

# OAC NEWS

The Obesity Action Coalition's Quarterly Magazine for Patients



July 2008

## *Walk on the Capitol* Draws Thousands to Our Nation's Capitol for Obesity Awareness

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## A Message from OAC Chairman, Jim Fivecoat

It's difficult to convey the excitement I felt on June 17th at our *Walk from Obesity – Walk on the Capitol* where around 3,000 of us rallied, listened to Joe Nadglowski and Caitlin VanZandt, and walked with the U.S. Capitol in the background.

Thanks to the dedicated efforts of both the Obesity Action Coalition (OAC) and American Society for Metabolic and Bariatric Surgery (ASMBS) Foundation staffs, the event went off without a flaw, exceeding all of our expectations. To read a complete event wrap-up, please see pages 11 and 12 of this magazine. You can also view a variety of photos from the event at [www.walkonthecapitol.com](http://www.walkonthecapitol.com).

While in Washington, DC for the Walk and the ASMBS Annual Meeting, most of your Board members, as well as OAC members and a number of members from the ASMBS, were able to spend time on "the Hill," meeting with the offices of 49 Senators and members of Congress.

We also held a legislative briefing with a boxed lunch for Senatorial and Congressional staffs. I had the honor to present at the briefing along with Dr. Robin Blackstone, who presented on the impact of obesity; Dr. Christopher Still, who presented on the available treatments for obesity; Jeff Haaga, who with me shared his personal struggles with obesity; and Joe Nadglowski, who talked about the OAC and our efforts.

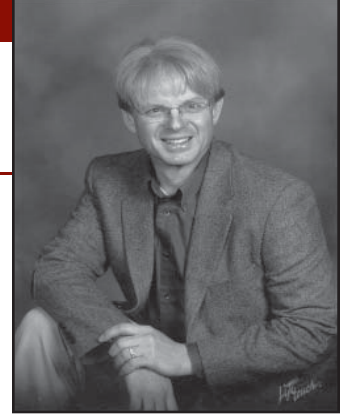
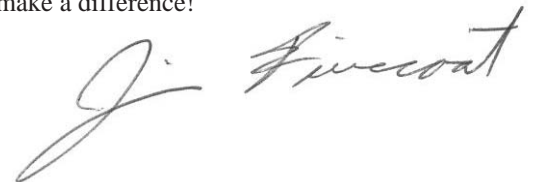
More than 50 legislative aides, leaving standing-room only, were present at the briefing. Our thanks to our DC Policy Consultant, Chris Gallagher, who pulled this event together and helped us navigate the Capitol offices. On the OAC Web site

([www.obesityaction.org](http://www.obesityaction.org)), you can find out more about what the OAC is asking our legislators to do for us.

This issue is jam-packed with a variety of helpful educational topics for you to view. Be sure to check out a complete review of popular commercial diet programs (i.e. Jenny Craig, Weight Watcher, Atkins Diet, etc.) starting on page 12. We all know that we have been enticed to try at least one of these programs (we probably have tried one, if not all of them, already). This article gives a complete look at what to consider when thinking about a commercial weight-loss plan.

I am also excited about the OAC's new Advocacy Action Center where you can easily become an "e-advocate." The Action Center allows you to locate and write your elected officials, all with a few clicks of your mouse. To learn more about this exciting new addition to our advocacy efforts, please see the article on page 17.

As always, the OAC continues to represent all patients affected by obesity. We thank you for your continued support. Events such as the *Walk on the Capitol* and the legislative visits on Capitol Hill are all done for YOU. Together, with one strong voice, we DO make a difference!



## OAC NEWS

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The Obesity Action Coalition (OAC) is an independent national non-profit patient organization dedicated to educating and advocating for those affected by obesity.

The OAC is governed under the authority of a National Board of Directors. Members of the OAC Board of Directors include: Jim Fivecoat, *Chairman*; Robin Blackstone, MD; Pam Davis, RN, CCM; Jacqueline Jacques, ND; Julie Janeway, BBA, MSA, JD, ABD/PhD; Georgeann Mallory, RD; Christopher Still, DO, FACN, FACP; and Barbara Thompson, MLS.

*If you are interested in contributing to this publication, or for reprint requests, please contact the OAC National Office.*

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Opinions expressed by the authors are their own and do not necessarily reflect those of the OAC Board of Directors and staff. Information contained herein should not be construed as delivery of medical advice or care. The OAC recommends consultation with your doctor or healthcare professional.

# Cholesterol

## What is it AND how should I monitor it?

These days, **cholesterol** is almost a household word. You see ads on TV and in magazines for the latest cholesterol-lowering treatments, hear about foods and diets that will keep your cholesterol in check, and hear people discuss their ratio of good to bad cholesterol like a change in the weather. **But in many ways, cholesterol is more confusing than ever.**

*By Jacqueline Jacques, ND*

My grandparents were the first people I ever remember talking about cholesterol. When I was a little girl, they suddenly adopted a radical dietary change – going almost overnight from steak, eggs and potatoes to a near vegetarian diet enhanced by fish and occasional chicken.

And the reason? Cholesterol. My grandpa's, so I was told, was too high, and these changes were intended to help him get it under control (which he did and lived a long and healthy life to the age of 93).

Back when my grandpa found out his was high, there was really just one number: total cholesterol. Now we have HDL, LDL, VLDL, Lp(a) and ratios to compare them. And when it comes to what controls cholesterol - we now know it is not just cholesterol in diet and genetics, but also in some fats, other nutrients, lifestyle factors and more.

### What is Cholesterol?

Cholesterol is a waxy, fat-like substance that is both made by humans and found in fat-containing animal products in varying amounts. As humans, we need cholesterol, which is why it is not all “bad.” Cholesterol is important to the structure of all cells and is the precursor to the creation of steroid hormones like estrogen and testosterone. We also use it to make vitamin D.

### Where Does Cholesterol Come from?

Most of the cholesterol in your body is made by you in your liver, and often the amount of cholesterol a person makes (as well as the type) is greatly influenced by genetics.

All sources of dietary cholesterol are from animal products such as eggs, shellfish, dairy products, beef and poultry. Daily cholesterol intake in excess of 300mg/day from dietary sources can raise blood cholesterol levels and contribute to heart disease.

## Types of Cholesterol

Total Cholesterol ♦ LDL ♦ HDL ♦ VLDL

When you have your blood tested for cholesterol, you may see a whole group of different numbers. Cholesterol can be broken down into subtypes including LDL, HDL, VLDL, and lipoprotein a [Lp(a)]. Your doctor may look at these “cholesterol fractions” and their ratios to determine your risk for cardiovascular disease. These are the most common values you will see:

- **Total Cholesterol** – Total cholesterol is still on most lab panels, and is really an outdated test. This value combines the total of your HDL (“good” cholesterol) and LDL (“bad” cholesterol) with a percentage of your triglycerides (another “bad” fat). Because the good and the bad are tossed together in this number, it really doesn't help us understand much about cardiovascular risk.

- **Low-Density Lipoprotein (LDL Cholesterol)** – Since cholesterol is a fatty substance, and fats do not dissolve in water, it has to be carried around in your body by something else. Cholesterol in our bodies is carried by protein – which we then call “lipoproteins.” LDL carries cholesterol out of your liver, where it is made, to other parts of your body where it is used to make hormones and other things. Excess is taken back to the liver, excreted into bile and eliminated through your digestive system.

However, if there is too much, it can also be deposited as plaques on the wall of your arteries – this is what we call

*Cholesterol continued on page 4*

atherosclerosis. For this reason, LDL is called “bad” cholesterol and is most associated with poor cardiovascular health. Ranges for LDL are as follows:

- Less than 100 mg/dL (2.59 mmol/L) - Optimal
  - 100-129 mg/dL (2.59-3.34 mmol/L) - Near optimal, above optimal
  - 130-159 mg/dL (3.37-4.12 mmol/L) - Borderline high
  - 160-189 mg/dL (4.15-4.90 mmol/L) - High
  - Greater than 189 mg/dL (4.90 mmol/L) - Very high
- **High-Density Lipoprotein (HDL Cholesterol)** – High-density lipoproteins carry much less cholesterol than LDL. They are made both in the liver and in the intestines. We call them “good” cholesterol, because they help to remove cholesterol deposits from artery walls.

Ranges for HDL are usually different for men and women:

- Less than 40 mg/dL for men, less than 50 mg/dL for women - Increased risk for heart disease
  - 40 to 50 mg/dL in men, 50 to 60 mg/dL in women - Average
  - Above 60 in men or women - Lowered risk for heart disease
- **Very Low-Density Lipoprotein (VLDL Cholesterol)**- VLDL is another type of “bad” cholesterol. It carries some cholesterol, but primarily transports another fat – triglyceride. After VLDL drops off the triglyceride it is carrying, it is then simply a protein and cholesterol “remnant.” Like LDL, these can lead to arterial plaque formation.

The liver also makes excess VLDL into LDL cholesterol. A normal level for VLDL is between 5 and 40 mg/dL. This is usually calculated as a percentage of your triglyceride level. If your triglycerides are over 400, this number is not accurate and may not be calculated.

