Primary care pediatricians give parents advice. Academic pediatricians give primary care pediatricians advice about what advice to give parents. Rarely, though, do we subject our advice to empirical trial. In “An Evaluation of Mother-centered Anticipatory Guidance to Reduce Obesogenic Infant Feeding Behaviors” in this issue of Pediatrics, French et al1 do just that, and they deserve to be commended for the effort. Reasoning that maternal behaviors play an influential role in children’s eating, French’s team contrasted advice directed at how mothers themselves eat with 2 more traditional approaches: a widely disseminated program of feeding advice called Ounce of Prevention, and a set of messages based on Bright Futures. Each intervention was delivered at a different clinic. Children were enrolled on or before 2 months of age. By 12 months of age, there were small but statistically significant differences in parent-reported feeding behaviors favoring the mother-focused advice.

The study is far from perfect. It relied on convenience samples, and, perhaps most importantly, there were baseline differences in the 3 intervention groups that could have accounted for some or all of the observed effects. But the study is important in that it holds up for empirical scrutiny a specific anticipatory guidance strategy; it begins to answer the crucial question, “How can we best spend the precious 15 or 20 minutes that comprise the well-child visit?”

Certainly there is no shortage of professional guidance about what primary care doctors ought to tell parents about children’s eating, but little if any of that guidance is grounded in studies done in primary care settings. Thus, for example, we know that young children’s acceptance of new foods increases with repeated presentations, but we do not know that telling mothers to present the same vegetable 10 dinners in a row leads to increased vegetable consumption. The American Academy of Pediatrics’ book, Pediatric Obesity: Prevention, Intervention, and Treatment Strategies for Primary Care,2 is full of good advice, virtually none of which has been tested in the clinic.

The difficulties only expand when we look beyond obesity prevention. In every area of preventive care (from safety, to sexuality, to sleep), there is a profusion of untested advice. The 1997 Guidelines for Health Supervision III weighed in at 436 g. The 2008 Bright Futures: Guidelines for Health Supervision weighs 1474 g, more than 3 times as much. In contrast, the number of pediatric office-based psycho-behavioral interventions that have earned the unequivocal support of the US Preventive Services Task Force, based on the evidence, is precisely zero.

And, of course, we do not deliver these interventions 1 at a time. We serve them up 1 after another, like waiters at a 10-course banquet. Various studies published in Pediatrics in recent years have embraced the checklist approach to assessing the quality of pediatric primary care, noting for example the average number of topics covered (or missed)
during a typical well-child visit.\textsuperscript{3} The common assumption seems to be that when pediatricians cover more, parents come away knowing more and are able to translate that knowledge into action. But we all know that this simply is not so. In the Healthy Steps experiment, physician extenders were trained to cover an extensive curriculum, but, with the important exception of reduced harsh discipline, few measurable changes in parent behavior or child health resulted.\textsuperscript{4} The rate limiting step does not appear to be our ability to deliver volumes of advice but rather parents’ ability to assimilate and act on it.

Where does all this leave us? It leaves us at the beginning. To start, we need to investigate individual quanta of preventive guidance. Years ago, for example, Adair et al\textsuperscript{5} showed that telling parents to put their 4-month-old infants to bed drowsy but not fully asleep resulted in decreased disruptive night waking at 9 months. I and others have argued that giving picture books and guidance about reading aloud results in increased book use and improved verbal language. Many more such components need to be tried and tested. Beyond that, we need to begin testing different combinations of screening and guidance, always keeping in mind the real-world limits of information transfer and behavior change and the real-world outcomes we are trying to affect. This is a daunting task, but luckily there are a lot of us, and an awful lot of parents looking for guidance. French et al have given us a start. I hope many will follow in their footsteps.

\textbf{REFERENCES}


What Do We Do With Our 15 Minutes?

Robert Needlman

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