

## COMMENTS AND RESPONSES

## Effect of Allowing Choice of Diet on Weight Loss

**TO THE EDITOR:** We applaud Yancy and colleagues' trial examining the effect of diet choice on weight loss (1). The trial's focus on behavioral determinants is a refreshing contrast to the many prior comparison studies of diets that have failed to support the superiority of any 1 particular diet for weight loss (2).

The hypothesis for this trial was that patient choice (low-fat versus low-carbohydrate) may promote diet adherence and therefore improve weight loss compared with random assignment to a diet (3). On the basis of the lack of a difference in weight loss between the choice and assigned diet groups, the authors conclude that "the opportunity to choose a diet did not improve weight loss." However, patients' diet choices seem to have been made only after they received counseling by interventionists to choose the diet most consistent with their dietary preferences, which were assessed at enrollment. Indeed, more than 70% of participants in the choice group chose the diet that matched their food preferences. Although providing information that enables patients to make an informed choice is consistent with shared decision making, actively promoting concordance between one's food preferences and diet plan may have skewed the decision-making process. We do not know what choice the participants would have made without counseling or with a different counseling approach. In fact, one could argue for counseling participants toward the opposing perspective of choosing a diet plan that minimizes exposure to temptation from preferred foods. The fact that most participants in the choice group aligned their diet plans with their food preferences suggests that the effects of choice and the counseling procedures were conflated.

It is also noteworthy that participants' food preferences were categorized on the basis of macronutrient content. Whether human food preferences strongly cluster according to macronutrient content rather than other factors, such as palatability, texture, sweetness versus savoriness, flavors, or form, is unknown. Although the proportion of participants classified into high-carbohydrate and high-protein preference groups is reported, the strength of these preferences is not. Because diet choice seems to have been intentionally tied to macronutrient preferences, the lack of differences between the choice groups may simply reflect a lack of strong macronutrient preferences.

Yancy and colleagues' investigation underscores the need for behavioral research that sheds light on the factors driving choice that actually lead to improved dietary adherence and weight loss; otherwise, it is difficult to know how to counsel patients on making an informed choice.

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**IN RESPONSE:** We agree with Drs. Pagoto and Appelhans that the effects of choice and the counseling procedures were conflated—indeed, this will always be the case if counseling is provided to a person faced with a choice. To clarify our study procedures, however, participants were not advised to select "the diet most consistent with their dietary preferences." Instead, we encouraged them to use all information provided and any additional information they obtained on their own when making their choice; in addition, although food preference information was provided, participants were explicitly informed that they could choose a diet consistent with or opposite to their food preferences. This is evidenced by the 29% who selected the diet that was not most closely aligned with their preferences. Furthermore, when asked the reason for their diet selection, participants rated several factors as having similar or greater importance than food preferences, including perceptions of effectiveness and the description provided (1).

We also agree that other factors besides macronutrient content may drive food preferences. As such, we described the diets in detail to participants, listing potential food items and menus for each diet. Therefore, the participants received a comprehensive picture of the 2 diets on which to base their decision that used any food preference factors (or other factors, such as health, cost, and convenience) that were important to them.

Finally, we wholeheartedly agree that more data are needed on the factors "driving choice that actually lead to improved dietary adherence and weight loss" and are currently doing follow-up analyses to answer that question.

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**Letters**

**TO THE EDITOR:** Carolla's essay (1) on the importance of physician-written letters to patients' families touched my heart and inspired reflection. Narratives of clinicians taking the time to contemplate and show value for patients in the form of a letter are notable. One example is a letter written to the family of a woman with breast cancer that was picked up by CBS and other national syndicates after the woman's son posted it online. It went viral (2). The positive public reaction, in addition to the private reactions of families who receive similar letters, shows the effect that a few moments of "above-and-beyond caring" can have. Patients' responses are consistent with the desire to know that they are seen as individuals and are valued as such by their clinical teams, even (especially) in an era of an overwhelmed health care system and frequently burned-out clinicians. Perhaps, like self-care, showing thoughtful caring for others at a human-to-human level is needed most when time seems to be inadequate and stress levels are high.

A growing body of evidence points to a "reflective practice" as 1 method to keep burnout at bay and promote self-aware, resilient professionals (3, 4). Carolla's essay will be added to a portfolio of resources used with my medical students to deepen their understanding of the value of reflective writing. This value includes the ability to enhance the bond among physicians, patients, and family through caring, written communication, as well as for the clinician's own well-being and resilience. I am certain that Carolla's letters to his patients' families support healing. His example will serve to inspire the next generation of physicians at the University of Arizona College of Medicine—Phoenix and beyond.