### Other Tests You May See

- **Lp(a)** – Lipoprotein a, or Lp(a) for short, is a genetic variation of LDL cholesterol. Studies have shown that higher levels of Lp(a) can lead to earlier, and perhaps more aggressive, development of arterial plaques.
- **Triglycerides** – Triglycerides are not cholesterol, but usually appear in the “lipid (fat) panel” that your doctor orders. Triglycerides are the primary storage form of fat in the body. Normally, we have low levels of circulating triglycerides in the blood, and when levels are elevated, it is a risk factor for heart disease just like elevated cholesterol. It is also a risk for fatty liver disease, pancreatitis (inflamed pancreas) and xanthoma formation (fatty growths under the skin). The normal ranges for triglycerides are:
  - Less than 150 mg/dL - Normal
  - 150-199 mg/dL - Borderline-high
  - 200-499 mg/dL - High
  - 500 mg/dL or above - Very High
- **Total Cholesterol/HDL ratio** – This ratio, which is calculated by dividing your total cholesterol by your HDL level, will sometimes appear on your lab results. It has been studied as a predictive number for developing heart disease, although in recent years, some doctors have come to feel it is not very useful. If your doctor is looking at this ratio, they will want you to keep it below 5:1.
- **HDL/LDL ratio** – This is another calculated number that compares your levels of “good” to “bad” cholesterol. It is best for this ratio to be above 0.3 – even better if it is above 0.4.

### Things that Influence Cholesterol Levels

There are many factors, from genetics to diet to lifestyle, which raise and lower our cholesterol levels – both good and bad. Sometimes, your doctor will use medications to keep cholesterol levels lower, but there are also things you can do on your own that can help.

### Good Foods to Help Control Cholesterol

There are other things you can do through diet to help lower cholesterol. Increasing the soluble fiber-containing foods in your diet has been shown to be beneficial. Good sources of soluble fiber include oats, peas, beans, apples, pears, citrus fruit, broccoli and carrots. Overall, most fruits and vegetables have soluble fiber.

Soybeans have been shown to be very helpful in lowering cholesterol. This can be tofu, tempeh, soy protein or other soy foods. For helping to lower cholesterol, the recommended amount of soy protein is 25 grams per day.

Another great dietary strategy is to include sources of beneficial essential fatty acids – especially sources of Omega-3 fatty acids. This includes salmon, tuna, sardines, walnuts, flax seeds, fish oil or flax oil products, or foods such as eggs, milk or yogurt fortified with Omega-3 fatty acids. Other good things to include in your diet to help keep cholesterol in check include foods like margarines that say they are made with sterols or stanols, olive oil, and the herbs garlic and cinnamon.

### Foods to Avoid

On the side of things to avoid, the most important are saturated fats, trans fats and very high-cholesterol foods. Saturated fats are those that are solids when they are at room temperature and turn to an oil when heated.

All fats are made up of carbon, hydrogen and oxygen. In a saturated fat, all the carbon bonds are occupied by (or *saturated* with) hydrogen molecules. These fats are mostly found in meat, poultry, egg yolk and full-fat dairy foods. They are also found in a few non-animal products such as coconut, cocoa butter and palm oil. Saturated fats are known to contribute to elevated cholesterol and are associated with heart disease risk when consumed in excess.



Trans fats, or trans fatty acids, are created when a fat is partially hydrogenated. Technically, the “trans” refers to the fact that the hydrogens are attached on opposite sides of the carbon molecules (versus on the same side, which would be “cis”).

Trans fats have received a lot of attention lately in relation to their role in cardiovascular disease. It is believed that they act in the body more like saturated fats than unsaturated fats, and studies have shown that they both increase LDL (bad) and lower HDL (good) cholesterol. In 2003, the United States Food and Drug Administration (FDA) passed legislation making it mandatory to label the trans fatty acid content of foods. Since 2006, this should appear on all food labels, making trans fats easy to spot.

Cholesterol is found in the diet in all animal products (meat, poultry, eggs, dairy, fish), and in baked goods that contain ingredients like milk, lard, egg yolk, butter or cheese. Daily cholesterol intake in excess of 300mg/day can contribute to heart disease. The TLC diet, mentioned in the below box, recommends keeping daily intake below 200mg.

### Things that Raise HDL

Raising your HDL is usually as important as lowering your LDL. Lifestyle factors that can help with raising HDL include weight-loss, moderate exercise and quitting smoking (or never starting). The American Heart Association recommends a target body mass index below 25 for optimal HDL.

Studies have generally shown that aerobic exercise, done for 30 minutes 3 times a week up to daily, raises HDL. Modest alcohol consumption may also help to raise HDL, but carries its own risks. Finally, the vitamin niacin (B3) is known to be effective for raising HDL levels. Niacin is also sold as drug Niaspan® for the treatment of elevated cholesterol. Proper use of niacin may raise HDL levels by as much as 35 percent.

If you are purchasing niacin on your own, it is important to know that there are two forms – crystalline niacin or nicotinic acid, which impacts cholesterol, and niacinamide or nicotinamide, which does nothing to cholesterol at all. Also, at the doses

typically used for this purpose, the uncomfortable side effect of flushing is extremely common. Niacin may also cause liver toxicity, stomach irritation, diarrhea and changes in blood sugar levels. For these reasons, it is a good idea for anyone who wishes to take niacin for cholesterol to consult with a qualified healthcare professional first.

### Can Cholesterol be Too Low?

With all this talk about lowering cholesterol, we also know that we need some. Cholesterol, as we said earlier, is important for making hormones and as a structural component of cells. There is some evidence that very low cholesterol is associated with increased cancer rates, and perhaps with depression. But we don't really know what too low would be.

Many people think that having LDL levels between 60 and 70 would be optimal, and it is generally suggested to keep total cholesterol below 200. Perhaps in the future, research will really tell us what is optimal to create a balance where we have enough cholesterol in the body to keep us healthy while not contributing to heart disease.

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### About the Author:

*Jacqueline Jacques, ND, is a Naturopathic Doctor with more than a decade of expertise in medical nutrition. She is the Chief Science Officer for Catalina Lifesciences LLC, a company dedicated to providing the best of nutritional care to weight-loss surgery patients. Her greatest love is empowering patients to better their own health. Dr. Jacques is a member of the OAC National Board of Directors.*

### Resources:

1. American Heart Association: [www.americanheart.org](http://www.americanheart.org)
2. National Heart, Lung and Blood Institute: [www.nhlbi.nih.gov](http://www.nhlbi.nih.gov)
3. National Library of Medicine Cholesterol Resources: [www.nlm.nih.gov/medlineplus/cholesterol.html](http://www.nlm.nih.gov/medlineplus/cholesterol.html)
4. Mayo Clinic Cholesterol Center: [www.mayoclinic.com/health/cholesterol/CL99999](http://www.mayoclinic.com/health/cholesterol/CL99999)
5. Health Central Cholesterol Information: [www.healthcentral.com/cholesterol](http://www.healthcentral.com/cholesterol)

## Things that Lower LDL

There are many things you can do on your own to help lower your LDL cholesterol. A good place to start is with the Therapeutic Lifestyle Change (TLC) program advocated by the National Heart, Lung and Blood Institute. The primary components of TLC include:

1. **The TLC Diet** – this is a very low saturated fat and low cholesterol diet with moderate calorie restriction. The diet also has programs that increase fiber and dietary sterols and stanols, which can further lower cholesterol.
2. **Weight-loss** – The TLC program advocated weight-loss for those who are overweight as part of an overall cholesterol-lowering program.
3. **Exercise** – They recommend 30 minutes or more on most or all days of the week.



# Weight Discrimination:

## A Socially Acceptable Injustice

By Rebecca Puhl, PhD

Obesity is highly stigmatized in our society. Overweight and obese individuals are vulnerable to negative bias, prejudice and discrimination in many different settings, including the workplace, educational institutions, healthcare facilities and even within interpersonal relationships.

Unfortunately, weight bias remains very socially acceptable in North American culture; it is rarely challenged, and often ignored. As a result, thousands of obese individuals are at risk for unfair treatment, and there are few outlets available to provide support or protection.

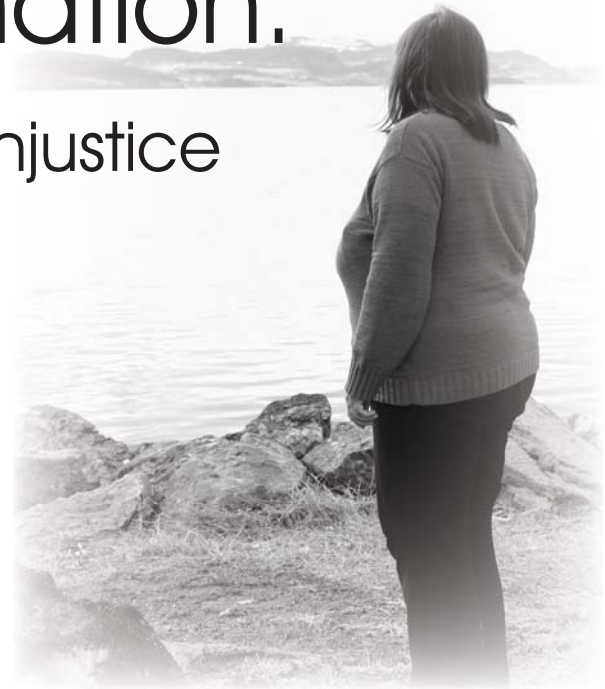
### What is the difference between “stigma” and “discrimination?”

