

# OBESITY

## Chasing an Elusive Epidemic

BY DANIEL CALLAHAN

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Obesity in America is so widespread and such a product of our culture that combating it is nearly impossible. We need to change almost everything about the way we live, more or less simultaneously. In order to succeed, an edgier strategy is needed.

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Obesity may be the most difficult and elusive public health problem this country has ever encountered. Unlike the classical infectious diseases and plagues that killed millions in the past, it is not caused by deadly viruses or bacteria of a kind amenable to vaccines for prevention, nor are there many promising medical treatments so far. While diabetes, heart disease, and kidney failure can be caused by obesity, it is easier to treat those conditions than one of their causes. I call obesity elusive partly because of the disturbingly low success rate in treating it, but also because it requires changing the patterns, woven deeply into our social fabric, of food and beverage commerce, personal eating habits, and sedentary lifestyles. It also raises the most basic ethical and policy questions: how far can government and

business go in trying to change behavior that harms health, what are the limits of market freedom for industry, and how do we look upon our bodies and judge those of others?

Obesity is ordinarily defined as an excess proportion of bodily fat and technically defined in terms of body mass index (BMI). A person whose weight is 10 to 19 percent more than average is usually considered to be overweight, and 20 percent or more than average is considered obese. Those who are 100 to 150 percent over normal weight are considered “morbidly obese.” Around 35 percent of Americans are obese, and 67 percent are either obese or overweight.<sup>1</sup> To put those figures in what might be called a visual context, a 2011 Gallup Health Survey found that the average American man now weighs 196 pounds, and the average woman 160—and both figures are 20 pounds higher than self-reported weights in 1990.<sup>2</sup>

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The survey also noted that men were, on average, 15 pounds over their ideal weight, and women were 22 pounds over.

### Prevalence and Causation

But there is a disturbing twist in those findings: “the percentage of Americans who describe themselves as overweight [35 percent of men and 42 percent of women] has remained essentially unchanged over the past 20 years . . . while Americans are getting heavier, many may not recognize it or acknowledge it.” They are also, the Gallup Survey reports, “notoriously poor judges of their children’s weight as well.” All of this helps “paint a picture of mass delusion in the United States about its rising weight.”

The rapid upward trend of the prevalence of obesity in earlier decades has recently shown some small signs of leveling off, but with no evidence that its prevalence is declining in any group. The United States is hardly alone in having this problem. The World Health Organization has called obesity a “global epidemic,” and another study projects an international potential of 2.16 billion overweight and 1.12 billion obese persons by 2030.<sup>3</sup> The United Kingdom and the United States have the worst figures, while Japan and Korea have some of the best. But almost every country is in trouble, including some developing nations with rising prosperity and emerging first-world habits. The common estimate is that about 17 percent of American children are obese—and many children who begin life obese are likely to remain so for the rest of their life.

The health impacts of obesity are notorious: bone and joint problems, heart disease, cancer, gall stones and liver problems, and diabetes. Obesity

shortens lives (although, surprisingly, not by much), but the costs of the diseases it causes make it an expensive condition. And to pour a little more salt on the cost wound, one study found that prevention of obesity will not decrease costs because “this decrease is offset by cost increases unrelated to obesity in life-years gained.”<sup>4</sup>

The causes of obesity include age (the body’s metabolism slows with age); gender differences (more common in women); genetics (obesity

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tends to run in families); illness (hypothyroidism); cultural acceptance or indifference (poverty, race); sedentary habits (long commutes, sitting at a desk or work bench all day, watching TV, lack of exercise); poor diet (few fruits and vegetables, processed foods, overly large food portions at home and in restaurants, sugared beverages); and, too often neglected, all the luxuries we possess—automatic garage door openers, can openers, food blenders and mixers, escalators, elevators, golf carts, automobiles, and so on.

### Strategies of Control

If there are many causes of obesity, the strategies to control it are no less varied. As a medical condition, obesity has been known to be dangerous for centuries and has fluctuated in its social acceptance.<sup>5</sup> But it was only vigorously targeted as a national public health threat in this country beginning thirty years ago, with the

advent of serious federal government interest and programs aimed at combating obesity. The public health field has deployed efforts in education, food labeling and advertising, food assistance programs, health care and training, transportation and urban development, taxation, and policy development. Most physicians do not discuss their patients’ obesity with them, but various efforts are under way to make discussion of it a basic feature of primary care medicine. The

aim is to catch those beginning to move into the overweight range early enough to prevent them from going any further. A number of corporations are using wellness programs and financial incentives to change the unhealthy habits of their employees.

