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## Social Causes of Obesity

Gregory Katz

Crystal smiled broadly as she walked into the exam room for her annual well child visit. At seven years old, she was developing appropriately and in the home stretch of second grade. She had no medical complaints, got along with her peers, and performed well in school. But her weight was in the 95<sup>th</sup> percentile for her height, and a few questions about the family revealed a worrisome pattern. Mom was obese with type 2 diabetes, and Crystal's 18 month-old sister was sitting in her stroller sipping on a bottle filled with juice. The physical exam revealed multiple decaying teeth, and her mouth was already shiny from several dental fillings. I asked her mother about what the family ate. It was the standard diet for many of our country's poorest citizens: fast food, juice, soda, a paucity of fruits and vegetables. Was this always the way they ate? Pretty much. Crystal and her sister were both picky eaters, fresh food is expensive, and Mom worked full time. She'd been lectured by doctors on previous visits about this already, and I thought she was annoyed with me for bringing up this tired topic. But as the conversation progressed, I realized this frustration was due to her resignation that the changes she needed to make were almost impossible. Mom was troubled by the situation; her family's health was important to her, but there is only so much that one woman can do with limited time and finite financial resources.

We live in an age where obesity, hypertension, coronary artery disease, and type 2 diabetes are epidemic in our society. Two thirds of Americans are overweight and a third are obese.<sup>1</sup> Meanwhile, we spend more than \$1.7 trillion annually on the medical care of people with chronic diseases and almost half of all Americans fall into this group.<sup>2</sup> This is largely a product of the modern world and the Western diet; obesity is a major driving force in the development and exacerbation of our health problems.<sup>3</sup> We are eating ourselves to death and bankrupting our health care system in the process. But how did we get here?

Beginning in the 1970's, the United States Department of Agriculture engineered farm subsidies that encouraged the overproduction of commodity crops like corn and soybeans and made them cheaply available. These policies were enacted with seemingly benevolent intentions: the price of food had spiked and President Nixon wanted to make eating more affordable. As a consequence, the government's agricultural policy goals shifted from trying to support prices for farmers to increasing yield in order to keep food costs low.<sup>4</sup> Low-cost corn provides the feed for big agribusinesses to raise cows, chickens, and pigs more quickly, and enables commercial food companies to inexpensively manufacture the high fructose corn syrup that has become ubiquitous in everything from soft drinks to whole wheat bread.<sup>4</sup> These cost savings are passed on to consumers, who can now purchase a 390 calorie double cheeseburger and a 150 calorie small Coke from McDonald's for the wallet-busting total of \$2.<sup>5</sup> Unfortunately, the same economies of scale do not exist for leafy green vegetables. And even if they did, a Big Mac will always be quicker, cheaper, and tastier than a serving of roasted broccoli and a skinless, boneless organic chicken breast.

As the costs of energy dense foods have plummeted due to oversupply in the marketplace, the income gap between the rich and the poor has dramatically increased. For many low income families, it's impossible for Mom to wake up at five, work all day, and still have the time and energy to cook a healthy dinner. That's before we even get to the fact that it's cheaper to head to the drive-through, and don't forget that even the pickiest eaters love French fries. It's easy to see how fast food has become a culinary staple for the impoverished. Children are constantly bombarded by cartoon characters in advertisements telling them to eat chicken nuggets and sugary cereal. School lunches are composed of pizza and cheeseburgers and vending machines at school sell cheap potato chips and Yoo-hoo. We have no nutritional education in many of our nation's classrooms, and physical education budgets are being cut

every year. As a consequence, obesity rates among poor children continue to increase, causing a concomitant rise in their lifelong risk of obesity and its myriad complications.<sup>6</sup>

In the clinic, we lecture patients repeatedly about feeding themselves and their children healthier food. But trying to make healthier choices isn't enough because food manufacturers exploit people who attempt to do the right thing for their families. When a bottle of Heinz ketchup touts the health benefits of lycopene, how can Crystal's mom be expected to know that the sodium and high fructose corn syrup decrease – if not totally negate – the condiment's healthfulness? A box of Honey Nut Cheerios brags about being packed with fiber to help lower cholesterol, practically screaming, "Eat me. I'm healthy!"<sup>7</sup> Forgive them for not also boasting about the 9 grams of sugar – from three different sources – per serving. Welch's is eager to tell you that its grape juice is packed with vitamin C and heart healthy antioxidants. But they aren't quite as eager to report the 38 grams (almost ten teaspoons!) of sugar in each eight ounce glass.<sup>8</sup> Motivation to make better choices is necessary but not sufficient; we must also arm our patients with the skills necessary to decipher deceptive and manipulative food labels.

