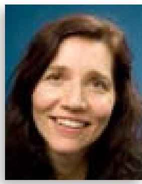

Editorial

Fat chance

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> *The devil has put a penalty on all things we enjoy in life. Either we suffer in health or we suffer in soul or we get fat.*
>
> Albert Einstein

This editorial is not about why people get fat. It is not about the fast-food industry or video games or television. I am not going to dwell on the lack of physical exercise in our schools or the demise of the family dinner. There will be no discussion of the "obesity epidemic," peppered with statistics showing the shift in obesity toward youth. I will not even be talking about why people should lose weight. I am going to assume that many of our patients are obese for a whole host of reasons and that these patients should lose weight because that is healthier for them.

What I would like to talk about in this editorial is where we, as family physicians, fit into the problem of obesity. Each time I have a clinic, I am faced with patients whose health is being adversely affected by their weight. They have often tried several approaches to weight loss, and most have failed. They want me to give them the secret—the key—to weight loss. Why they should expect that of me when all their efforts heretofore have failed is a "triumph of hope over experience," to paraphrase Samuel Johnson.

I am often at a loss to add to their frequently vast store of knowledge on weight loss. I discuss the balance between caloric intake and output. The need for exercise. I send them off to check out the Canada Food Guide and other Health Canada resources. I might recommend a dietitian, personal trainer, or special program. I tell them that there is no magic solution, no secret, no key.

At the next visit, very little has changed, except that I am no longer considered a credible resource in their quest for health (thinness). I have not fixed them; they are still obese. (Realistically, many of our patients are after "thinness," rather than health. Our goal, as their physicians, should be different.)

As a physician, it can be difficult to deal with these patients. It seems clear to us what needs to be done: eat less and exercise more. Yet, that appears to be impossible for our patients. So what can we, as family physicians, do in the face of such discouragement?

First, we need to recognize that obesity is our patients' problem, not ours (unless we too are obese). We should assess our patients for the presence of obesity and inform them of its consequences. We might even have the legal responsibility to do so.[1] The 2006 Canadian clinical guidelines on obesity emphasize the need to assess, as in smoking cessation, our patients' desire to change.[2] We cannot fix our patients' obesity on our own. Unless they want to address the problem, that is where our responsibility ends.

Our second task is to adjust our expectations. Obesity is a chronic problem, not one that can generally be addressed with a quick fix. We need to think about obesity more like osteoarthritis and less like a simple fracture. More like renal disease than acute otitis media. Sure, we have all had patients who have made substantial long-term lifestyle changes as a consequence of brief diet and exercise advice, but they are rare. If our patients don't want to make the neccessary changes, we should be patient. Reassess. Advise. Wait.

Third, we need to be aware of the many treatment options that are available for our patients.[2] Because obesity is such a complex problem, treatment plans are generally multifactorial, with an individualized approach. There is no "one size fits all" solution. While diet and exercise options are central to obesity treatment, there is growing interest in other types of treatment. There has been renewed attention to bariatric surgery as potentially "curative." There is also ongoing discussion about the roles of medication and psychotherapy.

In this issue, we take a look at 2 treatment options, discussed by 2 physicians with very different approaches. In his commentary, Sharma (**page 498**) argues that medications, in conjunction with lifestyle interventions, have an important role in the long-term treatment of obesity. Confining their use to the short-term only might be setting our patients with obesity up for failure. Cochrane (**page 543**) has an entirely different approach. He sees the development of self-efficacy as essential to the treatment of obesity. If our patients believe that they are capable of losing weight—that it is in their power to do so—they are much more likely to achieve that goal.

Our last task is to be supportive of our patients in their endeavours, particularly in the long run. Through the ups and downs. Losing weight—and keeping it off—is hard. Take a look at the Canadian guidelines on obesity for helpful resources in tackling this difficult issue.[2]

References

1. Caulfield T. Obesity, legal duties, and the family physician. *Can Fam Physician* 2007;53:1129-30 (Eng), 1133-5 (Fr).
2. Lau DCW, Douketis JD, Morrison KM, Hramiak IM, Sharma AM, Ur E; Obesity Canada Clinical Practice Guidelines Expert Panel. 2006 Canadian clinical guidelines on the prevention and management of obesity in adults and children. *CMAJ* 2007;176(8 Suppl):On-line 1-117. Available from: **www.cmaj.ca/cgi/content/full/176/8/S1/DC1**. Accessed 2008 Feb 27.

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