Weight stigma or bias generally refers to negative weight-related attitudes toward an overweight or obese individual. These attitudes are often manifested by negative stereotypes (e.g., that obese persons are “lazy” or “lacking in willpower”), social rejection and prejudice. Weight stigma includes verbal teasing (e.g., name calling, derogatory remarks, being made fun of, etc.), physical aggression (e.g., hitting, kicking, pushing, shoving, etc.) and relational victimization (e.g., social exclusion, being ignored, avoided, or the target of rumors).

Many obese individuals report being treated with less respect or courtesy than thinner persons and being called names or insults because of their weight. Thus, weight stigma can emerge in subtle forms, or it can be expressed directly.

Discrimination is distinct from stigma and negative attitudes, and specifically refers to unequal, unfair treatment of people because of their weight. For example, an obese person who is qualified for a job but is not hired for the position because of his or her weight may have been the victim of weight discrimination.

Other examples include being denied a job promotion or fired from a job because of one’s weight; being denied certain medical procedures or provided inferior medical care because of one’s weight; or being denied a scholarship, a bank loan or prevented from renting or buying a home because of one’s weight.



In each of these cases, the behaviors directed toward the obese individual depict inequitable treatment with no justifiable cause, and legal recourse may be an appropriate response in these situations.

### How common is weight discrimination?

Given the social acceptability of negative attitudes toward obese individuals, it may not be surprising to learn that weight discrimination is common in the United States.

In a recent study, we examined the prevalence of multiple forms of discrimination in a nationally representative sample of 2,290 American adults and found that weight discrimination is common among Americans, with rates relatively close to the prevalence of race and age discrimination.

Among women, weight discrimination was even more common than racial discrimination. Among all adults in the study, weight discrimination was more prevalent than discrimination due to ethnicity, sexual orientation and physical disability. Almost 60 percent of participants in our study who reported weight discrimination experienced at least one occurrence of employment-based discrimination, such as not being hired for a job.

On average, a person’s chances of being discriminated against because of weight become higher as their body weight increases. In our study, 10 percent of overweight women reported weight discrimination, 20 percent of obese women reported weight discrimination and 45 percent of very obese women reported weight discrimination.

Rates for men were lower, with 3 percent of overweight, 6 percent of obese and 28 percent of very obese men reporting weight discrimination. This finding also tells us that women begin experiencing weight discrimination at lower levels of body weight than men.

### What legal action can be taken for victims of weight discrimination?

Unfortunately, there are few legal options available for individuals who suffer weight discrimination. Currently, there are no federal laws that exist to prohibit discrimination based on weight.

With the exception of one state law (Michigan) and a few local jurisdictions that address discrimination on the basis of weight or appearance (e.g., San Francisco), the vast majority of people who experience weight discrimination in the U.S. must pursue legal recourse through other indirect avenues.

In particular, obese individuals have depended on the *Rehabilitation Act* of 1973 (RA) and the *Americans with Disabilities Act* of 1990 (ADA). Most cases filed under these categories pertain to weight-based discrimination in employment settings, and only a few cases have been successful. In addition, whether it is appropriate for obesity to be considered a “disability” under the ADA is questionable and could perpetuate bias further.

Overweight people who are not “morbidly obese” but who experience weight discrimination cannot file claims under the ADA because they are not considered disabled under this law. It places an unfair burden for individuals to prove that their obesity is debilitating and disabling in order to obtain fair and equitable treatment in the workplace.

These unresolved issues, in addition to public perceptions that place blame on obese people, have led to inconsistent court rulings and often deter obese individuals from taking any legal action.

Clearly, legislation is badly needed to protect individuals from weight discrimination. Massachusetts recently introduced legislation (House Bill 1844) to prohibit weight-based discrimination in employment settings. The hearing was held on March 25, 2008, with no opposition present at the hearing, and all expert testimonies were in favor of the bill. No decision has yet been made, but if this bill passes, it will be an important step in encouraging other states to follow suit.

Reducing weight bias requires major shifts in societal attitudes, and national actions are needed to establish meaningful legislation to ensure that obese persons receive the equitable treatment they deserve.

## Obesity Discrimination ON THE RISE

Despite the increasing prevalence of obesity, it appears that incidences of weight discrimination are only becoming worse.

In our research, we examined trends of weight discrimination throughout a 10 year period from 1995-2005 and found that the prevalence increased by 66 percent during this decade, from 7-12 percent of the general population.

This finding was not a result of increasing obesity rates, but rather specifically demonstrates that more people are experiencing weight discrimination.

### About the Author:

*Rebecca Puhl, PhD, is the Director of Research and Weight Stigma Initiatives at the Rudd Center for Food Policy and Obesity at Yale University. Dr. Puhl is responsible for coordinating research and policy efforts aimed at reducing weight bias.*

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For more resources on weight bias, including fact sheets, handouts, research articles, assessment tools, and PowerPoint presentations, please visit [www.yaleruddcenter.org](http://www.yaleruddcenter.org).





# Action!



From the time she was a child, Caitlin VanZandt, star of *Guiding Light* and *The Sopranos*, always knew she was a “bigger girl.”

By James Zervios, OAC Director of Communications

As a child, she was always in the 90<sup>th</sup> percentile for her height and weight. She loved going to summer camp for acting, and most summers lost a little bit of weight.

But, it wasn't until her mother commented about her weight that Caitlin realized her weight was an issue.

“I think I was around 10 years-old when I began to gain weight steadily. I mean, I always loved food and never really thought about it before then. Living in Manhattan, I walked everywhere, so I really wasn't inactive, but the weight stayed with me,” said Caitlin.

At 13 years-old, Caitlin was a size 16 and by high school, she was a size 18. She tried diets throughout her teen years, but they never really worked. She said to me, “I never felt the diets addressed the emotional side of my obesity, and that's why I think they didn't work for me.”

Little by little, Caitlin's weight continued to rise. She recalled one time where her weight became very apparent to her when she visited her gynecologist and the doctor told her she needed to lose weight. “I was like ‘Why are you telling me this? This isn't even your specialty.’ It just made me realize I had to do something,” said Caitlin.

She was beginning to feel the effects of her weight, such as being out of breath due to her asthma. By the time she landed her role on *Guiding Light*, Caitlin began researching weight-loss surgery;

however, Caitlin soon learned that her weight was more than just on the outside. “I remember when I was looking into weight-loss surgery, I often denied the fact that I even qualified for this procedure. Emotionally, it was difficult,” said Caitlin.

After looking at all her options, Caitlin decided on gastric banding. “For me, I felt the LAP-BAND AP<sup>®</sup> System was the best option. I liked it because it is reversible and adjustable,” confidently said Caitlin.

By this point, Caitlin knew what she wanted to do about her weight, but what about her role as Ashlee on *Guiding Light*? She knew she had to tell the show that she was having this procedure. After all, Caitlin (Ashlee) would soon start to lose weight. “I went in and told the producers that I was having weight-loss surgery, and to my surprise, they wanted to write it in the show,” laughed Caitlin. Caitlin, along with her character Ashlee, had weight-loss surgery in February 2008.

In June of 2008, Caitlin spoke on behalf of all those affected by obesity at the *Walk from Obesity – Walk on the Capitol* in Washington, DC. She shared with them her difficulties with the disease of obesity. One of the most important aspects Caitlin touched on that day was the emotional side of any weight-loss journey. “It's not a diet. It's an overall lifestyle change, and it definitely takes a strong and dedicated person to go through the change,” said Caitlin at the event.

Today, along with a thriving acting career on *Guiding Light*, Caitlin has lost more than 55 pounds in four months; however, even with this tremendous success, she still expressed to me an important and often overlooked aspect of any weight-loss treatment option—the psychological and emotional side.



*“I went in and told the producers that I was having weight-loss surgery, and to my surprise, they wanted to write it in the show,” laughed Caitlin.*

For Caitlin, she expressed to me that she finds great support through her friends and co-workers on *Guiding Light*. “I remember recently when I went shopping with friends and tried clothes on. They all would say, ‘you look so great in that,’ or ‘that looks so nice on you.’ With all the great compliments, I ended up buying a lot of clothes. Maybe even too much,” laughed Caitlin.

Being in the media spotlight day in and day out, Caitlin also expressed the struggles she faces with the media. “One of the struggles I have is the sensationalized aspect of the media. It’s like, I lost 55 pounds in four months, but yet the question always asked is ‘what is your weight or what did you weigh before surgery?’ Why does that matter? It’s like they’re obsessed with numbers. I am not defined by a number. To be honest, I don’t even own a scale,” said Caitlin.

“To have weight-loss surgery is a complete and utter life-changing experience. It isn’t a diet. Obesity is not just a health problem. It’s more of an emotional and psychological problem. To me, obesity is a several-pronged issue. I still have issues with self-worth, and it is important to deal with all of these issues. Inside, I feel that the more attractive I feel about myself, the more attractive I will be to others both inside and out,” said Caitlin.

