

Futility and Avoidance

Medical Professionals in the Treatment of Obesity

TWENTY years ago, I changed course in my internal medicine practice and decided, rather deliberately, to work on the problem of obesity. My friends, my colleagues, and my family thought I was crazy. The warnings were clear. "Don't risk your credibility and your career." "Don't venture into a part of medicine that no one takes seriously." "Don't move into the world of quacks and charlatans." My brother, a thoughtful, professorial cardiologist, assessed the situation in most negative terms. "The guys who deal with obesity are the sleaziest guys in medicine. Pills and shots!" he shouted. Another friend, also comfortably cloistered in academia, could not imagine how I could possibly want to spend my time working with fat, middle-aged ladies: "What on earth is there to talk about?"

Taking the Plunge

Even in my naive youth I was not oblivious to the risks involved in dealing with obesity. Although my credentials were fine (I had been a biochemist and had spent years working in fat metabolism and nutrition), I was terrified about the image and about the realistic possibility that I would be wasting my time. However, the challenge was too tempting. I hoped that I could offer my patients something better than what they had. I countered the reservations with a bit of uncharacteristic defiance: "It will take me the rest of my professional life to make this respectable. I think it's worth a try."

What I saw around me was an army of fat people and the consequences of their obesity. Almost everything in the pious pronouncements about the prevention of heart disease, about the management of lipid disorders, about diabetes, and about trying to become healthy depended on dealing with obesity.¹ The economic consequences, both in financial costs and costs in morbidity and mortality, are enormous.^{1,2}

Furthermore, the entire medical profession has continuously neglected the problem. The most common metabolic disease in the United States was treated with scorn, contempt, and indifference. It was left to management by non-professionals, to physicians who were indifferent to their

professional reputation, and to those who would use this problem for their personal greed.

The Status Quo

Medical professionals systematically avoid the problem of obesity. They send the obese patient to a dietitian who reinforces a recurrent litany of menu planning that has been therapeutically unsuccessful for the patient's last 30 years. Or worse, the 350-lb diabetic patient who has a cholesterol level of 300 mg/dL (7.75 mmol/L) and who is recovering from a myocardial infarction is urged to lose weight and the responsibility is shifted to a counselor in a commercial weight-loss program whose only credentials often are a personal experience in losing 20 lb in that program.

Unfortunately, there is a historical basis for this approach. Physicians have viewed nutrition as a social problem. In a more reflective moment, physicians may admit that they do not deal with obesity because there is not a great deal that can be done; the treatment of obesity is not very successful. Then, in order to shift the responsibility, some physicians declare that it is not worth treating obesity and would say, "Why bother? They can't (they don't) keep it off anyway." Galen said it well 1800 years ago, "All those who drink of this remedy recover in a short time, except those whom it does not help, who die. Therefore, it is obvious that it fails only in incurable cases." Finally, deep down is the insidious belief that obesity really is the patient's fault. Once again, we have the sociological convenience of blaming the victim.

None of this kind of analysis could be sustained in an ethics class for second-year medical students. Moreover, none of this analysis is accurate, or valid, or based on reality. Even if it were true, it would be an unconscionable neglect of the profession's responsibility to provide care to patients who are sick.

Defining Obesity

Some wonder if obese patients really are sick. Is obesity really a disease? At best, is it an emotional disorder; at worst, a self-indulgent bad habit? The evidence is substantial; obesity is a metabolic disorder; eating behavior and the regulation of body weight are carefully controlled physiologic systems in humans.^{1,3,4} Nature does not permit body weight to fluctuate randomly in other mammals; it is inconceivable that

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humans would have a randomly unstable weight. Even obese people are usually weight stable, albeit at an inappropriate level. We weigh what we are supposed to weigh, and the regulatory systems defend that weight with remarkable physiologic tenacity.