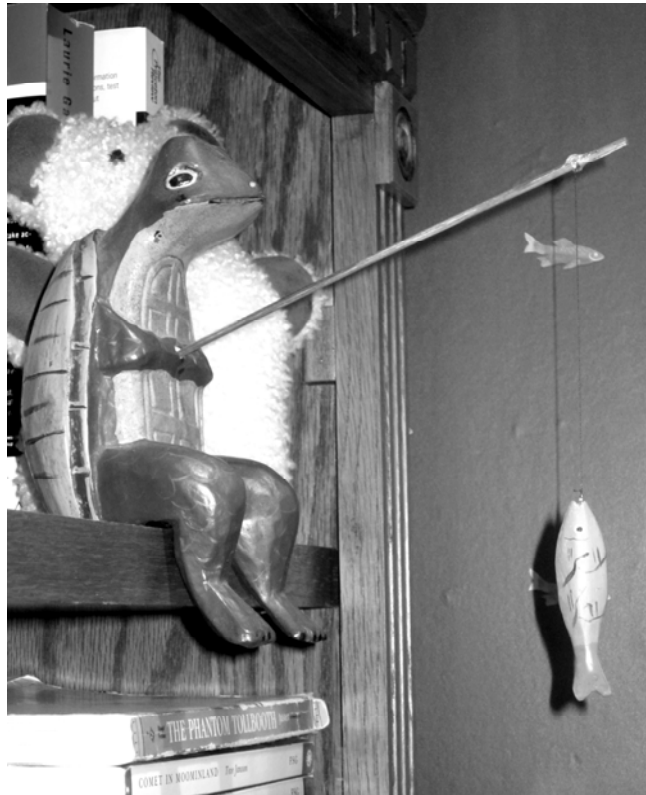
When the discussion of a physician's responsibilities inevitably comes around to the importance of preventative medicine, it is crucial that we remember that prevention means more than just increasing the availability of primary care doctors. It also means more than just providing the lip service of lifestyle counseling and the generic advice of telling Mom to give her children less soda and feed them more fruits and vegetables. Patient education and dietary counseling are more than boxes to be checked on the never ending to-do-list that makes up a doctor's day. Just going through the motions will not suffice. But sincere, personalized counseling is time consuming and difficult, and it doesn't always have a tangible impact on health outcomes. And for patients like Crystal, limited resources like time and money mitigate the potential for change. The reality of the situation is that these complicated problems just don't have simple solutions.

The medical profession exists at the intersection of public policy, economics, cultural values, personal decision-making, and education. The way we practice needs to take this into account, because chronic disease has a multifactorial etiology. We need to impress upon parents the stark reality that the choices they make today will affect their children for the rest of their lives. We need to educate children from an early age about nutritious eating and developing a healthy lifestyle. At the same time, it is imperative to change the economics of agribusiness to reflect the true price of our food; the real cost of that double cheeseburger is not just one dollar if eating it leads to diabetes and heart disease. Parents must take ownership of their families' lifestyles while physicians need to focus on more than just treating the symptoms of disease and giving generic dietary lectures. And medical education cannot continue neglecting the intimate relationship between diet and health.

As a member of the American Medical Association, I receive daily emails detailing new advances in research, changes in policy, and advice on how to navigate the infinitely complex web of health care payments and incentives. Often, these emails encourage me to lobby Congress in an effort to prevent Medicare reimbursements from being cut. Not once have I been pushed to advocate cutting farm subsidies or increasing funding for school lunches and physical education programs. We have a responsibility to look out for more than just our own financial interests; it is our duty as physicians to advocate for our patients' health at every possible level – from discussions with parents to negotiations with hospital administrators to our efforts to lobby Congress. Improving health care cannot be limited merely to expanding health insurance coverage and access to doctors. Health must be more than a peripheral issue in the way we debate policy. At the same time, physicians and patients do not need to await a governmental consensus before changing some of our own behaviors. To adequately tackle a problem of this magnitude and importance, we must expand the scope of our thinking.

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*Day Off*