Well Caitlin, you most certainly proved to all of us that beauty and attractiveness can be much more than just “skin deep.”

*Today, Caitlin enjoys spending time with her friends, working on Guiding Light and has recently begun taking belly dancing and tap classes.*



*Caitlin walks alongside Joe Nadglowski, OAC President/CEO, at the historic “Walk on the Capitol” in Washington, DC. To read more about this event, please see page 11.*

# OAC

## Chairman’s Council

The OAC is grateful for the generous support of its Chairman’s Council Members:

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To add your name to this list, please visit [www.obesityaction.org](http://www.obesityaction.org) or contact us at (800) 717-3117.



# THOUSANDS WALK IN SUPPORT OF



By James Zervios, OAC Director of Communications

What is advocacy? Is it writing a letter or calling your Congressman? Well, for one evening, in the heart of the United States, on the Nation's Capitol, it was 3,000 proud and strong voices walking on the National Mall.

On June 17, 2008, at 7 pm, thousands of individuals affected by the disease of obesity walked on the National Mall in Washington, DC to raise obesity awareness. This event was co-hosted by the Obesity Action Coalition (OAC) and the American Society for Metabolic and Bariatric Surgery (ASMBS) Foundation. As the event began, music played through the air as bus, after bus, after bus, unloaded anxious walkers ready to make a difference and raise their voices.

The festivities kicked off with OAC President/CEO and ASMBS Foundation Executive Director, Joe Nadglowski taking the stage as the anticipation grew. As a spectator in the stands, you could see in Mr. Nadglowski's eyes the amazement as 3,000 people stood before him eagerly awaiting his first words. "Welcome to the *Walk from Obesity – Walk on the Capitol!*" The crowd came alive.

## WALKING TOGETHER

Mr. Nadglowski illustrated to the crowd of thousands the reasons why we stood in DC on that day. Obesity awareness, access to care, patient rights and much more, were just a few of the reasons for this historic event.

People traveled from all over the world to be a part of the Walk. Attendees traveled from Australia, Brazil, Chile, Canada and many

more places. For the first time in history, united as one, all those affected by obesity were standing proud.

In attendance that evening, Caitlin VanZandt, star of *Guiding Light* and *The Sopranos*, addressed the crowd and shared her own experience dealing with obesity. Spoken clearly and calmly, her voice carried across the crowd as she illustrated the often forgotten emotional side of this disease. As if she spoke to each person individually, they all listened with intense faces eagerly awaiting the start of the symbolic Walk. Soon after, Mr. Nadglowski took the stage again, and with excitement, knowing he had 3,000 people behind him, said "Let the Walk begin!"

Step by step, everyone followed Mr. Nadglowski and Ms. VanZandt as they symbolically walked on the National Mall. As a spectator, you couldn't help but have an overwhelming feeling of pride, patriotism and excitement as the entire National Mall filled with white T-shirts proudly displaying the *Walk on the Capitol* logo.

## WALKING FOR OUR HEALTH

Not only were all those in attendance walking for obesity awareness, but they also walked for their health. Through Body Media, a company which produces self-monitoring devices, the OAC was able to calculate the actual number of steps and calories burned during the Walk. A total of 6,179,500 steps were taken and a total of 368,750 calories were burned just on that evening. This is an extraordinary and symbolic figure for all those in attendance.



# ON NATIONAL MALL OBESITY AWARENESS

## MAKING HISTORY

Both before and after Tuesday the 17<sup>th</sup>, rain blanketed the DC area, but not on this evening. The sun lit up the entire National Mall and made every T-shirt in sight shine. From the crowd, you could hear people laughing, cheering and just feeling an overall sense of prowess. "We did it!" "Look at the line of people!" "We made history here today!" These were just a few of the words spoken by walkers on this historic evening.

As Mr. Nadglowski and Ms. VanZandt rounded the corner of their second lap, leading the thousands to the end of the Walk and crossing the finish line decorated with a patriotic red, white and blue balloon arch, a sense of accomplishment fell over the crowd.

Mr. Nadglowski once again took the stage with Ms. VanZandt. Cheers could be heard all the way to the White House. Even if you were just sitting on a park bench and had nothing to do with the event or obesity, you could tell something historic was happening.

As the sun set on the National Mall, a place where millions of individuals throughout time have marched, walked or ran for their rights or the rights of others, you couldn't help but feel inspired. History was made that evening and doors were opened. It was advocacy in its finest form – the voice of the people.

## THANK YOU TO NATIONAL SPONSORS AND MEDIA SPONSORS

Several companies/organizations also supported the *Walk on the Capitol* by making a financial contribution. The support of these Sponsors made the Walk possible. Sponsors included: **Platinum Level: Allergan, Covidien, and Ethicon Endo-Surgery Inc.; Silver Level: Synovis Surgical Innovations; Bronze Level: Bariatric Advantage, Body Media, Care Credit, EnteroMedics, W.L. Gore & Associates, Karl Storz Endoscopy America, and OnQ Painbuster.**

The *Walk on the Capitol* also received media support from various companies, organizations and publications which helped spread the message of the Walk and its purpose. Media Sponsors included: **Bariatric Support Centers International; Bariatric Times; BariMD; Beyond Change; Chef David Fouts; "The New You" Radio Show with Cher and Jeff - The WLS Coaches; Healthwise Technologies; LivLite; Make it a Lifestyle; Obesity Care News; Obesity Surgery Journal; Mervyn Deitel, MD; SOARD; Today's Dietitian; Barbara Thompson, WLS Center; and WLS Lifestyles.**

## SPECIAL THANK YOU TO OUR NON PROFIT PARTNERS

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# COMMERCIAL WEIGHT-LOSS PROGRAMS

This article reviews some popular commercial diet programs so you can decide what is right for you, and also will help teach you how to analyze commercial programs.

By Stephanie F. Yeager, RD, LDN, and Christopher D. Still, DO, FACN, FACP

With all of the enticing advertising and attractive claims about quick weight-loss out there, choosing the right weight-loss program can be difficult. Many commercial weight-loss programs can provide short term answers and temporary results to the problem of being overweight or obese.

Many commercial diets can be very restrictive for quick results; as weight-loss slows down, it is easy for people to get frustrated and discouraged. Some programs provide low calorie diets and can teach the basics of healthy eating, while others offer expensive pre-packaged meals.

Pre-packaged meals can be appealing because of the ease of choice and convenience. However, when meals are pre-packaged, the basics of nutrition and healthy eating are not learned, weight maintenance becomes difficult and weight regain is often inevitable.

Liquid meal replacement plans, if used for too long, may be harmful because they can cause nutritional deficiencies. Also, these programs are often difficult to stick with for continued weight-loss because of not being able to maintain a “normal lifestyle.” Unfortunately, when normal eating resumes, weight regain often occurs, again, because healthy eating and portion control is not learned through the diet.

## JENNY CRAIG

### **About the Program**

The Jenny Craig program was founded more than 15 years ago and has 800 centers nationwide. It offers frozen or pre-packaged prepared meals to help with portion management and calorie control. This program offers weekly one-on-one nutritional and motivational counseling.

It was developed by registered dietitians and psychologists and tries to focus on lifestyle changes. Another option available is Jenny

Direct, an at-home personalized weight-loss program. Materials are delivered to your home, and weekly support consultations are delivered over the phone.

### **How the Program Works**

A typical Jenny Craig program consists of three meals and three snacks per day, which is calorie-controlled based on your height and weight. The breakdown of the diet is about 60 percent carbohydrate, 20 percent from protein and fats. You are required to purchase foods (main dishes) from Jenny Craig for the first

## TIPS FOR EVALUATION OF COMMERCIAL PROGRAMS:

- Make sure major food groups are not excluded.
- Make sure foods are not labeled as “bad” or “illegal.”
- Make sure gradual weight-loss is promoted.
- Make sure other behavior modification components are taught.
- Make sure exercise is encouraged.

### JENNY CRAIG (CONT.)

phase, which is defined as the first half of your total weight-loss goal. You can work with your diet counselor to incorporate other food groups, such as fruits, vegetables, dairy and grains to your meals.

After the initial phase, you can transition to grocery foods, however, you are required to keep a food diary and work with the diet counselors on food choices.

#### *What's the Consensus?*

Overall, the Jenny Craig diet is a well balanced reduced calorie diet in which you can expect to lose about 1-2 pounds per week.

#### *About the Program*

Nutri/System was founded more than 30 years ago, also offering prepackaged meals and dietary counseling. More recently it has crossed into an almost exclusively online weight-loss program, complete with online counseling and menu planning.

Nutri/System's most popular and latest nourishment program features meal plans based on low glycemic-index (GI) foods, which are primarily low sugar, low-fat, high fiber and high protein foods. The claim with low GI foods is to “help keep your blood sugar levels stable and your metabolism burning strong, so you can burn more fat.”