What difference have all these efforts made? The high and

steady prevalence of obesity and excessive weight provides one answer to that question: not much. The statistical difference is hardly discernible. Nor is that the worst of it. Even when serious efforts in various weight loss programs are made, or individuals undertake their own effort, the success rate is abysmally low. The weight may come off for a time, but most people regain it after a few years. It is hard to know whether to laugh or cry when the most important studies of obesity count a 5 to 10 percent weight loss a “success,” adding that even that much loss has a health benefit, not to be dismissed.<sup>6</sup> In a widely publicized reversal of an early decision, the Food and Drug Administration approved what would be the first new prescription drug in thirteen years to treat obesity, Qsymia (known as Qnexa before its approval). That announcement was presented in the media as an exciting development in the struggle against obesity, even though the drug leads, on average,

to only a 10 percent weight loss after one year, and in the second year those who take it are likely to gain back some of that lost weight. Bariatric surgery programs are now widely available, but their costs and assorted medical problems and side effects keep many from using them.

### Some Present Strategies

When all the data and trends are put together, it is only reasonable to conclude that little progress is being made. Educational efforts to reduce obesity have had little impact. Its prevalence is not decreasing, and the available treatments and weight loss strategies are successful for only a very small number of those targeted for such efforts. Most of the 67 percent who are overweight or obese will remain so for the rest of their lives, guaranteeing serious health problems as they get older. As with many other serious health issues where little progress is being made to reduce prevalence (diabetes and Alzheimer's disease, for example), those working in the field as advocates always seem professionally full of hope, settling for marginal benefits and optimistic about all the gains that could be made if and when other ideas begin paying off. And anyone searching the obesity literature can find some evidence for some success with some programs and strategies. Hope is not irrational, nor are expectations mere pie in the sky. It just takes a big dose of hope to brighten a dismal scene.

The most promising directions, I believe, fall into three categories. Strong and most likely somewhat coercive public health measures, mainly by government but also by the business community; childhood prevention programs; and social pressure on the overweight.

### Government and Business Initiatives

Only a powerful state and federal government effort to put in place policies on what economists

call the supply side will make a significant difference. At the top of that list is taxing sugared drinks and unhealthy processed foods (taxation), banning unhealthy food advertising to children and posting calorie information in restaurants (regulations), and reducing the costs of healthy foods (government subsidies). To be successful, all of those efforts must overcome the obstacles of a food and agricultural industry that powerfully resists such moves and has an army of lobbyists ready to sweep down on legislators prepared to move in that direction.<sup>7</sup> Mayor Bloomberg of New York City saw those forces in action in 2011 when they succeeded in shooting down his proposal for a tax on sugared beverages. His 2012 effort to limit the serving size of sugared beverages—which is still under review—ran into another industry-inspired onslaught (in the name of “choice,” of course) that was successful enough to help induce a 60 percent public disapproval rating for the policy. Industry makes billions of dollars selling its products and employs thousands of workers (always a good argument in poor economic times). Also at work are many of the same forces one sees in health care debates—among them, a strong, libertarian-minded cohort opposing government taxation and regulation whenever and wherever they are proposed.

The business community has taken some small steps to create wellness programs for employees and to use incentives and disincentives to reduce obesity, much as it has done to reduce employee smoking. Michelle Obama is the honorary chair of the Partnership for a Healthier America (PHA), which works to change the private sector and is said to have agreements with twenty companies—among them, Wal-Mart, Hyatt, and Darden restaurants. Wal-Mart's aim is to bring down the price of healthy foods, Hyatt has said it will change the way meals for children are marketed in its dining rooms, and Darden is reducing sodium in its food by 20 percent over the next decade.

Those are hardly dramatic steps, and only a handful of companies have taken them. Larry Soler, the chief executive officer of PHA, has said that “none of these companies are going to move forward unless they see it's going to be good for their bottom line.”<sup>8</sup> Whether it will be good for that omnipresent bottom line is likely to be a function of the extent to which the public takes the obesity problem seriously in the years ahead. Will they reward companies that conspicuously show they are serious? I doubt that Darden restaurants will find customers rushing to them to get meals with reduced sodium, particularly when its spokesperson said “we are going to be making changes silently and slowly.” Their client, she said, will not even know it is happening. That is not exactly conspicuous role modeling.

