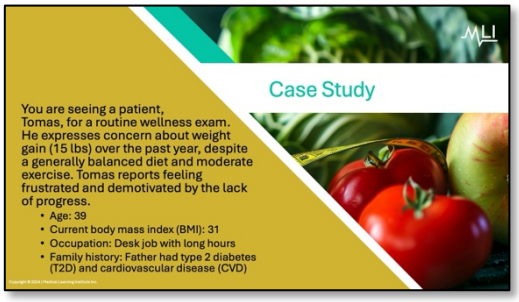
Chapter 1: Addressing the Weight of the Matter: Diagnosing Obesity

Jay H. Shubrook, DO, FAAFP, FACOFP: Hello, let's start with *Addressing the Weight of the Matter: Diagnosing Obesity*. I'm Jay Shubrook, a professor and diabetologist at the Department of Clinical Sciences and Community Health at Torrey University, California, College of Osteopathic Medicine.

I'm delighted to be joined by Matthea Rentea, MD, of the Rentea Metabolic Clinic in Indianapolis, Indiana, and a diplomat of the American Board of Obesity.



Case Study

Let's start with a case study. You're seeing a patient, Thomas, who presents for a routine well exam.

He expresses concern about weight gain over the past year, 15 pounds specifically, and despite trying to follow a general balanced diet and moderate exercise, he feels frustrated and quite honestly demotivated by this lack of progress and weight gain, despite feeling like he's doing the right thing. He's 39 years old. He's got a BMI of 31. He does have a job that requires long times at a desk without a lot of breaks, and of note, he has a family history of type 2 diabetes and cardiovascular disease in his father.

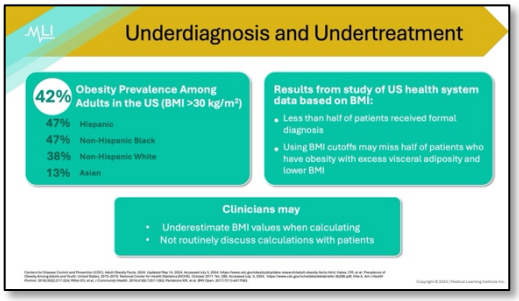
Matthea Rentea, MD: Oh, this is very common. This is everybody. We live in a world nowadays where we're not promoted to really move during the day, with sedentary jobs being the norm, and unfortunately, even when people try to work on this, their weight curve goes up and up, and they feel very frustrated by it, and I'm seeing this at very early ages. When someone's listed as 39 here in this case study, this is not uncommon at all.

Dr. Shubrook: How has it changed over time? Are you seeing this more frequently? Has this been pretty steady? How do you think COVID has affected this?

Dr. Rentea: I think there was a big uptick with COVID, especially younger patients. There was definitely, I know there were statistics for how much patients gained during that period, but I've been seeing this increase, and then also at a younger age, people have more comorbidities at a younger age. I think something really important to look at here is what is the actual definition of obesity? I'm going to first read, this is a definition from the OMA, the Obesity Medicine Association. I actually put this definition with my patients on the first visit we talk about it because it explains so much about what's happening.

It's a chronic, progressive, relapsing, and treatable, multi-factorial neurobehavioral disease. This is not something that's a singular fix when we have someone in front of us that struggles with this. Let's talk about what this leads to, but then I want to talk very practically about it. It is marked by an increase in body fat that promotes adipose tissue dysfunction and abnormal body fat mass physical forces. It results in metabolic problems, biomechanicals, psychosocial health consequences. What I always tell patients when they come in, I say, "Listen, this is a very complex disease that has many different aspects to it."

There are two main things usually when people come in that they're having problems with. Number one, the metabolic health aspect. Cardiometabolic, things like diabetes, blood pressure, cholesterol, but then there's also this aspect physically, the weight that's on them. They are getting things like advanced arthritis at an earlier age, the throat closing at night, obstructive sleep apnea. I explained, "Look, it's not usually just one or the other. This is why we really overall want to work on this." Then different risk factors are coming down the road.



Underdiagnosis and Undertreatment

One of the things that I really tell people, I say, "Listen, you're not alone," because even though we know that the magnitude of who is suffering with overweight or obesity is high, there is actually a lot of underdiagnosis and undertreatment. Number one, I think it's really important to know that if we think about obesity prevalence among adults in the US, so BMI 30 and over, actually 42% of the US population will fit in this category and that it's disproportionately affecting different ethnicities. Depending on where you're practicing, maybe if you're in a more underserved area, depending on who's living around you, these numbers are going to look different.