#### *How the Program Works*

Membership in the online weight-loss community is free-of-charge. Newcomers are assigned to a personal weight-loss counselor, who will track their progress and give advice as long as they follow the program. New members also receive a menu plan, a catalog of products, a food diary, a weight chart, an online weekly newsletter and a few other goodies to get them started.

Other services include online bulletin boards, chat room support groups and a free diet analysis. You can and are encouraged to purchase prepackaged entrées and snacks, however it is not mandatory. However, the menu plans incorporate the pre-packaged foods, so meal planning is difficult if you do not purchase the products.

However, some concerns include:

- **Not teaching basics of nutrition in the initial phase** – this could perhaps lead to long term weight re-gain.
- **Counselors are not dietitians** – as with many commercial programs, they are encouraged to sell products.
- **Cost of the program** – although prices can vary, the company says the average cost is about \$60-70 per week, which includes entrées and snacks. Other fruits, vegetables, dairy and some grains are purchased in addition from the grocery store. Additional fitness tapes and videos are also available for purchase. Membership options can also be purchased which can cost around \$400 for the first month.

The Nutri/System plan encourages three meals and two snacks per day. They offer more than 100 prepackaged foods to choose from; you can plan your own meals, or you can sign up for the 28-day meal package. As with others, you have to purchase additional fruits, vegetables and dairy products.

#### *What's the Consensus?*

This diet plan, if proper additional fruits, vegetables and dairy products are added, can also be well-balanced and calorie-controlled. Following these diet and exercise recommendations should result in about a 1-2 pound per week weight-loss. The program offers free chat rooms and online support which proves to be effective for many people.

One concern is the “bad” carb claim with high GI foods is not exactly a true claim. GI scores are based on single foods, i.e. if you eat them one at a time. So in real life, when you are eating a meal, combining foods and cooking foods affects overall GI score or value. Actually, eating a well balanced meal will in essence lower the GI score of a high glycemic food.

Another concern is that the pre planned, packaged meals do not teach good nutrition, as no thought is involved, thus leading to lack of learning the essentials to keep the weight off.

The final concern is the cost of the food, following the meal plan costs about \$60 dollars per week which does not include the fruits, vegetables and dairy products that must be purchased in addition to the prepackaged foods.

*Commercial Programs continued on page 14*

### NUTRI/SYSTEM

## WEIGHT WATCHERS

### **About the Program**

Weight Watchers was founded in the 1960's and offers weight-loss guidance and support. The plan emphasizes a well-balanced diet and encourages lifestyle changes and exercise.

Weight Watchers has come up with multiple plans for dieters, from which they can pick the one that fits their lifestyle more appropriately.

### **How the Program Works**

The flex plan is based on the point system. All food is assigned a certain number of points according to calories, fat and fiber contents. Dieters are assigned a certain number of points to consume in a day based on their body weight and the number of pounds they want to lose. This system teaches that all food can potentially be incorporated into a healthy eating plan as long as the daily point values are not exceeded.

Dieters learn to balance their food choices; they can also trade physical activity for more points. Another option is the Core Plan® that focuses on healthy foods (whole grains, fruits, vegetables and low-fat protein foods) without the need for tracking points.

Weight Watchers offers and encourages a lot of support, through weekly meetings (private, online or group) and weigh-ins, to give dieters encouragement, help, suggestions and strategies.

No foods are forbidden and no foods are required for purchase. Most foods, even restaurant foods, already have points assigned to them which makes keeping track much easier than needing to figure them out on your own.

Food logs are encouraged, which turns off a lot of dieters. But the benefits gained from keeping food logs will, in the long run, "outweigh" the effort it takes to keep them. Long-term weight-loss and maintenance is better achieved as basics of nutrition and balance is taught. Dieters learn that higher fat and calorie foods can be incorporated but do "cost" more points, therefore they must trade off the rest of the day or increase exercise to make up for those foods.

### **What's the Consensus?**

Overall, this diet plan can teach healthy, balanced eating to dieters for a healthy 1-2 pound per week weight-loss. Weight Watchers is most similar to what dietitians would teach (calorie counting) and most healthcare professionals regard it as a standard to measure other commercial programs against.

The support system can facilitate tools and encouragement needed for weight-loss, however, counselors are trained but are not always licensed dietitians. The cost of a membership is about \$20 per year, and meetings cost about \$10-\$15 per week, although many discount packages are often offered and the online version is about the same annual cost. Support online includes chat rooms, message boards, recipe ideas, meal plans and online journaling.

One concern when counting points is that many of the foods that are zero points often can have 60-80 calories in them. If many of these foods are eaten throughout the day, that can add up to prevention of weight-loss (especially for smaller older women, or those people with slower metabolisms) because the daily calorie intake is too high.

## SLIM-FAST

### **About the Program**

Slim-Fast has been around for more than 25 years and can offer quick weight-loss by substituting typical high calorie meals with a calorie controlled, sweet-tasting fortified meal replacement shake or bar.

The program offers online support with weight, diet and exercise charting, chat rooms with online buddies, chat sessions with registered dietitians, a weekly newsletter, exercise programs and meal planning. Slim-Fast now offers low-carb, optima, easy to digest, high protein and original products.

### **How the Program Works**

The diet plan is centered around two Slim-Fast meal replacements. One meal consists of a Meal-on-the-Go in a can or bar and the other is a Slim-

Fast Meal-on-the-Go combined with 200 calories of your favorite healthy foods. The third meal is a "sensible meal" of about 500 calories, with 1/2 of your plate filled with veggies, 1/4 with lean protein (such as chicken without the skin), 1/4 with starch, a salad on the side and fruit for dessert. A snack of 120 calories is offered as well throughout the day. Fruits and vegetables (about 3-5 servings) are encouraged in addition to the meals and snack.

As the dieter approaches their weight maintenance phase, they can incorporate two regular "sensible meals" per day, however, little instruction is given to wean from the products and therefore dieters are expected to rely on Slim-Fast products indefinitely for weight maintenance.



**SLIM-FAST  
(CONT.)**

***What's the Consensus?***

The cost of the shakes are about \$1.40 each and the meal replacement bars are about \$1 each. The main concerns are that dieters are not taught about nutrition basics and realistically are not going to include the Slim-Fast meal replacements forever. Therefore, weight regain may be inevitable. Another concern is the recommended calorie level may be too low for some dieters.

Overall, if followed correctly, total calories do not go below 1,200 per day, and the plan does

encourage additional fruits and vegetables leading to more balance than traditional liquid diets.

Meal replacement diets such as Slim-Fast are appealing because of their simplicity and convenience. This could be an option for those dieters who have plateaued in weight-loss or those who need a jump start.

It would be recommended to follow the Slim-Fast plan with a healthcare professional who can help teach how to wean from the shakes and to monitor for potential complications of a fast weight-loss.

**CURVES DIET**

***About the Program***

The Curves diet is through the Curves Weight-Loss and Fitness Program, a franchise of health clubs for women that provides a 30-minute workout including resistance training, aerobics and stretching. The program includes a meal plan, workout, online support and supplement regimen. The claim of following the Curves diet and fitness program will help you slim down and tone your body while resetting your metabolism at a faster calorie-burning rate.

***How the Program Works***

The Curves diet plan consists of three phases. Each phase consists of six small meals per day.

- Phase 1 lasts one or two weeks and allows no more than 20 grams of carbohydrates a day.
- During Phase 2, certain fruits and vegetables and some whole grains are allowed.
- Once you reach your desired weight, you progress to Phase 3 and no longer follow specific meal plans.

To reset your metabolism once you reach your weight goal, you are instructed to increase your calorie intake to about 2,500 per day. Within a day or two, you will probably gain about 3 pounds. At this point, you go back to Phase 1 diet for one to two days to “burn off the fat.” When you lose weight again, you return to Phase 3.

You are to continue this cycle for a couple of months until you do not gain weight, thus “resetting your metabolism.” The diet claims you may need to return to Phase 1 for one or two days a month to maintain your weight for the long-term.

***What's the Consensus?***

Overall, the Curves diet and fitness plan will work because the number of calories consumed in the Phase 1 and 2 stages are significantly less than that of which you are burning, thus leading to weight-loss. However, the claim to reset your metabolism is not necessarily an accurate one.

In order to maintain weight while consuming 2,500 calories per day, you must be burning 2,500 calories per day. Because the program has a strong exercise and muscle building component, you can potentially burn 2,500 calories per day. Alternating between the different nutrient deficient phases according to your weight fluctuations is not considered a solution for achieving and maintaining a weight-loss.

Also, dieters are not taught about good nutrition – they are merely following a diet. My suggestion would be to exercise by all means, but try another diet to follow.

**ATKINS DIET**

***About the Program***

The Atkins Diet is a high-protein, low-carbohydrate diet devised by Dr. Robert Atkins. The theory behind the diet is when you cut out carbs, your body burns fat stores to provide energy. As you burn more calories when your body burns fat compared with carbohydrate, you will lose weight.

Another aspect of the theory is by cutting out carbs, blood sugar levels remain more stable throughout the day, which is thought to prevent overeating.

***How the Program Works***

There are four phases to the Atkins diet. The initial phase, Induction, limits your intake of total carbohydrates to 20g a day (the recommendation for healthy eating is 250g a day).