Companies that work with incentives to change employee behavior have the diplomatic task of gaining employees' support. People have to be led to change their health-related behavior in ways that are not just tolerable, but also attractive. Of course, the companies could use their clout to control the conditions of employment: our way of health improvement or the highway. The latter method would likely attract public criticism and even civil rights objections based on the way employees live with and treat their bodies. At some point, these interventions would cross a threshold, becoming a coercive invasion of the employee's privacy and powers of self-determination. Nonetheless, companies could have a significant impact if they developed plausible and acceptable ways of pushing their employees toward better health habits, and they may have to come close to mild coercion to do so, while not overstepping a line that has yet to be determined.

### Children: Starting Early

The real front line in the fight against obesity is children. Prevention, in a word, is key. In one way, working with children has the ad-

vantage of adult authority: children can be cajoled into good eating and exercise habits, or forced into them if necessary. School children are not given a vote on school lunches or on what their parents serve them for dinner. But to help children means winning over parents. The way they treat their own bodies will influence their children's behavior and health habits. Good school lunch programs can easily be subverted if children can get unhealthy food in their homes. There are real political and ethical limitations to the use of government power to coerce parents into raising their children differently. There are scattered stories from around the country of seriously obese teenage children (three hundred to five hundred pounds) taken from their parents and put into foster care, but such extreme action may harm the child as much as the parents.

As with most other attempts to control obesity, progress has been slow and mixed. A major obstacle is that there is good evidence children have a significant genetic susceptibility to obesity if one or the other parent is obese, although a strong intervention while the child is quite young (under age ten) can still be effective. Beyond that, the main efforts against childhood obesity have focused on improving the food provided by schools or sold in them, ensuring access to good, affordable food at home, increasing children's physical activity in and out of school, and reducing exposure to the marketing of unhealthy foods through regulation, policy, and effective industry self-regulation. Resistance to government efforts to curb the advertising of unhealthy food by food and industry groups on the grounds of a violation of the First Amendment have been legally challenged, but with mixed success.

The food and beverage industries spend nearly \$2 billion a year marketing their products, and those efforts have been shown to make a significant difference to children's choices regarding foods. Ample research shows a striking correlation between television viewing and obesity. "The evidence is strong," one study reports, "that this linkage is driven as much or more by the advertising influence as by the sedentary nature of television viewing." In response to its critics, the industry points out—correctly enough—that it is the parents'

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responsibility to control what their children watch. Often addicted to television themselves and seeing no harm in it, parents do not discharge that obligation well. Parents also have a responsibility to press schools to provide good exercise opportunities and healthy foods and beverages. These efforts can work, but their intensity varies. Meanwhile, the food industry fights back, debunking scientific evidence, minimizing the harm, and spending considerable money lobbying legislators.

One way or the other, by the early 1980s most of the public health emphasis began moving away from earlier and generally unsuccessful efforts to change unhealthy individual behavior through education and exhortation. I believe only the government's power to tax, to regulate, and on occasion to come close to mild coercion would be sufficient to make a difference. The private sector could have a role to play by voluntary self-regulation and incentive programs, but that could likely be done only in ways that would not financially hurt

industry or alienate its customers. Yet fully deploying government power has been difficult politically. Not only does industry oppose regulation, but there are political limits to how much government can do to change individual behavior—whether by limiting television viewing, requiring exercise, or restraining market forces.

### Changing Individual Behavior

A return to the discarded idea of changing individual behavior may be necessary. One way or another, the public—a majority of whom are, after all, overweight or obese, while the balance are at some risk of becoming so—must be persuaded of a number of points. Whether or not they recognize their own role in it, they

need to understand that obesity is a national health problem, one that causes lethal diseases, shortens lives, and contributes substantially to rising health care costs. Not just their own welfare is at stake. They no less need to understand that, whatever they may think about the power and excess of government, it is inescapable in this case, as much as with national defense.

It will be no less necessary to find ways to bring strong social pressure to bear on individuals, going beyond anodyne education and low-key exhortation. It will be imperative, first, to persuade them that they ought to want a good diet and exercise for themselves and for their neighbor and, second, that excessive weight and outright obesity are not socially acceptable any longer. They need as well to be mobilized as citizens to support a more invasive role for government. Obesity is in great part a reflection of the kind of culture we have, one that is permissive about how people take care of their bodies and accepts many if not most of

the features of our society that contribute to the problem. There has to be a popular uprising when so many aspects of our common lives, individually and institutionally, must be changed more or less simultaneously. Safe and slow incrementalism that strives never to stigmatize obesity has not and cannot do the necessary work.