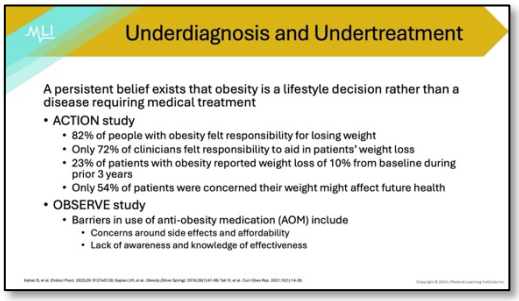
If you look at results from studies of US health systems data based on BMI, two things really pop out. Number one, less than half of patients receive a formal diagnosis. I always say if we can't diagnose, we can't treat. Then also another problem, let's say that you even were looking at the numbers and understood that and were really vigilant as a clinician, also using BMI cutoffs, it may miss half of patients with obesity with excess visceral adiposity and lower BMI. Again, it's not as easy as just a number. What's interesting also, clinicians, they may underestimate BMI values when calculating.

Now, hopefully this is a little bit lower because nowadays a lot of our EMRs, as long as there's a height and a weight, it's going to automatically calculate that. This has happened to me as well. You get the numbers wrong. Then not routinely discussing these calculations with patients. We understand that this is one of the main reasons we're doing this training, to understand even how to diagnose it, what to do with it because if you don't know how to talk to a patient about this, obviously it's a problem.

This just shows you that there's a very high prevalence of this, but yet we are not capturing it with diagnosing it, let alone talking to patients about it. Did you ever experience a challenge with talking to patients about this because in the beginning, I definitely did? Actually, bringing this up as a diagnosis.

Dr. Shubrook: Yes, I feel like that there are a lot of societal pressures, and a lot of societal, I would say quite honestly, myths about what a healthy weight is. I think that you really said something that's quite important. We've normalized our growth of our weight as a population, which means we underestimate when the weight is not at a healthy level. I do think, for me in my practice, one thing that's helped me is to make sure that I include a BMI diagnosis on every visit if it's above or below the goal, because it reminds me it's something else I should be looking at.

When I talk to patients and they push back, I always try to say that I want to try to help you be the best version or the best healthy version of yourself. I want to make sure that we know when things are tied together, how this could impact other parts of your life that might be quite important to you, being able to live long enough for your grandkids, being able to walk to the park. The key is finding what is the thing that's important to that patient and relevant as it relates to their current weight and their health.



Underdiagnosis and Undertreatment

Dr. Rentea: Something that I think is one of the most important things you might learn here is that there's this really persistent belief that obesity is a lifestyle decision. A lot of clinicians believe that patients are choosing to do these things. What we really want to stress here is that obesity is a disease. Patients will actually internalize that I'm the problem. I should be doing more. Why did I let it get to this? That's the word we use for that is internalized bias. One of the things I want to highlight with these two studies here, if you look at the ACTION study, they showed that 82% of people with obesity, they felt a responsibility for losing weight.

It's not going to come as a shock to patients in front of you that they're wanting to work on this. They're likely very aware of it. Only 72% of clinicians felt responsible for aiding patients in weight loss. There's a disparity happening there, right? Then the other thing that I really want to highlight is a lot of people are working on weight loss. If you look back, 23% with obesity report weight loss of 10% from baseline during the prior three years. If you really ask that history, most people are not just sitting there and not trying things. In fact, they're trying usually everything in their power.

If you look at the OBSERVE study, again, let's say that we did diagnose, and we do want to treat. What are some of the barriers? Barriers and use of anti-obesity medications included everything from concerns around side effects and affordability. We all understand this problem greatly. Can the patient even tolerate it? They're worried about the side effects. Can they even pick it up at the pharmacy? These things do hinder what we ultimately recommend.

Then also lack of awareness and knowledge of effectiveness. If you have not had a training like this and don't know what the statistics are, if someone is just doing lifestyle or if they've been struggling for 10, 20 years, and then what the difference of adding an anti-obesity medication can make. If you

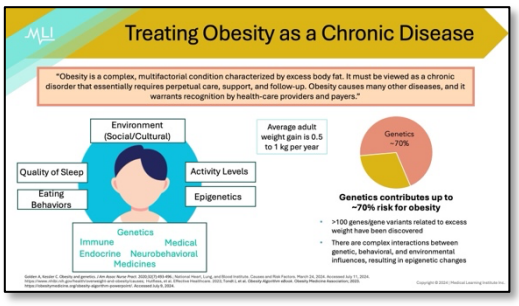
don't have that knowledge, then you might not ever even think to prescribe it or think to have that conversation.

