

Summary data from randomized, controlled trials of lifestyle treatment approaches indicate that interventions that offered at least 26 hours of face-to-face counseling regarding nutrition, physical activity, and lifestyle recommendations resulted in, on average, modest but clinically important changes in the mean BMI z score (at least −0.15 to −0.25; the z score represents the number of standard deviations by which the BMI differs from the mean in a reference sex- and age-matched population). Evidence was not adequate to support the recommendation of treatment with less intensive interventions (Table 3).29

** Dietary interventions **

Sugar-sweetened beverages, the leading source of added sugars in the diets of children and adolescents in the United States, contribute to obesity and additional health risks in adolescents and should be eliminated from the diet, given that such beverages lack any nutritional value.28 A meta-analysis of prospective observational studies indicated that over the course of 1 year, each additional 12-oz (0.35-liter) daily serving of sugar-sweetened beverage was associated with a BMI increase of 0.06 (95% confidence interval, 0.02 to 0.10, as calculated with the use of a random-effects model).29

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**Table 2. Laboratory Assessment of Adolescents with Overweight or Obesity.**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Diagnostic Criteria</th>
<th>Recommended Evaluation</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| Prediabetes and diabetes | Fasting plasma glucose level >100 mg/dl (≥5.6 mmol/liter) OR 2-hour result of an oral glucose-tolerance test ≥200 mg/dl (≥11.1 mmol/liter) | Fasting plasma glucose level, oral glucose-tolerance test 2-hour results of an oral glucose-tolerance test | Check glycated hemoglobin testing recommended at ≥10 yr of age  
Diabetes: symptoms (polyuria, polydipsia, weight loss) and random plasma glucose level ≥200 mg/dl (≥11.1 mmol/liter) |
Dietary patterns that emphasize plant-based foods (i.e., vegetables, fruits, and whole grains), lean sources of protein, high fiber intake, and low consumption of saturated fat are associated with better cardiometabolic risk profiles. Ketogenic diets, which are used for treating some seizure disorders in children, have been incorporated in some obesity treatment programs for adolescents indicate that benefits with regard to weight loss of 7 to 9% of the baseline body weight at 3 to 4 months of follow-up. However, these programs have substantial attrition, and there are insufficient data to inform long-term outcomes with these diets or with low-carbohydrate diets in adolescents.

Supervised marked caloric restriction (very-low-calorie diets) for weight loss in adolescents is not recommended. Studies have shown mixed results with the use of these diets; weight regain is typical, and there are concerns regarding long-term acceptability and safety, including risks of eating disorders, electrolyte or other metabolic disturbances, vitamin and mineral deficiencies, and adverse psychological effect. Although social emphasis on patient-imposed restrictive dietary behaviors is associated with a risk of disordered eating, supervised multidisciplinary weight management and treatment of obesity with ongoing support from a pediatrician, pediatric dietician, and mental health professional are not associated with an increased risk of eating disorders. Physical Activity Interventions

Dose–response studies of physical activity in adolescents indicate that benefits with regard to adiposity and cardiorespiratory and cardiometabolic measurements are observed with a daily average of 60 minutes of physical activity at a moderate-to-vigorous level of intensity. Randomized trials of supervised interventions of shorter durations of moderate-to-vigorous aerobic exercise or combined aerobic and strength training (median, 3 days per week for 40 minutes per session) have also been shown to result in clinically significant cardiometabolic benefit and reductions in percent body fat (by approximately 5 to 6%).

Multidisciplinary Interventions

A review of 26 randomized, controlled trials of multidisciplinary interventions of varying content (combinations of diet, physical activity, and behavior modification) and duration without pharmacotherapy in 2774 adolescents with obesity indicated only limited efficacy, with a mean differ-

### Table 3. Management of Obesity in Adolescents.

#### Nutrition recommendations

- Eliminate sugar-sweetened beverages and juices and decrease highly processed foods (e.g., fast foods) and snacks. Follow dietary patterns that emphasize plant-based foods, lean sources of proteins, high levels of fiber, and low levels of saturated fat. Eat regular meals, avoid snacking, and control portion sizes; parents should role-model eating behaviors, preparing meals at home, and eating together; avoid having calorically dense, nutritionally empty foods at home.

- Sedentary behavior and physical activity recommendations

- ≥2 Hr per day of screen time outside of school and work.
- 60 Min of moderate-to-vigorous physical activity daily.

#### Antioxidity medications

In adolescents ≥12 years of age, consider use of antioxidant medication, according to medication indications, risks, and benefits, as an adjunct to health behavior and lifestyle treatment.

