

Addressing Obesity Must Go Beyond Advising Patients to Eat Healthy and Exercise

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The health risks of being overweight or obese have been in front of the public for decades, with the Centers for Disease Control and Prevention emphasizing the links to acute and chronic diseases and a risk for all-cause mortality. Eating too much, walking too little is the simple answer, but of course if it were that simple, it wouldn't be a problem. Billions of dollars have been spent on education, research, and clinical care to decrease the prevalence of obesity and overweight. Many more billions are spent on diet and gadgets unsuccessfully trying to correct the problem. Now the country faces the specter of a surgical solution for increasing numbers of people.

But the constant mentioning of obesity may be having the effect of tuning the public out. Life is difficult with stresses of work, family, economic struggle, and other pressures, and the well-known link of overweight and obesity to socioeconomic status and other social determinants of health make finger wagging by clinicians and advice to eat healthier fall flat. In his extraordinarily sympathetic essay in the October 31, 2016 issue of *The New Yorker* on the increasing cultural and economic divide in our country, George Packer writes, "When you visit a farm-to-table restaurant and order the wild-nettle *sformato* for 30 dollars, the line between social consciousness and self-gratification disappears. Buying synthetic-nitrate-free lunch meat at Whole Foods is also a way to isolate yourself from contamination by the packaged food sold at Kmart and from the overweight, downwardly mobile people who shop there. The people who buy food at Kmart know it."¹ Physicians, as a group, are coming from family backgrounds more familiar with Whole Foods than Kmart, and our patients know it.

So if clinicians are going to be successful in changing the trajectory of obesity in their communities, they have to engage in what Walker Percy called "zone crossing,"² stepping out of comfortable hospitals and clinics and into parts of society that have the biggest risks not only for

for the better. Whether through research strategies that include patients and communities or using data to address issues of availability of food or significant adjustment in the attitudes of clinicians away from condescension and toward empathy, the manuscripts in this issue acknowl-

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obesity, but for every chronic illness that relates to it. They need to shop and walk and even live where their patients live, or at least engage in honest and open ways that might decrease the professional and economic isolation that Packer writes about. A historic town in the mountains of New Mexico had a public hearing on a petition for Family Dollar to build a store just down the road from the center of town. At the hearing, the people who argued against it were almost exclusively Anglos, and those who argued for it were Latinos and Native Americans. But the difference was socioeconomic, not racial. One man put it succinctly, "I can't afford to drive 30 miles to Walmart to buy milk or buy it at the local general store for twice what I should pay. I shouldn't have to decide between milk for my family or pay my electric bill."³ If society is going to honestly address obesity, it needs to understand it as a symptom, not a cause.

Fortunately, in this special issue of *WMJ*, many of the articles discuss strategies and attitudes about obesity that at least offer the possibility of engaging with people in communities in a way that is respectful, understanding, and has a higher chance of success in changing things

edge the struggle to improve outcomes through collective action. The effort will take a long time and a great deal of work, but it has a greater likelihood of positive change than end of visit diet advice for patients who go back to a reality their doctors don't understand.

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