Dr. Shubrook: Yes. I want to really highlight that we make a difference as clinicians if we're willing to recognize that people have done a lot before they come to us. Sadly, many people don't come to us because they feel like they've been disrespected or pushed aside or minimized their efforts in the past. I think we have a responsibility to be that partner and be open to hearing their journey.

Dr. Rentea: When we think about treatment of obesity, you're going to hear me say a million times this time that it's complex. I want you to think about if we say obesity is a disease, what's actually all going to be entailed here? Number one, we really need a patient-centered communication approach. They need to be involved with this. You're going to hear me say this again, a lower point down here, but we need them to be the center of this. We're going to have to collect a lot of data. We're going to have to take this away from judgments of what they are or are not doing or what you're thinking. What does the actual data show us?

Where's their weight at? What do the labs look like? Waist circumference? There's a lot of data that we can collect in this field. Then evaluation and assessment. We take all of this together and then we are going to do something with all of that. The management plan needs to involve motivational interviewing. We can think what the best plan could be, but we need to talk to the patient in front of us and see what is their readiness level? What can they take on? What logistics are involved in this for them?

It's really a bi-directional communication that needs to exist. Then ultimately at the end, if we do all that, if we did it right, and we're actually involving the patient, we're collecting data and we're using our clinical skills, we're doing all of that, we're going to end up with a really multifactorial treatment approach that's going to involve likely something a little bit different for every patient. We can know the basics.



Treating Obesity as a Chronic Disease

Here again is another quote that we just have to read this because you have to hear this a few times to bathe your brain in this. We've talked about how it's complex. We get it's multifactorial. Okay. We get that excess body fat, but here's the point that I really want to highlight here. It must be viewed as a chronic disorder that essentially requires perpetual care, support, and follow-up. Then the next part of this quote really highlights that we need buy-in from healthcare providers and payers. One of the things that I stress when patients come into work with me, I say, listen, this really isn't a one and done.

This is really me supporting you likely for years to come because when we say that they need continued support, someone will do really great. Then they will have a period of either some regain or they'll be struggling. That's actually part of this chronic disease management. Now, a little fact that I think is such an amazing pocket fact that you can have with you is right here in the middle of the slide

that's highlighted, that the average adult will have a weight gain of about half to one kilogram per year. Again, let's put that into pounds because most of us talk in pounds to patients.

One kilogram is going to equal about 2.2 pounds. What I will tell patients right from the get-go is, "Look, most people are gaining on average one to two pounds per year. Even if you come into work with me, even if we're doing this work and you just stabilize your weight curve." There's this concept in obesity care. If you look at someone's graphs, when did they start to gain weight? What's happening? Maybe, classically you'll hear, okay, in college, some weight came on, with kids, some weight came on. Different life events, or there's this slow creep that you tend to see 30, 40, 50 years old.

Even if we can stabilize that, that's a win. That's a big point that I like to highlight to people. Then again, really just with this training, understanding how complex this disease is. Another great pocket fact is that about genetics contribute to about 70% of the risk of obesity. We have highlighted here that there's over 100 genes and variants that are related to excess weight gain and that have been discovered. Here's how I relate that to patients. I say, "Listen, you actually didn't wake up and decide that you wanted weight management to be a challenge. A lot of this is genetically influenced."

I have a lot of patients actually cry with me when I say, because their whole life they've been told you were the problem. You need to make different decisions. What if I suddenly came to you and said, "A lot of your weight set point, it's genetically determined how you're responding to these foods, how you're responding to all these different things. A lot of people around you that don't suffer with overeater obesity, they don't have that challenge. A lot of that's genetically influenced."

Dr. Shubrook: I do also think that it is very important to recognize that you got to work really hard to be able to not gain weight because we live in what I would say an obesogenic environment that does lots of things to make it easier for us to eat highly processed foods, to be sitting at our desk, to be very effective, because that's what a good worker does.

