

(CATMAT),² and the Committee has now been made aware of these errors.

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Competing interests: None declared.

DOI:10.1503/cmaj.1041439

To self-cite or not to self-cite

The article by Apoor Gami and associates¹ on self-citation in the diabetes literature included 1 self-citation (out of a total of 9 references), which involved 3 of the study's authors (reference 6 in the original article). Thus, self-citations constituted 11% of the article's citations, which is more than the reported mean of 18% and median of 7%.

We agree that this phenomenon is prevalent in the literature. We, too, have published articles with self-citations.^{2,3} In fact, this letter now has a self-citation rate of 66%!

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DOI:10.1503/cmaj.1041115

[Three of the authors respond:]

Raheem Kherani and Michelle Fung note that we referenced one of our own publications in our recent article about self-citation.¹ In fact, we acknowledged this (in the second paragraph of the Interpretation section of that article), as an example of the necessity or utility of self-citation. However, Kherani and Fung have calculated the rate of self-citation incorrectly. Author self-citations, as described in our article, are subsequent citations to an article by one of its authors. Thus, our citation of the paper by Montori and colleagues² raised the self-citation count of that article by 1, but it did not affect the citation count of our present article.¹ Calculating the proportion of self-citations to the latter would involve dividing the number of our subsequent publications that cite it by the total number of subsequent publications that cite it.

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DOI:10.1503/cmaj.1041206

How children see themselves

In their recent research letter, Gail McVey and associates¹ suggest that fear of being overweight and the desire to be thinner lead to behaviours such as "dieting and other extreme weight control methods." Their proposed solution is to increase the education of key individuals, including primary care physicians.

In designing a prevention program, it is important to realize that teenagers' fear of becoming overweight is reasonable. Given the significant social discrimination against obese individuals in areas such as marriage, income, health care and education,^{2,3} as well as the rise in obesity among children and teens,^{4,5} it is not surprising that some teens go to great lengths to prevent weight gain.

It would have been useful if the authors had reported how many respondents in their sample were aware that their eating behaviour was inappropriate. Such awareness has a great bearing on what preventive measures will be effective. In particular, it would be helpful to determine how a physician should manage care for a girl at serious risk of obesity if dieting is not an option.

In most people, dieting and disordered eating are symptoms of the underlying issue of body dissatisfaction. It is not clear how effective educational prevention programs will be in addressing this problem. However, it seems advisable to determine the overall impact of such interventions (including any possible adverse outcomes) before recommending this approach to primary care physicians.

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DOI:10.1503/cmaj.1040921

[The authors respond:]

Although the issue raised by Jacqueline Quail and associates is valid, teaching children and families to have tolerance for diversity, including diversity in size and shape, is paramount to decreasing body dissatisfaction and reversing social discrimination against overweight and obese individuals. Developing such tolerance is especially important given the link between weight-based teasing and depression or suicide in youth.¹ Certainly, efforts to promote healthy eating and active living should not be ignored, but dieting in youth has been linked to weight gain.^{1,2} Similarly, weight loss programs targeting obese children have been associated with only minimal weight loss.^{3,4} Furthermore, pressures to lose weight can create a cycle of dieting and low self-esteem.^{3,5}

Because of the link between dieting and body dissatisfaction, extensive school-based research has been conducted on ways to increase body satisfaction and encourage healthy lifestyles. This universal prevention approach has led to improvements in healthy eating, global self-esteem and body satisfaction among children in the upper grades of elementary school.^{6,7} Although this student-directed intervention has shown promise, it is equally important to sensitize adults to their role in the promotion of children's body image and healthy lifestyles, without focusing solely on weight.

Effective ways for schools to deliver these health promotion messages are available.^{6,7} Physicians can help to engage families in the following ways: educate patients about natural increases in weight and body fat experienced during puberty, encourage family-wide healthy eating and active living practices,^{8,9} discourage restrictive dieting, model respect for diversity in weight and shape, teach the emotional and physical benefits of physi-

cal activity, help families to recognize the impact of weight-based teasing and suggest that families encourage these messages in school communities.¹⁰

It may not be surprising that children are dieting to prevent weight gain. However, taking steps to promote health and fitness in all youth, without increasing weight and shape preoccupation, can help to decrease unhealthy weight loss behaviours such as those that we reported.¹¹

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DOI:10.1503/cmaj.1041129

Correction

In an In the Literature article on the benefit of tight glycemic control in diabetic patients undergoing coronary artery bypass grafting,¹ the table should have included a footnote stating that it was adapted, with permission, from the study reviewed.²

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1. Cheng AYY. Does tighter perioperative glycemic control improve outcomes for diabetic patients undergoing coronary artery bypass graft surgery? *CMAJ* 2004;171(1):30-1.
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DOI:10.1503/cmaj.1041617

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