

able to use the technique with sufficient frequency to maintain their skills.

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The authors respond

We thank Lardner and Spencer for their response to our article.

Our conclusion regarding investment in ultrasound and near-infrared imaging for routine IV placement was in reference to our setting and other similar settings, specifically. In our setting, IV placement is a core nursing skill. Nurses in our emergency department place the IVs. As such, they are viewed as experts in starting pediatric IVs. Extrapolating from our enrolment data, we estimate that 70 IVs are started by nurses each week in the pediatric section of our department. Thus, our nurses are experienced at IV placement. Our data support this; across all arms (which showed no difference in first-attempt success rate), the range was 65.9%–74.7% success on first attempt.¹

Our emergency department (adult and pediatric) has a pool of roughly 200 nurses who work regularly. Out of this pool, 83 nurses were keen to participate and underwent training. We estimated that only those nurses who felt that the research was important and the technologies might offer benefit, and who were comfortable with the technological procedures would consent to participate. We were satisfied with this approach and assessed that our training package was sensible and similar to other studies.² Because we agree that training and skill maintenance with ultrasound is complex, we

discussed this quandary in the paper in some detail.

Our trial was pragmatic in the sense coined by Schwartz and Lellouch.³ The study design was sound. It was a well-designed randomized controlled trial, adherent to the CONSORT standards of reporting.⁴

We stand by the results of our study. We are not saying that ultrasound is of no value when performed by experienced clinicians. However, the question does remain: How do we provide the best first-time success to all children who require the placement of an IV line in an emergency setting? Given the training we provided, the results were no better than the usual method.

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Many hands lighten the obesity load

Fletcher and Patrick¹ make an excellent case for population-level measures to curb obesity rates, but fail to highlight opportunities for improvement in primary care and medical education.^{2,3}

In the average family practice, about 4.4 hours per day would be required to provide only A-level preventive screening to adults over 25 years of age.⁴ It is not surprising then that only 23% of obese individuals have a documented care plan.⁵

Innovative tools exist to make obesity prevention quicker, easier and more effective. Simply adding a signed prescription with clear instructions can

increase patient adherence to exercise and diet advice.⁶

Modifications to physician education are also required. Most medical curricula in Canada do not offer formal education in obesity prevention.¹ Canadian medical graduates report dissatisfaction with current nutrition education and their ability to provide nutrition counselling to patients.⁷ To that end, an enhanced medical education curriculum is being developed and piloted in Canada.²

The past 50 years of battling Big Tobacco has shown that physicians can offer leadership in both clinical innovation and healthy public policy.^{8,9}

We are proposing a multilevel approach to obesity prevention, integrating physicians with allied health, public health and community incentives. This is the foundation of our multiclinic pilot study, Prevention Rx, which is currently under evaluation.

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Letters to the editor

Letters have been abbreviated for print. See www.cmaj.ca for full versions and competing interests.