**Bariatric surgery**

Consider in adolescents ≥13 years of age with severe obesity: class 2 obesity, BMI ≥35, or 120% of the 95th percentile for age and sex, whichever is lower, and a clinically significant coexisting condition; or class 3 obesity, BMI ≥40, or 140% of the 95th percentile for age and sex, whichever is lower, with or without a clinically significant coexisting condition. Ensure that adolescents are able to adhere to principles of dietary and medical recommendations and do not have an eating disorder. Refer to a center with a surgeon experienced in pediatric bariatric surgery and a comprehensive, multidisciplinary program for presurgical, surgical, and postsurgical care with long-term follow-up.

### Table 4. Approved Antiobesity Medications for Use with Intensive Behavioral and Lifestyle Therapy.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Age for Use</th>
<th>Mechanism</th>
<th>Dose</th>
<th>Common Side Effects</th>
<th>Serious Adverse Events and Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orlistat</td>
<td>≥12</td>
<td>Lipase inhibitor</td>
<td>120 mg (oral) 3 times daily with meals</td>
<td>Bowel urgency, diarrhea, flatulence with rectal leakage</td>
<td></td>
</tr>
<tr>
<td>Phentermine</td>
<td>≥12</td>
<td>Amphetamine analogue; increases catecholamines and serotonin; suppresses appetite</td>
<td>Daily dose for age 4.5 to 7.5 mg short-term (1 wk) or ≥7.5 mg long-term (up to 1 year)</td>
<td>Headache, nausea, palpitations, restlessness, dizziness, insomnia</td>
<td></td>
</tr>
<tr>
<td>Topiramate</td>
<td>≥13</td>
<td>Anticonvulsant</td>
<td>25–100 mg/day divided therapy with XR (up to 400 mg/day) or extended-release</td>
<td>Headache, nausea, dizziness, fatigue, gastrointestinal symptoms: constipation, dyspepsia, abdominal pain</td>
<td></td>
</tr>
<tr>
<td>Liraglutide</td>
<td>≥12</td>
<td>GLP-1 receptor agonist</td>
<td>1.2 mg once weekly for 0.5 mg daily to a target dose of 3 mg daily over 4 wk (0.5 mg, 1 mg, 1.7 mg)</td>
<td>Diarrhea, nausea, vomiting, constipation, dyspepsia</td>
<td></td>
</tr>
<tr>
<td>Semaglutide</td>
<td>≥12</td>
<td>GLP-1 receptor agonist; delayed gastric emptying, increased appetite</td>
<td>Daily dose varies according to age (0.5 to 3 mg) and is adjusted to effect (as side-effect profile indicates) over 4 wk (0.5 mg, 1 mg, 1.7 mg)</td>
<td>Nausea, vomiting, diarrhea, constipation, abnormal weight gain</td>
<td></td>
</tr>
<tr>
<td>Setmelanotide</td>
<td>≥6</td>
<td>Melanocortin receptor agonist</td>
<td>Daily dose varies according to age (0.5 to 3 mg) and is adjusted to effect (as side-effect profile indicates) over 4 wk (0.5 mg, 1 mg, 1.7 mg)</td>
<td>Hypocalcemia, hypokalemia, postural hypotension, psychiatric reactions (including suicidal ideation and depression)</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- The new england journal of medicine
- Dietary patterns that emphasize plant-based foods (i.e., vegetables, fruits, and whole grains), lean sources of protein, high fiber intake, and low consumption of saturated fat are associated with better cardiometabolic risk profiles.
- Ketogenic diets, which are used for treating some seizure disorders in children, have been incorporated in some obesity treatment programs for adolescents and have shown short-term safety and efficacy (weight loss of 7 to 9% of the baseline body weight at 3 to 4 months of follow-up). However, these programs have substantial attrition, and there are insufficient data to inform long-term outcomes with these diets or with low-carbohydrate diets in adolescents.
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**Clinical Practice**

**Table 3. Management of Obesity in Adolescents.**

**Nutrition recommendations**

- Eliminate sugar-sweetened beverages and juices and decrease highly processed foods (e.g., fast foods) and snacks.
- Follow dietary patterns that emphasize plant-based foods (e.g., vegetables, fruits, whole grains), lean sources of protein, high levels of fiber, and low levels of saturated fat.
- Eat regular meals, avoid snacking, and control portion sizes; parents should role-model eating behaviors, preparing meals at home, and eating together; avoid having calorically dense, nutritionally empty foods at home.

**Sedentary behavior and physical activity recommendations**

- ≥2 Hr per day of screen time outside of school and work.
- 60 Min of moderate-to-vigorous physical activity daily.

**Antioxidity medications**

In adolescents ≥12 years of age, consider use of antioxidant medication, according to medication indications, risks, and benefits, as an adjunct to health behavior and lifestyle treatment.