### Stigmatization

When I was first drawn to think about obesity, I could not help thinking about the success of the anti-smoking campaign of recent decades. That campaign went simultaneously after the supply side (the tobacco industry) and the demand side (individual smokers). As a smoker, I was at first criticized for my nasty habit and eventually, along with all the others, sent outside to smoke, and my cigarette taxes were constantly raised. The force of being shamed and beat upon socially was as persuasive for me to stop smoking as the threats to my health. I was also helped by the fact that others around me were stopping as well. If they could do it, so could I. The campaign against smoking was a public health triumph, not eliminating smoking by any means but greatly reducing it, so that smokers now make up only about 20 percent of the population.<sup>10</sup> The campaign to stigmatize smoking was a great success, turning what had been considered simply a bad habit into reprehensible behavior.

Misled by the public health community's acceptance—and even enthusiastic embrace—of supply and demand measures against and outright stigmatization of smoking, I naively assumed that community would do the same against obesity. I had not realized that smoking was the exception—that the public health community generally opposes anything that looks like blaming the victim. This fact was surely evident in the struggle against HIV, as well as in other campaigns over the decades against the stigmatization of people with many

other diseases. It has not been hard to find examples of stigmatization turning into outright discrimination, even (notoriously) in health care.<sup>11</sup>

Why is obesity said to be different from smoking? Three reasons are common: it is wrong to stigmatize people because of their health conditions; wrong to think it will work well, or at all, with obesity; and counterproductive with the obese because of evidence that it worsens rather than improves their condition. Ethically speaking, the social pressures on smokers focused on their behavior, not on them as persons. Stigmatizing the obese, by contrast, goes after their character and selfhood, it is said, not just their behavior. Stigmatization in their case also leads demonstrably to outright discrimination, in health care, education, and the job market more generally. The obese are said to be lazy, self-indulgent, lacking in discipline, awkward, unattractive, weak-willed and sloppy, insecure and shapeless, to mention only a few of the negative judgments among doctors and nurses.

As for government doing something about the discrimination, as of 2009 Michigan was the only state that prohibits weight discrimination in employment. There has been a wariness about using the American Disability Act against such discrimination out of fear that obesity might come to be seen as an outright disability (though for many it is disabling), not just a potentially unhealthy condition. And while there are many efforts under way to change the perceptions and judgments about the obese in the health community, there seems to be no evidence that a significant change is taking place.

While the public health community, and particularly those who take on obesity, have vigorously rejected deliberate efforts to stigmatize the obese, the fact of the matter is that they are already stigmatized, and notably among health care workers. As Governor Chris Christie of New Jersey found out when he was considered a possible presidential candidate,

a number of jokes about his weight were made on TV and in other media, with some (possibly serious) concerns voiced about his health prospects. Yet it is hard to imagine that much progress can occur toward solutions for obesity unless we bring some form of social pressure to bear against it. If we are left with nothing but the need to change almost everything about the way we live, more or less simultaneously, progress seems improbable. How long will it take, for instance, to get rid of lengthy commutes to urban centers, to wean people from their TV and iPad screens, to get everyone and their children to eat healthy food and get regular exercise, and to get industry to stop inventing and selling us unhealthy junk food (and to get over its convenience and our liking for it)?

For any of those good goals to have real bite, it will be necessary to make just about everyone strongly want to avoid being overweight and obese. Education has not shown itself to be up to that task. Fear of illness has not, either. No technologies—surgery or pills—have made a major difference. Stigmatization, we have been told, is counterproductive. Moreover, it is a telling commentary on the difficult road ahead that obesity experts have become willing (even if not happily) to settle for a success rate of 10 percent or less in finding ways to effectively help people lose weight and, most critically, to keep from putting it back on.

In saying all that, am I not minimizing a variety of signs that progress can be made? Here are some examples. School lunch programs are improving, as are various educational, behavioral, and health promotion interventions for children.<sup>12</sup> A variety of weight-loss interventions have shown themselves effective in achieving and sustaining significant weight loss.<sup>13</sup> In 2011, the Centers for Medicare and Medicaid Services ruled that it will pay for high-intensity obesity counseling. Earlier, in 2003, the U.S. Preventive Services Task Force recommended that “clinicians screen all

adult patients for obesity and offer intensive counseling and behavioral interventions on screening for obesity in adults.”<sup>14</sup>

Yet with the exception of school luncheons and similar dietary efforts with children, most of the examples of success are the result of intense individual counseling, a costly and time-consuming effort that requires, at a minimum, people willing to accept it. That thousands of people each year ask for counseling, and even larger numbers take weight loss as a serious goal, shows that individual choices and efforts count. But the figures on the prevalence of overweight and obese people—the 68 percent (close to 200 million)—make clear the limits of individual counseling and therapy. If this is a public health crisis—and surely it is—nothing less than an enhanced, edgier, population-directed strategy is needed.