Designation of Obesity as a Disease

Dr. Rentea: Many medical associations and societies, they've recognized obesity as a medical condition, but actually, this has only been for about the past 11 years because this was back in 2013 that these different organizations started to notice this. It hasn't actually been that long.

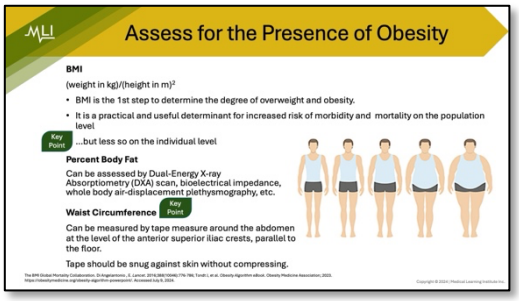
Dr. Shubrook: I think it's important for us to recognize that because there is a consensus in the medical community, we do have clinical treatment guidelines and a consensus statement that was reiterated in January of 2023, that the body mass index or BMI is used to screen for obesity. Of course, it is only one piece of a lot of information as we make a determination of whether someone has excessive weight.

It should not displace clinical judgment. The United States Preventive Task Service Force has recommended that clinicians offer or refer patients with a BMI of 30 or higher to intensive multi-

component behavioral interventions. Matthea, there's a lot of controversy about BMI. I'd love to hear your thoughts.

Dr. Rentea: I'll tell you this. I think it's a screening tool. We need things that everyone can use, but then we understand it has limitations. I think that you have to go a little bit beyond that. You have to look at their labs. You have to look at the distribution of adiposity. If you have the privilege of having some type of a body composition test or if you can use a waist circumference, you said it so beautifully, you've got to use other clinical skills and not just rely on this one number.

I just always really highlight to patients, "Listen, you are not this number. My main goal for you is not mid-range normal BMI. I care much more about XYZ." As long as they understand they're not going to live or die by this number, we need other things that are in the mix. Of course, in medicine, we have to make things black and white to move forward with some decisions.



Assess for the Presence of Obesity

Dr. Shubrook: What is the BMI? The BMI is really looking at weight in kilograms divided by height in meters squared. It is the first, but not the only step in determining the degree of adiposity, overweight, or obesity. What is great about it, as I mentioned, it's practical, it's certainly easy to do, and it's free. It has been associated for risk of morbidity and mortality at a population level. There is value at the much wider perspective. We know that you've had patients who maybe are athletes, and they have a higher BMI, or someone may not have a much higher BMI, but you clearly see this adiposity.

I think it's important to know that the BMI is great at a population level. It is useful to some extent at an individual level, but it's less valuable at that individual level where you really need to have additional markers and clinical indicators. You mentioned some of those already, and not everyone has these tools, but if you have the ability to do a DXA scan to assess for visceral adiposity, or bioelectrical impedance, or certainly whole-body air displacement, these are all things that you could utilize.

I do think one thing that is affordable is waist circumference. I would tell you if you're going to do waist circumference, you probably want to make sure you have a set person in your office that does it, and does it well, because the waist circumference is only as good as the person who's doing it and doing it reliably. All it takes is a tape measure. Again, you use a tape measure around the abdomen at the level of the ASIS, or the anterior superior iliac crests.

Parallel to the floor, make it snug without compression, and make sure that you're working with your patient, they're comfortable in a private place when you're doing that. That's something we could do as a second level assessment in our office today. Matthea, what do you do? Because certainly as a specialist in obesity, you might be doing more, but what do you do, and what do you recommend for us?

Dr. Rentea: I do the waist circumference, actually. This is something on the first visit. I want metrics that we can follow. One thing that's really great with waist circumference is that it's going to help you for some of those where I'm going to call it indeterminate BMIs, where you're 31, 32, and you don't know, they don't actually have very much metabolically that's happening as far as illness. This will start to help you to determine what category that they fall into. Waist circumference is actually going to be very helpful for you in those scenarios. Then I think it's something nice also for the patient to be able to follow.

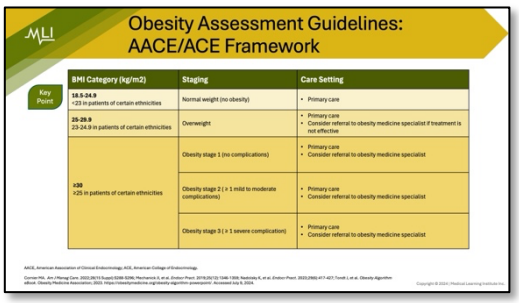
I just really stress, I like how you said, hey, have the same person do it all the time. If I have them do it at home, they do understand the correct place in the back, where to look for the top of the hip there. Then I say, "Hey, you have to be all the way at the end of expiration." I make sure if they're going to do it at home, that they know how to follow it. I do use the bioelectrical impedance scales.