**Bariatric surgery**

Consider in adolescents ≥13 years of age with severe obesity: class 2 obesity, BMI ≥35, or 120% of the 95th percentile for age and sex, whichever is lower, and a clinically significant coexisting condition; or class 3 obesity, BMI ≥40, or 140% of the 95th percentile for age and sex, whichever is lower, with or without a clinically significant coexisting condition. Ensure that adolescents are able to adhere to principles of dietary and medical recommendations and do not have an eating disorder. Refer to a center with a surgeon experienced in pediatric bariatric surgery and a comprehensive, multidisciplinary program for presurgical, surgical, and postsurgical care with long-term follow-up.
ence in BMI of 1.18 with intervention as compared with control after at least 6 months of follow-up. Although participants reported high levels of satisfaction with the interventions and improved quality of life, the potential effect of self-reporting bias, attrition, and variable adherence on overall outcomes of multidisciplinary interventions is difficult to assess.

Antibesity Medications

The addition of approved weight-loss medications has improved the outcomes of multidisciplinary weight-loss programs in clinical trials. Antibesity medications that have been approved by the Food and Drug Administration for use in adolescents are shown in Table 4. Orlisat, a lipase inhibitor, is associated with flatulence, oily spotting, and fecal urgency and incontinence—side effects that limit use in adolescents. Phentermine, an amphetamine analogue that suppresses appetite, is approved for short-term (612 weeks) in adolescents older than 16 years of age and is approved in combination with topiramate in adolescents at least 12 years of age when accompanied by counseling that topiramate is a teratogen and information regarding appropriate contraception.

Randomized, placebo-controlled trials have shown the effectiveness of two glucagon-like peptide 1 (GLP-1) receptor agonists—liraglutide and semaglutide—in adolescents when combined with lifestyle therapy. In one placebo-controlled trial, liraglutide administered subcutaneously at a dose of 3 mg daily resulted in greater reduction in the BMI (estimated difference, –4.6%) and body weight (estimated difference, –4.5 kg) at 50 weeks of treatment. In another controlled trial, semaglutide (administered subcutaneously at a dose of 2.4 mg once weekly) resulted in greater reduction in BMI (–16.7%) and body weight (–177 kg) at 68 weeks, as well as greater reductions in waist circumference and levels of glycated hemoglobin, lipids (except HDL), and alanine aminotransferase. Both agents are approved for indefinite use in adolescents 12 years of age and older. The major adverse effects are gastrointestinal symptoms; key contraindications include a personal or familial history of medullary thyroid carcinoma, acute kidney injury, gallbladder disease, or pancreatitis. Metformin is frequently administered off-label for obesity in adolescents. In a meta-analysis of 38 randomized trials involving children or adolescents (2199 participants; mean age, 13.7 years; daily dose range, 500 to 3000 mg; duration, 12 to 192 weeks), metformin reduced the mean BMI by 1.1 as compared with controls. Topiramate, an anticonvulsant that is used for migraine prophylaxis, is also prescribed off-label for obesity treatment as needed. If surgical intervention is considered, the overall outcomes of multidisciplinary interventions are consistent with these guidelines, with the acknowledgment that the costs and limited access to these therapies and the inadequacy of long-term outcomes data for medication use are major barriers.

Bariatric Surgery

In a cohort study involving adolescents, bariatric surgery (Roux-en-Y gastric bypass and vertical sleeve gastrectomy) was associated with weight loss and BMI changes. In one study, the use of weight loss at 5 years (Table 3). Remission rates 5 years after surgery were approximately 80% for type 2 diabetes and 68% for hypertension. A randomized, controlled trial of surgical treatment as compared with nonsurgical treatment (8 weeks of low-calorie diet) in Sweden showed a 2-year change in BMI of –12.6 and –0.2, respectively. Most posturgical complications are mild, but up to 8% of adolescents have major perioperative complications. Long-term complications include deficiencies in nutrients (e.g., iron, vitamin B12, and folate), reduced bone mass, and amenorrhea. The incidence of alcohol-use disorders has also been reported to be higher among adolescents after metabolic and bariatric surgery, although whether the disorders occur more commonly in adolescents with obesity who undergo surgery than in those who do not is unclear. Weight regain after surgery varies; approximately 60% of adolescents who were followed for 5 years after undergoing gastric bypass maintained a reduction from the baseline body weight of at least 20%, whereas 8% regained at least 95% of the initial weight loss. Important predictors of weight regain among adolescents after surgery include younger age and lack of presurgical weight loss.