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**IN RESPONSE:** I appreciate Dr. Hartmark-Hill's kind comments about my essay. I am touched that it may be a tool to inspire

future physicians. Nearly 40 physicians have taken the time to communicate their comments to me—mostly by e-mail but also with handwritten notes and letters. I have heard from oncologists as well as other subspecialists. All comments have been positive. I am truly stunned by the response. Clearly, the article has struck a chord with many. In a sense, it went viral, *Annals* style!

Of course, our patients desire state-of-the-art care. This is what our training is all about, and this is what most of us are prepared to deliver. What the physician often overlooks is that patients also crave recognition that they are human beings with the right to be treated with kindness and respect. Physicians have a duty to convey that they care for their patients' total well-being. The technology, impersonality, and endless delays of oncology treatment can be off-putting to even the most sophisticated and terrifying for many. In the process of delivering the best technical care, physicians may lose sight of their patients' humanity—and their own.

The letter is a simple, low-tech way to aid the family as they cope with the loss of a loved one, and that is its primary purpose. Writing it is an active way to provide closure for physicians and to say goodbye to persons with whom they may have become close. I applaud Dr. Hartmark-Hill's observation that it can also be a time for physicians to privately reflect on the care that they have delivered and ask a few critical questions of themselves: Did I give the best care possible? What could I have done differently? What have I learned from this patient and family? Did I provide for the emotional needs of the patient and family? At the end, did I help my patient cope with the fear of death?

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**OBSERVATION****On-Demand Delivery of Influenza Vaccination**

**Background:** Engaging young, healthy persons in primary prevention can be difficult. For example, vaccination remains the single best option for preventing influenza; however, only approximately 30% of adults aged 18 to 49 years receive the vaccine (1). Many factors contribute to this problem, but geographic accessibility, availability at convenient times, and perceived ease of vaccination may increase coverage (2-4). Because of these circumstances, pharmacies are increasingly important sites for vaccine distribution (1); nevertheless, many persons remain unvaccinated. New options for making influenza vaccination available might reach some persons who would otherwise go unvaccinated.

**Objective:** To describe a vaccination effort that was designed to appeal to persons for whom convenience is especially important.

**Methods:** In 2014, HealthMap Vaccine Finder, an organization that connects the public to local vaccine providers through a searchable online map, and Uber, a mobile appli-

cation that connects riders and drivers, created UberHEALTH, a 1-day opportunity on 23 October in Boston; New York City; and Washington, DC, and on 16 November in Chicago (5). Users could request delivery of influenza prevention packs to their home or office with the option for a nurse to administer 1 to 10 doses of influenza vaccine. Registered nurses were arranged through Passport Health, a company with clinics that provide travel medicine and immunization services in most urban locations in North America, and Pager, a company in New York City that provides medical services at the patient's site for common illnesses and minor injuries. The program was publicized using e-mail messages to application users; blog posts; and social media, such as Facebook and Twitter. Vaccine delivery and administration were free, and the application donated \$5 for each request to the American Red Cross for childhood vaccinations. Interested persons in Chicago; Boston; and Washington, DC, were invited by e-mail to complete a 4-question online survey.

**Findings:** Vaccines were requested at 2378 sites, and nurses vaccinated 2057 persons. Of the 2024 persons who were sent surveys, 486 (24%) completed and returned them. Respondents indicated that they were definitely likely (30.2%), somewhat likely (50.0%), or definitely not likely (19.8%) to receive the vaccine from traditional providers and that the delivery of the vaccine was very important (78.2%), moderately important (15.6%), or not important (6.2%) to their decision to be vaccinated.

**Discussion:** We conceived of this effort as a proof of concept. We believe that the results show that such an effort is feasible because of the availability of new information technology and the new organizations that the technology makes possible. They also indicate that substantial numbers of persons who are willing to be vaccinated against influenza but are deterred by inconvenience will participate in a program that provides vaccination when and where they want it. Whether such efforts are practical depends on cost-effectiveness, scalability, and other considerations that we did not address. If these types of programs are shown to be prac-

tical, we imagine them being useful when near-complete immunization of the population is necessary to prevent circulation of an infectious agent, especially one with severe consequences.

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