They can be quite pricey. They do have lots of locations where they can go and do it at a much more affordable price. Mainly, I do this specifically because we're talking about a lot of anti-obesity medications today. I'm just very vigilant that we're not losing muscle mass. Again, even if we can just do waist circumference, massive win. You don't need to do all of it to make a big impact.

Dr. Shubrook: One of the few good things that came out of COVID, for us at least, was the fact that many of these visits can be done by telehealth. By doing telehealth, one, it's going to make it easier for the patients. Sometimes it's two, also really valuable to have more touch points. The more touch points someone has, it really allows us to, one, work with the patient on their goals. Two, not be so separated from setbacks, because invariably there'll be setbacks. We want to make sure that we're there for support. Do you do telehealth in your practice? How do you address that in the overall management?

Dr. Rentea: I do. It's actually a majority of my practice. The reason being, it's a follow-up interval because people, they can't do the one week follow-up with me, the one month. It's a lot of follow-up that's needed. Again, it's going to vary by practice, as far as how much you as a clinician take on or how much you have support staff, whether it's a dietician, things like that. I find that telehealth, again, patients feel safe sometimes when they're home or at work in a place where they don't feel like they need to come in and be poked and prodded.

If we just think about historically how patients have been treated, we can change a lot in the clinic. Again, it's a comfort factor. It's another touch point. I've seen their results really improve with that when they have more touch points of being able to talk to me.



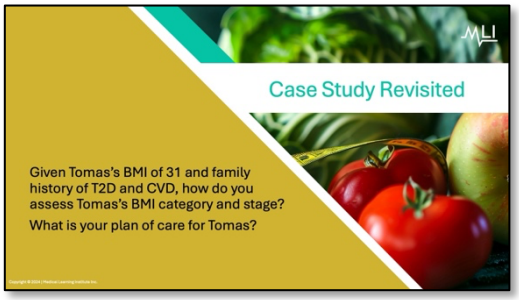
Obesity Assessment Guidelines: AACE/ACE Framework

Dr. Shubrook: We know now that we've recognized obesity as a clinical condition and a condition that needs to be addressed. There have been assessment guidelines, not only from the obesity society, but also from endocrine societies. We're looking here at the AACE and ACE framework. Looking

at the BMI and considering this one as the current weight stage, but then two, the care setting.

I think what I would tell you before we do anything else is that it's going to take a team regardless where someone's at across this weight continuum. Primary care is critically important because the patient best. You have an ongoing relationship with your patient. Even if you have weight in the normal category, you should be working to prevent that weight gain that we talked about earlier as you start to age. As you start to see a BMI in the overweight category, I think it's actually important to recognize that you can pull in a multidisciplinary approach.

If you need help, and many of us do need help in primary care, because this takes a lot of time, this is a great time to bring in the help of an obesity medicine specialist to help. Once the person's weight gets to the stage one, stage two, or stage three obesity, we're going to need a multidisciplinary approach. That primary care clinician is still going to be actively involved in maintaining their best health. Involving an obesity medicine specialist, involving dieticians, involving physical therapists or exercise physiologists, this requires a team just like diabetes and other chronic diseases. I think it's important for us to know that we don't have to do it alone.



Case Study Revisited

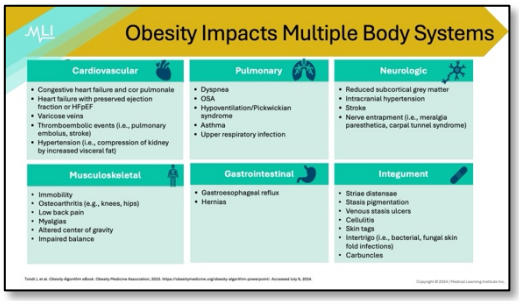
Let's go back to Thomas. We had talked about Thomas earlier. He had a BMI of 31 and a family history of type 2 diabetes and cardiovascular disease. He talked about his frustration of gaining 15 pounds in the past year. How do you assess Thomas's, well, first of all, BMI category and stage? Then, is there any other workup? What would be your plan of care for Thomas?