The next phase is the Ongoing Weight-loss phase, which allows you to slightly increase your carb intake by 5g daily for a week at a time until you find your Critical Carbohydrate Level for Losing

# ADVOCACY NEWS

## ADVOCACY ACTION

### OAC Members Speak to Legislators on Capitol Hill in Washington, DC

The week of June 16 was an amazing week for the OAC on the advocacy front. With a legislative briefing and visits on Capitol Hill, the OAC proudly represented the more than 93 million Americans affected by the disease of obesity, and the OAC will continue these efforts. Here is a recap of the week of exciting and successful events!

#### *OAC Legislative Briefing*

On June 16, 2008, OAC members took part in a legislative briefing on Capitol Hill in Washington, DC, to discuss the impact of obesity and its treatments.

The briefings were attended by more than 50 legislative aides. The main focus of the briefings was on the importance of obesity awareness and why improving access for all treatments of obesity is crucial.

The aides heard a variety of presentations from members of the OAC Board of Directors. The first presentation given by OAC Board member, Dr. Robin Blackstone, detailed the overall picture of the obesity epidemic and discussed the prevalence of obesity in the U.S. as well as the many co-morbid conditions associated with the disease.

Following Dr. Blackstone's presentation, the aides next heard from OAC Board member, Dr. Christopher Still. Dr. Still discussed the treatments of obesity. He explained the differences in medical weight management and bariatric surgery, and how each therapy was appropriate for certain individuals depending on body mass index. Dr. Still emphasized that you must incorporate a multi-disciplinary plan consisting of an overall lifestyle change in order for any treatment to be effective.

The next presenter was OAC Chairman Jim Fivecoat. Mr. Fivecoat, who has been personally affected by obesity, detailed the disease of obesity from an employer's point of view. He discussed the many facets of obesity in the workplace such as obesity cost, healthcare cost and much more. He also rounded out the presentation by discussing his



*From left to right: OAC member, Jeff Haaga; OAC Policy Consultant, Chris Gallagher; OAC Chairman, Jim Fivecoat; OAC President/CEO, Joe Nadglowski; OAC Board Member, Dr. Robin Blackstone; and OAC Board Member, Dr. Christopher Still.*



*OAC Member Jeff Haaga courageously shares his personal story with more than 50 legislative aides on Capitol Hill.*

*Capitol Hill continued on page 17*

# NEWS *from the OAC*

## OAC LEGISLATIVE ACTION CENTER LAUNCHED

We need your voice now! To assist you in your advocacy efforts, the OAC is proud to offer its newest advocacy tool – the OAC Legislative Action Center.

The Action Center allows you to get involved in the OAC's advocacy efforts and takes you through the process of advocating from start to finish. Through the Action Center, it now only takes the amount of time to type in your name, address and zip code to contact your elected officials.

In the month of June, we held several major events on Capitol Hill, such as a special legislative briefing on our country's growing obesity epidemic and the *Walk from Obesity - Walk on the Capitol*. You can help build upon our success by going to the OAC's Legislative Action Center and sending a pre-prepared message to your elected officials.

Here are two items that you can take action on now:

- On the House side, we are trying to eliminate a number of roadblocks that continue to impede access to bariatric surgery for morbidly obese Medicare beneficiaries and support a resolution urging more action in regards to obesity.
- On the Senate side, we are asking Senators to light a fire under the Department of Health and Human Services to encourage NIH to update their decade-old treatment guidelines on obesity.

Your voice on these issues is important. Please visit <http://capwiz.com/obesityaction/home/> for more information and start advocating today!

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## OAC MEMBERSHIP IS IMPORTANT AT ANY LEVEL

Membership in the OAC is important for many reasons. Not only is it a great first step toward getting involved and a great way to support the OAC, but it also makes our voices stronger.

Our membership is comprised of so many different individuals who are interested in advancing the cause of obesity. Our members include both patients and professionals, as well as organizations.

If you are someone who is directly affected, your voice is why the OAC exists. If you are a professional or organization, your support and voice are equally as important. Consider becoming a member of the OAC today! Various membership levels are available and each is accompanied with valuable member benefits, including a subscription to the OAC's official Magazine, *OAC News*.

*To join the OAC today, please see page 23 for more information.*

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### *Capitol Hill continued from page 16*

own personal story with obesity as a weight-loss surgery patient. In his story, Mr. Fivecoat stressed mostly that treating his obesity lead to improvement/remission of many of his co-morbidities, such as sleep apnea, hypertension and GERD.

Lastly, the aides heard from OAC member Jeff Haaga. Mr. Haaga is affected by morbid obesity and is trying to access treatment. Passionately, he shared with the aides his struggles with obesity, as his two daughters sat in the audience equally sharing in their father's pain and frustration. He explained his efforts in his home state of Utah where he has formed his own obesity coalition in hopes of influencing and educating his elected officials on this epidemic. Mr. Haaga concluded his presentation by telling those in attendance that access to weight-loss treatment options and obesity awareness are two very important nationwide topics that need to be addressed by elected officials in the U.S. Congress.

As you can tell, the briefing was a tremendous success and a wonderful opportunity for the OAC to spread its message and represent those affected by obesity. The OAC urged all of the aides present to share the information they received that day with their legislative offices and welcomed further discussion.

### *OAC Legislative Visits*

In addition to the briefing on Capitol Hill, OAC members also spent the week of June 16 visiting their elected officials. Each member had the opportunity to speak to their legislators and illustrate how obesity has affected their lives, as well as the lives of their families and friends.

The legislators heard from these individuals who stressed the emotional impact of obesity and how it's not just a physical disease, but also that it affects someone on a psychological level. They discussed the ever-increasing negative stigma associated with obesity and shared with the legislators the many battles the OAC has won throughout the years in regards to obesity stigma.

OAC members also urged their elected officials to make a difference and begin taking proactive steps toward increasing obesity awareness.

For more information on how you can become an OAC Advocate, please visit the OAC's Legislative Action Center at <http://capwiz.com/obesityaction/home>. The Action Center is updated daily with new alerts and initiatives. For more information on the Action Center, please view the above article.





# Weight-loss Surgery Abroad: Traveling Toward *Disaster*?

By Julie Janeway, BBA, MSA, JD, ABD/PhD, and Karen Sparks, BBA, MBE

Treatment for morbid obesity and related diseases is no longer limited to western nations, and patients seeking bariatric surgical treatment are no longer limited to their own borders. What patients cannot get domestically, they will get internationally.

Patients are flocking to other countries for everything from dental care, to state-of-the-art hip resurfacing. Patients are also flying off to foreign lands seeking weight-loss surgery in increasing numbers – and most of the time all they are buying is a plane ticket and box full of trouble.

## Medical Tourism

It's called *medical tourism*. Medical tourism, (also called medical travel or health tourism), is a term initially coined by travel agencies and the mass media to describe the rapidly-growing practice of traveling to another country to obtain healthcare.

A growing number of tourists are combining holidays with healthcare, and that is because a growing number of countries are offering expensive and inaccessible or unobtainable medical care at third-world prices.

Some of these individuals either cannot afford the treatment they need at home (for the uninsured), while others are going for

procedures not covered by their insurance, such as weight-loss surgery (which includes adjustable gastric band surgery and gastric bypass) and attendant plastic surgery for body re-contouring.

Medical tourism trends continue to grow every year. Medical tourism is expected to be a global \$2 billion dollar market by 2012. The informal channels of communication and scheduling between medical service provider and customer often have no contracts and little information about, or connection with, each other.

This type of loose arrangement means less regulatory or legal oversight to assure quality and competence, and less formal recourse to reimbursement or redress. Not only is there very little in the way of agreements or defined expectations, but the potential for disagreement or disaster can lead to attempted litigation in a foreign jurisdiction.

## Why People Go Abroad for Medical Treatment

A large draw for medical travel is convenience and speed. Countries that operate public healthcare systems are often so taxed that it can take considerable time to get non-urgent medical care. The time spent waiting for a weight-loss surgery

procedure in Canada can be anywhere from three to eight years, and gastric banding is not covered at all. Patients must pay out-of-pocket for the banding procedure, and for all pre-care and follow-up care as well.

In contrast, in Mexico, Brazil, Germany, Thailand, Cuba, Colombia, the Philippines, or India, a patient could feasibly have an operation the day after arrival, and in many cases for one quarter to one sixth of the price at home. The rate at which you can get it set up and paid for determines how fast you can have your surgery. Supply and demand - capitalism is alive and well outside the United States.

### Perceptions of Going Abroad for Treatment

Perceptions of medical tourism are not always positive. In places like the U.S., which has high standards of quality and regulatory agencies and oversight organizations to help insure competence and experience, medical tourism is viewed as risky.

While the tourism component might be a big draw for some Southeast Asia countries that focus on simple procedures, India is positioning itself as the primary medical destination for the most complex medical procedures in the world – including weight-loss surgery. India's commitment to this is demonstrated with a growing number of hospitals that are attaining the U.S. Joint Commission International (JCI) accreditation to help capture the U.S. medical tourism market.