A REAS OF UNCERTAINTY

Questions remain with regard to why the prevalence of obesity continues to increase and the effects of environmental drivers (e.g., pollution and polyfluoroalkyl substances). The extent to which the increasing use of antiobesity medications (including more potent medications, such as dual-agonist peptides [tirzepatide], that are currently being investigated) and bariatric surgery for obesity during adolescence will increase the proportion of adolescents who reach and maintain reduced BMIs is unknown, given the threshold that 60% of adolescents have a substantial weight regain that occurs when antiobesity medications are discontinued for any reason. Lifelong treatment of obesity is needed but is burdensome and cost-prohibitive, with disparities in access. Long-term data regarding treatment effectiveness and safety, including mental health outcomes, are needed to determine benefit–risk ratios. More than 26% of adolescents are overweight, with an anticonvulsant that is used for migraine prophylaxis, is also prescribed off-label for obesity treatment as needed. If surgical intervention is considered, the overall outcomes of multidisciplinary interventions are consistent with these guidelines, with the acknowledgment that the costs and limited access to these therapies and the inadequacy of long-term outcomes data for medication use are major barriers.

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Prior experience with the VA Healthcare System is highly preferred; additionally, the Louis Stokes VA is also a Spinal Cord Injury Hub and preferred candidates will also demonstrate experience with infections in patients in acute and long-term residential spinal cord injury units. As the facility possesses an attached skilled nursing facility, experience or certification in geriatric infections of Veterans in long-term care facilities will be highly considered. Academically engaged candidates with prior presentations at national meetings and willingness to participate in the education of nurse practitioners, fellows, residents and medical students are strongly encouraged. The Cleveland VA Medical Center is a teaching affiliate of Case Western Reserve University. The successful candidate will be appointed at Case Western Reserve University School of Medicine at an academic level commensurate to their experience. Preferred candidates will have completed three years of Internal Medicine training in an accredited program, as well as a fellowship in Infectious Diseases. Board-Certified candidates with prior presentations at national meetings and community organizations to help patients to connect to the care they need, no matter where they are located in the rural Berkshire County. As the largest employer in Berkshire County, BHS supports patients in the immediate Cleveland area as well as a fellowship in Infectious Diseases. Board-Certified candidates with prior presentations at national meetings and community organizations to help patients to connect to the care they need, no matter where they are located in the rural Berkshire County. As the largest employer in Berkshire County, BHS supports patients in the immediate Cleveland area as well as several surrounding rural communities, through both face-to-face and virtual modalities. The qualified candidate may also assume administrative oversight of an active outpatient IV therapy program in conjunction with a pharmacy care coordinator.

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The Kaiser Permanente Center for Black Health and Wellness is equity in action. It's another important step in our commitment to equity, inclusion, and diversity— and I can't wait to see it come to life as soon as possible. I'm proud to be part of this effort and part of an organization where eliminating health care disparities is a high priority.

— Jane Akpamgbo, MD

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**Minimum Requirements:**
1. Must be board certified or eligible in Internal Medicine by date of hire.
2. Experience/interest in medical education and quality improvement.
3. Experience in management and administration at a major medical institution.
4. Preference will be given to current and former New Mexico Residents, and those who are interested in practicing in the Mountain West.

**Preferred Qualifications:**
- Attended a US Medical school as a third and fourth year medical student OR served at least two years in a residency, internship, fellowship, or an equivalent-accredited medical school.
- Experience in management and administration at a major medical institution.
- Experience in medical education and quality improvement.
- Experience in management and administration at a major medical institution.
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**Highly Desirable qualifications include:**
- Experience in management and administration at a major medical institution.
- Experience in medical education and quality improvement.
- Experience in management and administration at a major medical institution.
- Preference will be given to current and former New Mexico Residents, and those who are interested in practicing in the Mountain West.

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For complete description and application requirements for Posting Requisition 21106 please see the UNM jobs application system at: https://unmjobs.unm.edu

The positions are open until filled.
Inquiries may be directed to Dr. Deepti Rao, Professor, Division of Hospital Medicine, Department of Internal Medicine, University of New Mexico, 1250 Medical Center Drive, B319, Albuquerque, NM 87131, Att: (Drao@salud.unm.edu).

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If you would like more information please contact:

Diane Forte Willis
dfortewillis@emersonhosp.org
phone: 978-287-3002
fax: 978-287-3600

About Concord, MA and Emerson Health

Our core mission is to deliver exceptional, patient-centered care that is highly reliable, safe, compassionate, equitable, efficient and coordinated. While we provide most of the services that patients will ever need, the hospital’s strong clinical collaborations with Boston’s academic medical centers ensures our patients have access to world-class resources for more advanced care.

Located just 20 miles northwest of Boston in historic Concord, Massachusetts—known for its rich history, revolutionary war sites and many famous authors—Concord is a great place to raise children with top-ranked public and private schools.

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