Dr. Rentea: One of the first things I would say to Thomas, I would say, "Is it okay if we discuss your weight today?" I really want to stress that because we know all this data in front of us. It's clear as day in our mind, but we need to remember we're a clinician, but we have someone in front of us that they're not dealing with this all day long. I assess that this patient is open to talking about that. Then I say, "Listen, I hear this family history that you have, and I'm seeing currently in front of me what your health condition is looking like." Given where your weight is right now, I bring up the concept that this is actually a chronic disease.

I see how do you feel about that because a lot of people have not thought about it in that context before? Then I actually explain, I do actually go through the staging, and I say, "I'm doing this because I want to explain to you at this what we see later." I really baby step them into understanding that it can be a chronic condition. Then are they open to working on different things and hearing some possibilities? First, I see if they're even open to that. Then of course, additionally, I would be ordering labs and seeing how many different specialists we're going to bring in and what we're going to do. For me, it's really first seeing, are they open to talking about this?

Dr. Shubrook: Yes. I think, again, that's going to set a working relationship. I probably thank Thomas for, one, bringing it to our attention and the fact that he's worried about it. That is super important. I

think knowing that weight trajectory is going to help us understand where we're at. He mentioned 15 pounds in the past year, which is remarkable. What happened in this past year? Are there other factors that were involved and other conditions or has this been a continual weight? Like many people, maybe they just didn't notice it until now when there was a time for you to actually check your weight.



Obesity Impacts Multiple Body Systems

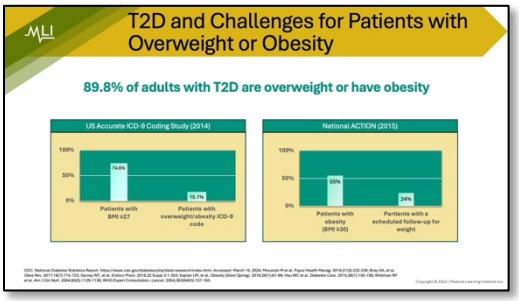
Dr. Rentea: We've talked about a lot how obesity is a complex medical disease. The reality is it's affecting every single organ within our body. Today, we're just going to talk about six different areas here. Everything is related. That's what I say. Specialists always want to pretend that one thing is the only thing. Let's just go through a few here. We really, if someone suffers with overweight or obesity, we now want to put on our glasses of seeing if we can find anything else that's happening with them.

For example, with the cardiovascular system, we're going to look, is blood pressure a challenge? Are there any varicose veins that I'm seeing? Is there any heart failure? We're really going to look at the cardiometabolic aspects there. Then of course, heart and lung are related. We're going to see, do they have any shortness of breath? Is there any undiagnosed sleep apnea? We're going to look at that. Even neurologic, we see that the brain structure is changing with this. This is really important to understand that this is not just an aesthetic thing with obesity, what we're seeing. It's actually affecting the physiology within our body. Looking at stroke risk, nerve impingement can be actually an incredibly common one.

The classic scenario that I see is someone that will have diabetes, will have a bilateral carpal tunnel syndrome. Then again, did we miss overweight or obesity with treating that? Musculoskeletal, again, immobility, that they are limited potentially with what they can do. Lots of arthritis at an earlier age. Back pain, things like that. If we look at the GI tract, is there reflux, hernias?

Then when we talk about integuments of skin, this is actually fascinating because you can tell a lot here even just with just looking at someone in the room without even taking clothes off or anything. One of the things that I really look at, I'll look for if there's insulin resistance around the neckline, is there acanthosis nigricans? I'll look for any venous stasis, so are there any discoloration in the legs? Skin tags, again, these are all things that are related to this, and so we need to start to not just think, oh, there's a skin tag, but go back and say, is there insulin resistance? Is there overweight or obesity? Pull everything together.

It will help for their care to feel more unified. The main point here, the takeaway from this slide would be, if patients with a BMI either at or over 25 or under 23, and patients of certain ethnicities, they should be evaluated for weight-related complications, and patients with weight-related disease should be evaluated for overweight or obesity. Really think both directions. Don't get locked into one.



T2D and Challenges for Patients with Overweight or Obesity

What's interesting is a lot of the time as clinicians, we will really focus on things like type 2 diabetes, but we'll miss overweight or obesity. These are two really nice studies that highlight this directly with numbers.