### What Consumers Should Know

But do not think that it is just that easy. This should not be an “if you build it, they will come” scenario. There are other issues to consider and most of them will lead right back to your safety and your well-being pre and post-surgery.

Standards, processes, regulation and oversight are everything when it comes to watch-dogging medical care. The medical tourism consumer has no way to determine whether the facility and provider with whom they are scheduling has any more experience, training or even familiarity with the procedure than they state they have. In most cases there are no public documents that can be checked and no regulatory agencies that can be consulted.

There is not even really any way to check whether they actually know how to do a minimally invasive surgery or whether they have appropriate tools and equipment with which to perform it. You may be expecting six little wounds and wake up with a 12-inch long incision. Too late now...

Additionally, there is no way to check if the hospital or surgical facility is in compliance with the standards we would expect from a U.S. surgical facility, or whether the equipment being used dates from any time after WWII.

- Does the facility have appropriate emergency and back-up measures and systems like an emergency room or critical care facility?
- Are they using black market implants, medications, surgical implements and other materials or equipment?
- Are the medications, supplies and other materials outdated, recalled, expired or stored correctly?
- Is the surgical suite really sterile, or is it just separated from the waiting room by plastic sheeting?

### What this All Means

In considering leaving the country for medical treatment, the types of concerns stated above have crossed the minds of many. The answer for these patients has been to stay away from the more “exotic” countries, and seek treatment in Europe which is perceived to have the same, or relatively close standards in treatment and care, as the U.S. or Canada.

Although Europe has shown itself to be a world leader in some areas of medicine, it is not necessarily a world leader in all areas of medicine. So, be very careful in generalizing about where you are going in relation to the type of treatment you are seeking.

### It is Not Just about the Surgery

For weight-loss surgery patients, there are a number of other concerns and considerations that should be taken into serious account before booking a medical tourism jaunt. First and foremost, weight-loss surgery is NOT just about the surgery. In fact, any experienced and trained bariatric surgeon will tell you that it is really only worth about 10 percent of the success equation. The other 90 percent is found in the pre-care, the education, the skill training, the support portion, the follow-up care, and the behavior and lifestyle changes, among others.

When a patient seeks surgery out of the country, there is usually little to no pre-surgery care, screening, testing/evaluation, education or skill training simply because there is not time in the trip or in the schedule. Appropriate pre-surgical programs can take anywhere from two weeks to six months (excluding patients with particular issues that require treatment longer than six months).

Patients are often not even asked, let alone required, to submit medical records for evaluation and consideration. The pre-surgical work-up, evaluation and training are almost universally missing in medical tourism, and patients may never even see a behaviorist, an internist, an exercise physiologist or a dietitian. And speaking of dietitians... even if a patient does have a nutrition consult, that is all it is – a consult. There is no ongoing nutritional support, evaluation and education. Additionally, not all dietitians in the U.S. are required to be licensed or certified, and virtually anyone can call themselves a nutritionist. In other countries, there is no guarantee that the “dietitian” has any formal training at all, especially as it relates to obesity and bariatric surgery.

The dietitian may also have developed a food protocol based on the local cuisine, customs, lifestyle and food availability and that may not translate at all to the patient's home environment. The patient could be left with little direction on what to eat, what not to eat, and when and how to eat it.

Finally, the dietitian may not be able to give the patient any useful advice or resources on appropriate bariatric vitamins or supplements that are/may be necessary to achieving healthy nutritional status. The education, evaluation and support will simply be missing, and setting the patient up for post-surgical failure.

*Traveling continued on page 20*



So, you see? It's not an, "if you build it, they will come," scenario. There is a lot to consider. How about this consideration: some countries, such as India, Malaysia, Costa Rica or Thailand have different infectious diseases than Europe and North America, or different prevalence rates than Western Europe, the U.S. or Canada. Patients who have not had years to build up resistance or tolerance to these diseases are at serious risk for exposure, especially when they are in a weakened state such as with the immune system compromise that often accompanies morbid obesity, or the weakened state that follows surgery.

Of special concern is exposure to gastrointestinal diseases (i.e. Hepatitis A, amoebic dysentery, paratyphoid), mosquito-transmitted diseases, influenza and tuberculosis (i.e., 75 percent of South Africans have latent tuberculosis). Has that crossed your mind?

### **Traveling Back Home Post-Surgery**

Finally, consider that patients often travel long distances on planes shortly after surgery. Air travel severely limits a person's ability to walk around, and the cabin is pressurized, both of which can seriously contribute to the formation of a deep venous thrombosis in the leg, which can quickly become a fatal pulmonary embolism (PE). If this happens mid-flight, no matter how many doctors are on board, they won't be able to save you.

If you decide to stay in a warm, exotic climate and lay in the sun to heal, well good for you. You may decrease your chances of getting a fatal PE. But remember, scars will be darker and more noticeable if they sunburn while healing. So maybe that is not such a great option either.

### **Your Options**

As you can see, patients have much to consider when choosing their treatment option. One of your best options may be to continue fighting for coverage for your obesity treatment, surgical or not. Keep researching for options within the U.S. Keep attempting to manage your obesity the best you can in the mean time, and do not let your desperation get the better of you and send you from the frying pan into the fire.

Many of us are working tirelessly to bring you coverage and access to appropriate medical care so you do not ever have to think about going out of the country in order to try and save your own life. If after reading all this, you are still considering medical travel, then remember: you get what you pay for. Aren't you worth the best? We know you are.

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### **About the Authors:**

*Julie Janeway, BBA, MSA, JD, ABD/PhD, is a gastric bypass patient and co-author of the best-selling book The REAL Skinny on Weight-loss Surgery: An Indispensable Guide to What You Can REALLY Expect! – 2<sup>nd</sup> edition. Ms. Janeway is a college professor and public health and bariatric educator who teaches patients, medical professionals and others all over the country. Ms. Janeway is a member of the OAC Board of Directors.*

## **Post-care Considerations**

Not all the problems stem from lack of appropriate pre-care, though. Other post-care questions and concerns rear their ugly little heads as well.

- Who will do my blood tests?
- Can I find a practice at home that will let me come to their support group?
- Do I understand the importance of a support group?
- Who will do my band fills?
- If I have emotional difficulties, who will see me for these?
- How will I find reliable resources and educational materials?
- What if I have a complication, who will see me?
- What if I develop adhesions or a hernia – will a surgeon take on my case to help me?
- Can I trust that an emergency room in my community will know how to treat me, especially if I arrive unconscious and unable to relay my situation?
- Who will monitor my nutritional status?
- What if I need medications for specific issues related to my obesity or my surgery? Who will I see for that?
- Will I be made aware of what I am supposed to do following surgery, when I am supposed to do it, for how long, why I am supposed to do it, and how it will help me?
- Will there be a language barrier I have to overcome in trying to get information?
- What if I begin to put the weight back on? Who will help me then?



*Karen Sparks, BBA, MBE, is a gastric bypass patient and co-author of the best-selling book The REAL Skinny on Weight-loss Surgery: An Indispensable Guide to What You Can REALLY Expect! – 2<sup>nd</sup> edition. Ms. Sparks is a college professor and public health and bariatric educator who teaches patients, medical professionals and others all over North America. Ms. Sparks is a member of the OAC Advisory Board.*

*Resources used for this article may be found on the Web version on the OAC Web site at [www.obesityaction.org](http://www.obesityaction.org).*



# Body Image vs. Health Risk:

## What's Your Motivation for Weight-Loss Surgery?

By David Engstrom, PhD, ABPP, FAClinP

**Body image** is loosely defined as a person's perception of their own physical appearance, or the internal sense of how one's body appears to others. Although it is a complex subject, research suggests:

1. Body image dissatisfaction is greater in women than in men.
2. A person's body image is often dramatically different from the way their body actually appears to others.

There is no doubt that there is still a great deal of stigmatization and moralizing about obesity and excess weight in this society. Many scientific studies demonstrate this point. They show that people with excess weight, in comparison with their normal-weight counterparts, are often perceived as being:

- "Less intelligent"
- "Lonelier"
- "Having less self-control"
- "More lazy"

While these perceptions are often not true, they still persist and can have a marked effect. We have all heard remarks like, "she ought to just push herself away from the table," or "he should get to the gym."

To the outside world, the reasons people with morbid obesity seek bariatric surgery may be a mystery. The obvious reason might be to "look better" or to "feel better about their bodies." The bottom line is that society still too often views this procedure as the "easy way out," or a "quick fix" for lifelong problems.

### Perceptions and Social Stigma

Although body image seems to develop naturally as we mature, there is probably a large part of our body image that is socially derived, from these real or imagined perceptions, judgments and comments of other people. When you add this social stigma to a person's previous failure at dieting, already low self-esteem and poor body image, it is not difficult to imagine that the idea of significant weight-loss through surgery is appealing for a number of reasons.

Despite the fact that a primary goal of bariatric surgery is to prevent, improve or cure medical health problems or comorbidities, the psychosocial effects of the surgery are just as powerful and important. Several recent studies have reported dramatic positive changes in the body image of patients following weight-loss surgery. So what really motivates people to seek this surgery in the first place?



### Motivation

First, a few facts about motivation itself. There are four types, or sources, of motivation.