### Varieties of Social Pressure

Our best long-term possibility is to find ways of inducing a majority of the population to do what a minority now already do: working to stay thin in the first place and to lose weight early on if excess weight begins to emerge. That will take social pressure combined with vigorous government action. The social pressure will aim to push the public to accept strong interventions, just as it could induce them to change the way they eat, work, and exercise. While obesity is not in any ordinary medical sense a contagious disease, it is subtly contagious in a social sense. When it is as common as is now the case, those who are overweight hardly notice that others are the same: it is just the way ordinary people look. We need them to notice the others and to want something different for

themselves—and those others will be similarly motivated.

But can there be social pressure that does not lead to outright discrimination—a kind of stigmatization lite? That will, I concede, be a difficult line to walk, but it is worth a try. I would couch the social pressure in the following terms, finding ways to induce people who are overweight or obese to put some uncomfortable questions to themselves:

- If you are overweight or obese, are you pleased with the way you look?

**THOSE WHO are overweight hardly notice anymore: it is just the way ordinary people look. We need them to notice. Can there be social pressure that does not lead to outright discrimination? That will be a difficult line to walk, but it is worth a try.**

- Are you happy that your added weight has made many ordinary activities, such as walking up a long flight of stairs, harder?
- Would you prefer to lessen your risk of heart disease and diabetes?
- Are you aware that, once you gain a significant amount of weight, your chances of taking that weight back off and keeping it off are poor?
- Are you pleased when your obese children are called “fatty” or otherwise teased at school?
- Fair or not, do you know that many people look down upon those excessively overweight or obese, often in fact discriminating against them and making fun of them or calling them lazy and lacking in self-control?

That last question in effect aims to make people acutely aware of pervasive stigmatization, but then to invoke it as a danger to be avoided: don’t let this happen to you! If you don’t do something about yourself, that’s what you are in for. Many of the other questions invoke vanity as a value, or the good opinion of one’s neighbors, friends, or fellow employees, or the risk of illness. Use all of them together, carrots and sticks. That will not much help most of those who are already overweight or obese. But beyond marginal improvements, most of them are already lost.

They should surely not be neglected, but the important work is to be done with those not yet in that condition.

In their interesting book, *Nudge: Improving Decisions About Health, Wealth, and Happiness*, Richard H. Thaler and Cass R. Sunstein make

a persuasive case for what they call “libertarian paternalism.” That seemingly oxymoronic phrase refers to policies that make an explicit effort “not to burden those who want to exercise their freedom,” but nonetheless try to “influence choices that will make choosers better off, *as judged by themselves*.”<sup>15</sup> Such policies aim at “self-consciously attempting to move people in directions that will make their lives better. They nudge.” Removing trays in cafeterias reduces the amount of food people will eat, effectively making it more troublesome to get the food, but not denying it to them. Putting the fruit at eye level and the fatty foods on the bottom shelves makes a difference as well. Mayor Bloomberg’s effort to reduce beverage cup size counts as a nudge tactic also.

None of the social pressure tactics will directly change the conditions of poverty that make so many people susceptible to obesity, or will

necessarily induce the food and beverage industries to change their deleterious ways. But they can change the background pressures—creating a potent force for public opinion, making it easier to use government to bring forth necessary regulations and prohibitions, shaming delinquent industries, and leaning on the public to take the problem more seriously.

The need is for a bottom-up approach to create and sustain a truly effective antiobesity campaign that matches the necessary top-down structural efforts. One obvious target would be the large number of people who are unaware that they are overweight. They need, to use an old phrase, a shock of recognition. Only a carefully calibrated effort of public social pressure is likely to awaken them to the reality of their condition. They have been lulled into obliviousness about their problem because they look no different from many others around them. They need to be leaned upon, nudged, and—when politically feasible—helped by regulations to understand that they are potentially in trouble. They should not want to be that way, nor should others.

What I am suggesting—empowering the victims, not blaming them, and that individual responsibility is necessary—has its risks. But if the

individual and public health impact of being overweight and obese is dangerous, then it is hard to imagine any kind of strong and effective efforts that will not meet resistance. The failure of efforts to date to make much difference suggest that a change of strategy is necessary.

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