In 2014, there was a study that showed we will have patients in front of us that have a BMI at or over 27, and that will be 74.5%. Actually, we're only diagnosing it in the chart. This was an older study, it was an ICD-9 code at that time, but we're only getting about 15% of that. Again, we're just not capturing what's happening. Then if you look here, the 2015 study, again, patients with obesity, BMI over 30, it was in the 50%, but again, only in the 20% is what we're getting as far as who we're scheduling for weight follow-up. There's a massive disconnect as far as what we're looking at and what we're missing. Again, it speaks to that under-diagnosis that's happening.

Dr. Shubrook: I think it's a missed opportunity. If someone is always looking for ways to get treatments covered, if we were able to document that BMI in addition to their other conditions, it shows that we have been working on it for a while, and we really support the justification for maybe obesity-specific treatments. I think it's important for us to know that that's not just a trivial thing, and one, we should be talking to our patients about it, but two, we should be documenting it because it is part of our comprehensive care.

Dr. Rentea: Again, I think what really needs to happen here is that we need to start to catch these things sooner, so really further upstream. If we can find, for example, when the weight curve starts to go up or when some of these conditions start, if we can catch it earlier, we can have a lot more impact so that a lot of these things don't need to either develop to begin with or that they don't progress. Do you have any ways that you help patients understand that in the clinic when you're starting to see these patterns emerge?

Dr. Shubrook: What I like about this is this is an opportunity for us to really make it easier for us and for our patient. I take myself as a lumper, not a splitter. I know that if I have a patient with six conditions, I feel like I'm juggling to try to manage all of these things, and you can only imagine how the patient feels. Here's an opportunity. If there's something that underlies multiple conditions, I can work with them to say, if we could help address this component, you're going to be able to have five different things improve often without medications. Sometimes medications are necessary, but this allows us to really focus a pathway that will let our patients see multiple benefits.

I think that makes it, one, easier for us to keep track and stay focused, and two, I think it makes it more doable for our patient. Let's go back to our case. Knowing that we've talked about all these different components of assessing overweight and obesity, how to have a patient-centered approach, how to tie it in other conditions. How do you have this discussion with Thomas now, recognizing that he's already telling you about his weight reduction attempts, his challenges with his current job, and his concern about cardiovascular and metabolic disorders?

Dr. Rentea: I think this is a perfect opportunity to use all the things we talked about in this session. Taking an opportunity to ask him more questions, like you were saying, "Hey, what things have been happening in the past year for you?" Gathering more data at that visit, looking more comprehensively at labs, are there missing labs? Do we fully know that there's any other metabolic conditions happening?

Really evaluating all of that, seeing if you can get some of that introductory data, and then seeing what is he open to starting with? Maybe you have a few ideas even before you get back some of that data, some lifestyle things you can change until you look at labs, until you bring him back. Again, I always want to encourage in these scenarios, this is going to take many visits of you talking about this with the patient, so don't try to do it all in one session. Even in an hour, it usually can't be accomplished.

Dr. Shubrook: As you said, I always like to thank the patient for bringing this up. I think they're being an active participant in their care. It is important to one, let him know his BMI status and his weight category and how that's important related to his health, because he does have concerns about that but give him the news to say, "We'll work on this together, but it will take some granular data so we really know what it is that's happened and what you're doing so we can make your work more efficient to improve your health."

This brings us to the end of part one of the series, *Addressing the Weight of the Matter: Diagnosing Obesity*. We've taken a look at misconceptions, the undertreatment of obesity in primary care settings, clinical diagnosis guidelines and obesity and comorbid conditions and their relationships. I think this is a super important topic because we see this every day in primary care. Our patients are struggling. They want our help and often they don't feel that we're available for them. I think we can do a lot by being patient-centered, bringing a patient team to help the patient and recognizing this is a long-term chronic disease that's going to need our ongoing help. Matthea, how do you speak to the importance of this topic?

Dr. Rentea: I really tell the patient that by us doing this work, we're going to improve the quality of their life and the longevity of their life and most people want to hear that I'm going to be able to do all the things I want to do. I'm going to be able to be present for everyone I want to be and I'm going to live a long time. People usually really like to hear that.

Dr. Shubrook: Thank you so much for joining me today. We'll ask you all to join us in part two of the series, *No One-Size-Fits-All Approach: Individualizing Obesity Treatment*.