- External motivation is often initiated by outside sources, like friends, family or doctors. "They made me do it."
- Guilt-driven motivation is, as one might expect, a result of trying to escape from negative feelings. "I would feel badly if I didn't do it."
- Identified motivation is a result of wanting to be like, or identifying with, someone else who is doing the behavior in question.
- Internal motivation is when the desire to change arises within the person. "I like doing it... it's fun." Studies that examined motivation to exercise or to lose weight have shown that the most enduring source of behavior change is internal motivation. That is, the more a person's motivation comes from within, as opposed to some outside agent (e.g., doctor, spouse), the more likely it is that behavior change will continue.

*Body Image continued from page 22*

Weight. This is the maximum amount of carbohydrate you can eat each day to lose between 1 and 3 lbs a week. For some people, this may only be 25g carbohydrate, for others it might be 50g.

The third phase, Pre-maintenance, is when you have just 5-10 lb left to lose. During this phase, you increase your carb intake by 10g each day for a week at a time. The idea is to slow down your weight-loss to no more than 1 lb per week.

The final stage, Lifetime Maintenance, aims to help you maintain your weight by limiting carbs to less than 90g a day.

### **What's the Consensus?**

Although people can lose considerable amounts of weight in a short period of time following this diet plan, most people are unable to follow it for the long-term because it restricts a vast amount of food groups. Most people tend to regain weight quickly when they are no longer able to stay on the Maintenance phase, which is essentially, low carbohydrates for life.

Initial concerns of following this diet plan are side effects such as bad breath, weakness, tiredness, insomnia, nausea and dizziness. Constipation often occurs because of the avoidance of high-fiber foods such as fruits, vegetables and whole grains. Long-term side effects include increasing risk of heart disease, some types of cancer and nutritional deficiencies because of following an unbalanced diet that is high in fat, particularly saturated fats, which are found in meats and cheeses.

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### **Body Image** continued from page 21

It is clear that there are many sources for motivation, and they should be examined carefully, especially when the subject is weight-loss surgery.

At our practice, we examined the motivating factors for a group of 65 of patients who were seeking bariatric surgery. They were each asked about their primary motivating factors, including:

- Health concerns, including medical co-morbidities
- Improvements in self-esteem, including feelings of self-worth and enhanced body image
- Increasing physical functioning, including better mobility and ability to accomplish physical tasks
- Business or job advancement
- Increased social attractiveness

They were asked to rank-order their reasons for seeking surgery, from 1 (most important) through 5 (least important). The results of this assessment are shown below.

*What is your most important reason for seeking bariatric surgery?*

|                               |     |
|-------------------------------|-----|
| Health Concerns               | 62% |
| Increase Physical Functioning | 11% |
| Improve Self-esteem           | 19% |
| Business or Job Advancement   | 5%  |
| Social Attractiveness         | 3%  |

Finally, as mentioned with previous diets reviewed, eliminating food groups or macronutrients from your diet is not considered a solution for achieving and maintaining weight-loss. The bottom line is for it to be a lifelong behavioral change; dieters should learn about good nutrition and its application to daily life instead of just following the diet.

### **Conclusion**

If you are in the market for a diet, you are faced with hundreds of choices, many with claims that sound like exactly what you need. It is important that when you are choosing a diet to help you reach your weight-loss goals, you evaluate them based on one that will work for you, your lifestyle and will help you achieve your goals.

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### **About the Authors:**

*Christopher D. Still, DO, FACP, FACN, has been studying developments in nutrition support and obesity for nearly a decade. Dr. Still's interest in weight-loss comes from his personal experiences with obesity. Dr. Still once weighed 365 pounds, and losing the weight was a life and career changing experience. Dr. Still is certified by the American Board of Internal Medicine, the American Board of Nutrition and the American College of Nutrition, among others. He is also a member of the OAC National Board of Directors.*

*Stephanie F. Yeager, RD, LDN, has been with the Center for Nutrition and Weight Management at Geisinger Health System since 2002. She completed her Bachelor's in Nutritional Sciences and Exercise Physiology at Penn State University in 2002 and her Dietetic Internship at Geisinger Medical Center in 2004.*

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One clear finding here is that health concerns far outweigh all other categories of motivation for bariatric surgery. These may represent either current or future concerns about physical health and well-being. When motivation to improve physical functioning is added to health concerns, the total for both represents nearly three quarters of all primary reasons.

### **Body Image and Self-esteem**

Although "body image" was not a separate category, it is assumed that this issue is incorporated into the categories of "improve self-esteem" and "social attractiveness." Together, these two areas were primarily endorsed by 22 percent of the respondents.

People obviously choose to have bariatric surgery for many reasons, and these cannot easily be broken down into distinct categories. While our data suggests that health concerns are well in front of other reasons, there were secondary reasons, including body image, which play a part in their decision-making as well.

Of equal importance is the person's source of motivation. Be sure to examine yours, and make certain the decision is an internal one!

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### **About the Author:**

*David Engstrom, PhD, ABPP, FAclnP, is a clinical health psychologist, board certified in Clinical Psychology. He is a psychologist at Scottsdale Bariatric Center. Dr. Engstrom is an active member of the American Society for Metabolic and Bariatric Surgery and currently serves on the OAC Advisory Board.*



# OAC Membership

*Building a Coalition of those Affected*

## About OAC Membership

The OAC is a grassroots organization and was created to bring together individuals impacted by the disease of obesity. One of the first steps to getting involved and making a difference is to become a member of the OAC.

Membership allows the OAC to build a Coalition of individuals impacted, bringing a unified voice in obesity. These are the individuals that make up OAC's membership:

- Those who are currently struggling with their weight, whether obese or morbidly obese
- Those who are seeking treatment for their obesity
- Individuals who have successfully and/or unsuccessfully treated their obesity
- Friends, coworkers and family members of patients
- Professionals whose work is dedicated to those affected
- Organizations that support efforts in obesity

You probably find yourself fitting into one of the categories above. This is because obesity affects just about every person in the U.S. and directly impacts more than 93 million Americans. With this number continuing to grow, so must our voice. And that is where **YOU** become an important part in what the OAC strives to do.

## Membership Categories and Benefits

The OAC wants **YOU** to be a part of what we do. No matter how you're impacted, having individuals join our efforts who believe in making a difference is essential. That's why the OAC offers various member categories, so you can get involved at your desired level.

Several valuable benefits also accompany your OAC membership, including an annual subscription to OAC News. Each membership category offers something different. To learn more about membership benefits, please visit the OAC Web site at [www.obesityaction.org](http://www.obesityaction.org).

### *Not ready to join the OAC as a paid member?*

You can become a "Friend of the OAC" and still have your voice be heard. When joining the OAC in this category, you can get involved in our efforts while receiving electronic benefits. There is no charge to become a "Friend of the OAC." To sign-up, check the box below and complete the application.

Sign me up as a "Friend of the OAC"

# Membership Application

Yes! I would like to join the OAC's efforts.  
I would like to join as a/an:

- Patient/Family Member: \$20
- Professional Member: \$50
- Physician Member: \$100
- Surgeon Member: \$150
- Institutional Member: \$500 (*Surgery centers, doctors' offices, weight-loss centers, etc.*)
- OAC Chairman's Council: \$1,000 and up

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Payment Information

Enclosed is my check (payable to the OAC) for \$ \_\_\_\_\_.

Please charge my credit card for my membership fee:

Discover®  MasterCard®  Visa®  Amex®

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

**Mail to:** OAC  
4511 North Himes Ave., Ste. 250  
Tampa, FL 33614  
**Or Fax to:** (813) 873-7838



## About the OAC

The Obesity Action Coalition (OAC) is a non profit patient organization dedicated to educating and advocating on behalf of those affected by obesity, morbid obesity and childhood obesity. The OAC distributes balanced and comprehensive patient educational materials and advocacy tools.



The OAC believes that patients should first be educated about obesity and its treatments and also encourages proactive patient advocacy. The OAC focuses its advocacy efforts on helping patients gain access to the treatments for obesity. As a membership organization, the OAC was formed to bring patients together to have a voice with issues affecting their lives and health. To learn more about the OAC, visit [www.obesityaction.org](http://www.obesityaction.org) or contact us at (800) 717-3117.

## OAC Resources

The OAC provides numerous beneficial resources for patients, as well as professionals. All OAC resources are complimentary and may be ordered in bulk. To request materials, please contact the OAC National Office at (800) 717-3117 or send an email to [info@obesityaction.org](mailto:info@obesityaction.org).

### Magazine

OAC News - OAC's quarterly education and advocacy publication for patients

### E-newsletter

- *Obesity Action Alert* - the OAC's free monthly electronic newsletter

### Brochures/Guides

- BMI Chart
- OAC Insurance Guide

- State-specific Advocacy Guides
- More than 100 obesity-related topics located on the OAC Web site
- *Understanding Obesity Series*
  - *Understanding Obesity Brochure*
  - *Understanding Obesity Poster*
  - *Understanding Morbid Obesity Brochure*
  - *Understanding Childhood Obesity Brochure*
  - *Understanding Childhood Obesity Poster*
  - *Understanding Obesity Stigma Brochure*



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