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By Novid Parsi

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There's an idea we commonly have about obesity. In brief: People with obesity choose to eat too much and not exercise enough. But this idea grossly mischaracterizes the disease and the people who have it.

Certainly, the population is getting heavier. Forty-two percent of U.S. adults now meet the clinical definition of obesity, up from 31% two decades ago, according to the Centers for Disease Control and Prevention, whose most recent data is roughly five years old. Today, that figure is probably closer to 50%, experts say.

"Obesity is not a rare disease—this is half the population," says Fatima Cody Stanford, MD, Associate Professor of Medicine, Harvard Medical School, and Obesity Medicine Physician-scientist, Massachusetts General Hospital. "This isn't about 'them over there.' We must recognize that and do something different because what we're doing isn't effective."

Obesity has been associated with more than 200 diseases and complications, most prominently cancer, cardiovascular disease, liver disease and Type 2 diabetes. Despite this, only 1% of U.S. doctors are trained in treating obesity, according to a study published in the medical journal *Obesity*. It's not just a U.S. problem. More than 1 billion people globally now have obesity, according to the World Health Organization, which expects that figure to continue to climb.

Despite the prevalence, several harmful myths about the disease persist.

MYTH #1

Obesity is a choice—and a personal failing.

Obesity medicine specialists agree: Perhaps the single most pervasive and damaging myth about obesity is that it's the individual's fault. "One of the biggest misconceptions is that persons with obesity choose their fate—that it's a moral failing on their part," Stanford says. "This concept is pervasive both in the medical community and society."

Experts emphasize that obesity is not a choice and not a condition. "Obesity is not a mechanism of self-destruction. It's a disease," says Lee M. Kaplan, MD, PhD, Director, Obesity and Metabolism Institute, Boston.

"Obesity is a chronic disease caused by an excess of body fat, and I emphasize disease. That's something that's not readily accepted by many healthcare providers and the public," says Judith Korner, MD, PhD, Professor of Medicine, Division of Endocrinology, and Director, Metabolic and Weight Control Center, Columbia University Irving Medical Center, and Chair, American Board of Obesity Medicine. "Because we tend to see obesity as a choice, we view its treatment as optional. The treatment of obesity is often regarded as cosmetic, when in fact we're treating a disease," Korner says.

"The biggest myth is the notion that obesity is a personal responsibility and a consequence of bad behavior related to diet or physical activity. We know that's not the case," says William Dietz, MD, PhD, chair, Sumner M. Redstone Global Center for Prevention and Wellness, Milken Institute School for Public Health, George Washington University. "It's a disease of excess adipose tissue that's set in place by a disease-promoting environment, with physical inactivity and diet as major contributors."

"In my practice as an obesity medicine physician, not one patient has come to me and said, 'I've never tried to improve my health.' Nobody wants to live with the stigma and fat-shaming associated with obesity that exists in the world," says Selvi Rajagopal, MD, Assistant Professor of Medicine and Obesity Medicine Physician, Johns Hopkins University School of Medicine.

"We don't blame people for getting cancer or high blood pressure. But because obesity is a disease you wear and it's visible, people are blamed for their disease," Stanford says.

Regrettably, healthcare professionals aren't immune to the culture's fat-shaming and blaming. "Among the most stigmatizing people in the lives of people with obesity are their medical providers and family," Dietz says. Blaming and shaming people can have devastating health consequences. As patients feel threatened and stressed, they lose motivation to improve and turn away from the healthcare system altogether. "They don't want to interact with the healthcare community," Korner says. As a result, their health worsens.

WHAT CAN HEALTH

Treat everyone, regardless of size, with dignity and respect, Stanford says.
That might sound like a no-brainer, but patients with obesity too often do not receive respect in healthcare settings. "If you treat people with respect, they will respond positively, and they will get the best long-term outcome," Kaplan says. "When you respect that patients are trying to live normal lives and are not lazy or dumb, they will shed tears, not of joy or sadness, but of relief that someone understands."

One related tip, Korner says: Avoid calling patients obese. "People don't like that word," she says.

1

Ensure the physical setting is accessible for people who carry excess weight.
Consider the experience that people with obesity will have in your office, from start to finish. Does the waiting room have only small armchairs, making it difficult or even impossible for people with obesity to sit down? Do you have only regular-sized but not larger-sized blood pressure cuffs? Do you have appropriately sized gowns? Can people with excess weight sit comfortably on the examination table?

"There are a lot of nonverbal cues that a patient gets before they see the doctor that tells them they don't belong," Stanford says.

2

Don't assume the patient's health problems are caused by obesity—or that they're even there to talk about their weight.
Often, healthcare providers immediately assume that, regardless of the reason for the patient's visit, obesity is the real problem. "This is a common theme. Doctors presume everything must be secondary to the person's weight," Stanford says.

3

Ask patients for permission to discuss weight and make them part of the decision-making process.
If the patients are in the office to seek weight-loss treatment, they're fully aware of the issue. If they aren't in your office for that reason, and if their weight could present health risks, ask them whether they're concerned about their weight and would like to discuss it at this time. If they do, engage them in a shared decision-making process.

PROVIDERS DO?

Ask them what they see as contributors to weight gain. Ask what they might change. Ask what they've already done about their weight in the past.

"Rather than a hierarchical relationship where providers tell patients what to do, ask the patients what they think they can and need to do. This is the appropriate form of care, but it's not the one that's used very frequently," Dietz says.