Endorphins regulate eating behavior,⁵⁻⁸ and thermoregulation controls the dissipation of excess calories.⁹⁻¹² The regulation of body weight is at least as complex as any other biological regulatory system. It involves neurochemical, gastrointestinal, and hepatic signals, mechanical and humoral processes, genetic factors, and the autonomic nervous system. Some of the time, some of the control can be overridden by the patients' deliberate behavior. This occurs in the context of social and situational factors, emotional and stress factors, the patients' recognition of what they have eaten, and their anticipation of what will be happening. Somehow, the forces are orchestrated to sustain a beautiful symphony in normal-weight people and chaotic dissonance in people with the disease of obesity. Perhaps nothing in biology is more important for survival than eating. Its control is not a casual process.

There is no reason to believe that patients' behavior causes this disease. Even in 1760, Flemmyng noted "that not all corpulent persons are great eaters or thin persons spare feeders. . . . Tho' a voracious appetite be one cause of corpulency, it is not the only cause; and very often not even the conditio sine qua non thereof."¹³ For over two centuries, thoughtful physicians have realized that overeating and obesity are not necessarily the same. Yet during all the years of my education (and for all of the nonmedical world around me), there was an assumption that people are fat because they eat too much; they are punished for their own willful misconduct. There is remarkably little evidence that patients become fat because they overeat. A more reasonable analysis is that, if they overeat, they do so because they have the disease of obesity.

Helplessness and Recidivism

There is even no basis now for the two traditional futility arguments: that there is nothing that can be done and that the recidivism rate is too high. There is no longer any validity to the classic pessimism of Stunkard and Reader: "Most obese persons will not stay in treatment for obesity. Of those who stay in treatment, most will not lose weight and, of those who do lose weight, most will regain it."¹⁴ We can now successfully manage the first two of these three issues. Patients will sustain the effort and stay in a comprehensive program. Patients can usually lose weight. They can usually achieve, and can often maintain, a more comfortable and healthy weight. They can learn how to override their metabolic regulators and they can learn how to maintain their weight loss. The task is enormous, the long-term results are still dismal, and the cure rate is still zero.¹⁵ It is not a curable disease. We should have no expectation that losing the weight will affect the basic physiologic abnormality any more than normalizing the blood glucose resolves the disease of diabetes.

Abandonment

We don't abandon our diabetic patients because we can't cure them. We don't neglect our schizophrenic patients because the recidivism rate is high in schizophrenia. We don't

discard our patients with AIDS because they have caught their disease. We don't forsake our alcoholic patients because we believe that they can make it right if they simply stop drinking.

The implications of the futility and avoidance analysis affect both patients and the medical profession. Patients can get good help from some commercial weight-loss programs, but they also can get bad help from untrained counselors who are managing complicated medical problems. In desperation, patients turn to outrageous schemes offering certain cures. This reinforces the image of obesity treatment as a commercial hustle to sell snake oil. The medical profession is avoiding its responsibility, neglecting the needs of patients, and frustrating the many competent physicians who want to cope with the problem, but feel unable to do anything useful.

Call to Arms

The insidious image of sleaze pervades and discourages physicians who might choose to take on the challenge of the problem of treating obesity. It is an orphan disease of monumental size that does not fit neatly into the classification schemes of medical education. No one trains in obesity as one might in gastroenterology or psychiatry. No one is willing to take the professional risk.

When I think about the frustration of treating obese patients, I sometimes consider Robert Browning's lines: "Ah, but a man's reach should exceed his grasp, or what's a heaven for?"¹⁶ The experience has been as gratifying and as challenging as anything I have done in medicine. I feel now how I imagine physiologists might have felt in the early part of the century when they knew that blood glucose had to be controlled and there was a sense that they were getting closer to the secret that was insulin. Body weight also has to be regulated, but surely by a system much more complex than insulin. We are much better at managing patients even though we are only a little bit closer to understanding the mystery of how we weigh what we weigh. We should not leave the mystery to the profiteers and the quacks.

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