

when atrial fibrillation develops in patients, particularly those who are young and active, there is a reduction in the quality of life, which improves with both rate control and restoration of sinus rhythm. I believe a physiologic rhythm and a physiologic rate have additive benefit.

The point I was making in my editorial was that an effective and safe antiarrhythmic agent would meet an unmet need and make the rhythm-control approach more attractive.

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Shattuck Lecture: Improving American Health

TO THE EDITOR: In his Shattuck Lecture on improving American health, Schroeder (Sept. 20 issue)¹ argues that the low U.S. international ranking in health can be attributed primarily to behaviors such as tobacco use and overeating. He suggests that expanding efforts to change these behaviors represents the best hope for improving health. However, changing the policies that promote unhealthy behavior and lifestyles may be more effective than seeking to alter habits one person at a time.² For example, each year, the tobacco, food, and alcohol industries spend billions of dollars to persuade Americans to consume their products in ways demonstrated to cause illness and premature death.³ The automobile, firearms, and pharmaceutical industries hire thousands of lobbyists and contribute tens of millions of dollars to encourage legislators to resist or weaken legislation that would impose more stringent health safeguards on their products.^{4,5} Voters and physicians should insist that the government protect public health against the special interests that profit from the lethal but legal products that impose such a heavy burden. Only then will the United States achieve the improvements in health that Schroeder advocates.

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TO THE EDITOR: Schroeder provides a timely reminder that being a superpower does not necessarily translate into being a healthy nation. He rightly points out that intervening in smoking and obesity will probably yield the most health gains. Similarities between the two are obvious, yet putting obesity among behavioral causes of poor health can confuse the public health agenda. Factors associated with obesity are the product of lifestyle changes that are driving the behaviors of whole populations. These lifestyles are shaped by wider socioeconomic and developmental trends (e.g., food commercialism, urban development, and international trade). As such, obesity from the etiologic and interventional standpoints belongs to the environmental sector of population health. This has important implications for intervention, especially in light of the failure of most behavioral programs targeting obesity and the apparent inability of the health care system to respond to such a colossal epidemic.^{1,2} Apparently, solutions will ultimately lie in public health policies that will create environments in which healthy lifestyles will not only be the most rational but also the most affordable and profitable for people.

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TO THE EDITOR: Schroeder's assertion that injury from secondhand exposure should not be considered "a peril that attends obesity" is puzzling and contradicts the observation that persons who observe weight gain among their social contacts more readily accept weight gain themselves.¹ It also affects us in other "secondhand" ways. For example, in the 2004 advisory circular of the Federal Aviation Administration (FAA) on aircraft weight and balance control,² standard weight had to be increased by 11 lb (5 kg) for men and by 18 lb (8 kg) for women. That this was not considered a trivial matter is evidenced by the FAA's statement that a recent airplane crash was, in part, attributed to overweight passenger load.² Obesity was indicated as a contributing cause in the capsizing of a boat on Lake George that resulted in 20 deaths.³ The boat capacity was computed from an average weight of 140 lb (64 kg) — a number left behind by most Americans many Twinkies ago. Obesity not only affects the bearer but may cause injury from secondhand exposure as well.

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TO THE EDITOR: Schroeder argues that "the pathways to better health do not generally depend on better health care" and claims that improved public health "is more likely to come from behavioral change than from technological innovation." In particular, he suggests more aggressive measures in the fight against fat, including taxes, food-stamp restrictions, and mandated advertising campaigns against unhealthy diets.

Although no one disputes the untoward effects of a widening waistline, whether individual decisions about eating — as well as other forms of private, personal conduct — ought to be further medicalized and subject to additional government

intervention is less obvious. Undoubtedly, important gains are to be had from optimized behaviors, but at what price? Is the cost of becoming "number one in health" best measured in dollars or liberties? Does the doctor's practice stop at the office door or the refrigerator door?

Perhaps it is time for physicians to reconsider the boundaries of their profession. Yes, "we can do better," but should we?