Get a complete understanding of the patient's history with weight.
In her initial visits with patients who have obesity, Rajagopal asks about their weight history across their entire lives, like whether their parents experienced obesity during childhood. This can shed light on the role of genetics and hormones, which may inform potential treatments.

Tell the patient you understand that they did not choose to have obesity.

Explain that obesity results not from the person's choice to eat more or move less but from a biological dysfunction. "That's what causes other diseases, and it's what causes obesity," Kaplan says.

Avoid the blame game.
Providers tend to dole out advice on how to lose weight. When the patient hasn't lost weight or has lost and regained weight, providers often blame the patient for not following instructions—instead of considering that the treatment wasn't right.

Find the right treatment for the right person.
People are different. Some people's bodies respond to changes in lifestyle, others to weight-management drugs or surgery.

"Think about the treatment of obesity as a staged approach," Dietz advises. First, behavioral changes, such as diet and physical activity. Second, weight-reduction medications. And third, bariatric surgery. At each phase, the provider and patient should make decisions together.

"It's about working with the person in their individual context to figure out how they can navigate their life in a healthier way," Rajagopal says.

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MYTH #2

People just need to move more and eat less.

The thinking goes: If people only exercised more and ate better, healthier, less-processed foods, obesity would be resolved.

Ultra-processed food is one factor in obesity, to be sure—but only one. There are many internal and external contributors and influencers, including biology, environment, socioeconomic conditions and mental health. Stress-related obesity, for instance, rose during the COVID-19 pandemic. "When the body experiences stress, it goes into storage mode to defend itself against stress. The higher the chronicity of stress, the greater the fat storage," Stanford says.

People are different. Some—but not all—people gain weight when they eat highly processed foods or when they don't exercise. Some people respond to stress by eating more, others by eating less. Some people respond to sleep deprivation or disruptions to their circadian rhythms by gaining weight.

"We in the general medical community often fail to address the complex interplay of genetics, environment and behavior when we counsel patients in general but especially patients with less-healthy weight gain," Rajagopal says.

For all its advances, modern society has an abundance of cheap, easily accessible foods that are high in fat, high in sugar and highly processed. We have modern conveniences that allow us to move less. Many people can earn a livelihood while sitting at a computer all day. In our 24/7, sleep-deprived culture, we can scroll on our devices, stream our shows and order our food at any time, day or night.

"The modern environment is the perfect storm. It has something for everybody," Kaplan says. "No matter which drivers of obesity you're susceptible to, they are now more prevalent. We have very few environmental factors, if any, that push against obesity."

A NEW ERA

Weight-management drugs such as Ozempic and Wegovy have been grabbing headlines in recent months, but obesity experts see them as much more than the latest fad. "These are game-changers," Dietz says. "We're in a new era of the effectiveness of drug therapy."

When individuals with obesity eat meals, their brain may not receive the signal telling them they're full, and they can stop eating. That signal has been switched off. "The newer medications turn that switch back on," Rajagopal says. Considered safe for long-term use, these medications repair the connection between the gut and brain so that when we eat, we recognize we're getting full and must stop because it's uncomfortable if we don't.

But these medications are also prohibitively expensive for many people with the chronic disease of obesity, Dietz notes. "These drugs are unlikely to be available to the people who need them most."

MYTH #3

Overeating causes obesity.

"Overeating doesn't cause obesity. Obesity causes overeating," Kaplan says.

Our bodies have a corrective mechanism that determines how much weight and fat we have. "The body doesn't want to gain weight. It wants to have a certain amount of weight, and it regulates that," Kaplan says.

Over the past 30 years, an explosion of scientific research has shown that weight and appetite are regulated by signals in our bodies, particularly our brains. "Although the manifestation is excess fat, the central miscommunication seems to be occurring from signals received or generated in the brain," Korner says. "It's the brain that signals us to feel hungry and when to feel full."

What has led our bodies and brains to want more fat? "The short answer is we don't know. The longer answer is it could be a million different things," says Korner, who cautions against equating correlation with causation. Still, features of modern life—such as our disrupted sleep and circadian rhythms and our easy, cheap access to highly processed foods—all can affect the body and the amount of fat it wants to have. "We eat more to gain weight, not because we want to eat more but because our bodies want to have more fat," Kaplan says.

Our genetics haven't somehow changed in the past few decades, but our environment has. "We place our bodies in an environment that predisposes us to greater adipose fat storage," Stanford says. "We assume obesity is just about what people are eating or they're not exercising enough. But our entire life set us up to have obesity."

MYTH #4

The right quick fix can stop obesity for good.

We crave the magic bullet. We think there must be a "single answer for success: the best diet, the best medication, the best exercise," Korner says. "That's really not true." Obesity is a complex disease—not one problem with one solution.

"We need a multipronged approach," Korner says, including nutrition, physical activity, adequate sleep and, if warranted, medical therapy and bariatric surgery.

Obesity isn't an acute disease; it isn't a broken bone or the common cold. Obesity is a chronic disease, so the treatment has to be long-term, too. A few nutrition visits or several months of medical therapy won't be enough. "We don't treat any other disease like that," Korner says. When someone gets a prescription for high blood pressure or high cholesterol, they're not taken off the drug or refused insurance approval once their blood pressure and cholesterol levels get under control.

"The treatment and medications we use—not for everyone but for most people—need to be used for life," Korner says. This holds true for new weight management drugs such as Ozempic and Wegovy. "If you stop the therapy, the disease hasn't disappeared, and its manifestations will come back. The most common question I get is, 'When I lose my weight, when can I come off the medication?' I spend an inordinate amount of time explaining this to patients."