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THE AUTHOR REPLIES: My Shattuck Lecture contained three central messages: the United States lags behind other developed countries in the health of its people; in order for improvement to occur, efforts must concentrate on the health of the poor; and the best prospects for such improvement are combating smoking and obesity and physical inactivity. Though I received many responses online about the first two messages, the four letters comment only on the third. Freudenberg argues that policies aimed at the tobacco and food industries hold more promise than individual approaches. In my lecture, I addressed policies that have worked in tobacco control and could potentially work for obesity. I agree that the food and tobacco industries will oppose these policies and that public health and clinical champions should support them.

Maziak contends that the causes of obesity are environmental, not behavioral, and calls for environmental solutions. The same argument could be made for smoking, which is so heavily influenced by the \$15 billion annual marketing efforts of the tobacco industry. Maximal improvement will come from coupling environmental strategies with individual clinical efforts.

Messerli and Greenberg assert that tobacco use and obesity cause similar collateral damage to others. I disagree. The Surgeon General estimated that 50,000 of the 440,000 annual deaths from tobacco use are caused by exposure to secondhand smoke.¹ Whether you believe the Centers for Disease Control and Prevention's high estimate of deaths from obesity (365,000 per year)² or its much lower estimate (112,000 deaths per year),³ neither cites any deaths from secondhand obesity. Furthermore, there is no advocacy group against obe-

sity comparable to Americans for Nonsmokers' Rights.

Lott expresses the libertarian view that physicians and governments should stay out of attempts to change individual behavior, even if that behavior is harmful. The same argument could be made for mandatory use of seat belts in automobiles and helmets for motorcycle riders, drunk-driving legislation, and the use of fluoride to combat dental caries.⁴ In the case of tobacco use and obesity, I would be more sympathetic to Lott's argument were it not for the huge marketing efforts of the tobacco and food industries, which, if unopposed, would be even more influential than they already are. Although I agree that clinical efforts should avoid coercion and stigmatization, I come

down on the side of urging clinicians to do all they can to improve the health of the public.

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Control of Neglected Tropical Diseases

TO THE EDITOR: Hotez et al. (Sept. 6 issue)¹ present an excellent review of current global approaches to neglected tropical diseases. However, vigilant ongoing (post-intervention) surveillance to ensure that these diseases do not rebound should not be ignored. The integration of disease-control programs using a "rapid-impact package of drugs" is a feasible and probably cost-effective way to improve the quality of life for billions of people. The authors advocate monitoring and evaluation to judge the success of these programs but do not emphasize ongoing surveillance. Although surveillance may present a resource challenge in many environments, it also poses a statistical challenge as these heterogeneously distributed parasitic diseases become less common. A comprehensive, integrated surveillance plan should be incorporated into the cost estimates for the control or elimination of neglected tropical diseases. New approaches for determining the burden of these diseases as they become less prevalent should include improved diagnostic tools and novel epidemiologic techniques.

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1. Hotez PJ, Molyneux DH, Fenwick A, et al. Control of neglected tropical diseases. *N Engl J Med* 2007;357:1018-27.

THE AUTHORS REPLY: Huppertz and Durrheim comment on the need for surveillance. For the neglected tropical diseases, control and surveillance strategies are determined by the epidemiology and by the precise objectives of the intervention. For example, human African trypanosomiasis was controlled yet resurged during the period from the 1960s to the 1990s in Angola, Democratic Republic of the Congo, and Sudan, because surveillance stopped, health systems collapsed, and the mobile-team approach was abandoned.¹ Today, human African trypanosomiasis is again under control, and effective surveillance is crucial in order to avoid a new resurgence. In contrast, soil-transmitted helminthiasis and schistosomiasis require regular preventive mass chemotherapy to reduce severe morbidity, and subsequent monitoring of lot quality assurance sampling is enough.^{2,3} With lymphatic filariasis, onchocerciasis, and trachoma, surveillance after control must monitor reduction of transmission. The critical tools referred to by Huppertz and Durrheim are being developed or deployed. However, cost and expertise are constraints on routine use, because health systems are overburdened and human resources are scarce where neglected tropical diseases are prevalent. Sadly, introducing routine surveillance