



EDITORIAL

The "Health at Any Size" Movement: Where is it going?

This editorial is based on "A Healthy Approach to the 'Health at Any Size' Movement," by Steven Jonas, M.D., M.P.H., M.S., which appeared in Healthy Weight Journal, Vol. 16, No. 3, May-June, 2002, pp. 45-47, used with the permission of the editor.

In one segment of the overweight/obesity community there is a growing approach to the issue called the "Health at Any Size" (HAAS) movement. Presently, it stands on three legs. The first is the recognition that for many overweight/obese people, for whatever reasons permanent weight loss is difficult, if not impossible, to achieve. The second is that the research purporting to establish a link between obesity and an increased risk of morbidity and mortality is faulty. The third is that it is indeed possible to be healthy and overweight at the same time.

The data supporting the first leg appear to be strong. Constructors of the second (1), citing methodological flaws in many studies, hold to the hypothesis that obesity is either not harmful to health, or at least the case that it is has not been convincingly made. They even try to make the case that obesity is in some instances health promoting.

However, there is a very large body of epidemiological and clinical evidence to support the position that obesity does indeed pose a significant health risk. It was reviewed, for example, in the *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults* from the National Heart, Lung and Blood Institute (NHBLI), published in 1998 (2). In 1999, several extensive review articles appeared in an issue of *JAMA* largely devoted to the subject of the prevalence and consequences of obesity (3-5). They

came to the same conclusion as did the NHBLI report.

Careful methodological analysis along the lines done by Drs. Ernsberger and Koletsky (1) can and does find certain flaws in many of the studies cited. The researchers, whose methods they criticize, would surely have many bones to pick with the critique of their work. Beyond that, however, one need only to step back and recognize a basic concept of epidemiological science called "the weight of evidence." It states that a hypothesis may be considered supportable as theory when there is an overwhelming body of study findings that generally point in the same direction.

When one applies this macro-analytical tool to the obesity health-risk literature, as the extensive reviews cited above and many others have done, one is led to conclude that despite certain methodological problems in many of the individual studies, the evidence is overwhelming that obesity significantly increases the risks of morbidity and early mortality. Furthermore, there is a "dose-response" curve for those risks.

However, does this understanding not then throw the HAAS movement back into a crippling dependence on the necessity of weight loss for overweight/obese people, which would contradict the entire ethic of the HAAS? In my view, not at all. Recall the data-supported first leg of the present HAAS tripod: Weight loss is, for whatever reasons, extremely difficult for most. Recall also, the HAAS third leg: The presently overweight person does not have to become thin or thinner in order to be healthy (6) (other than, to be sure, if one is morbidly obese).

Not only does recognizing that obesity is a health risk not weaken the HAAS movement, it strengthens it. By acknowl-

edging that reality, the HAAS movement can use the argument to encourage overweight people to promote their health in a manner consistent with the thoughts that underlie the firm two legs of the HAAS' foundation. The position that a state of health can be achieved by overweight/obese people, without dieting and weight loss, can then come to be seen as very helpful for that population. But that approach does not deal with the current situation. The HAAS movement does. The question is, how do we move forward?

Consider that the word "health" is at the heart of the HAAS movement. On the personal level, health is produced in part by a series of health-promoting personal behaviors, such as exercising regularly, maintaining a normal weight, eating a balanced diet, not smoking cigarettes, fastening one's seat-belt, and so on and so forth. These behaviors are not interdependent. The lack of any one health-related personal behavioral outcome does not mean that a person is totally "unhealthy." It does mean that engaging in any new health-related behavior makes one a healthier person.

This version of the HAAS movement proclaims that, contrary to both the public perception and the conventional medical position that weight loss is the only answer, if an overweight person undertakes health-promoting behaviors other than weight loss it is indeed possible to be both overweight and healthy at the same time.

If one is overweight and exercises on a reasonably regular basis while eating a reasonably balanced diet (doing both without a focus on weight loss), does not smoke cigarettes, does not abuse other addictive drugs, practices safe sex, follows an age- and sex-appropriate health-risk appraisal protocol, and so

Continued on page 13

followed by detailed and state-of-the-art lectures by Brian Shiple, D.O. (Exertional Leg Pain), Robert Nirschl, M.D. (Patellofemoral Syndrome), and Ben Pearl, D.P.M. (Conservative Treatment for Plantar Fasciitis).

The marathon medical tent was crazy on Sunday—lots of action! The heat contributed to numerous injuries including collapse, heat stroke, cramps, blisters, hypoglycemia, chest pain, asthma and hyponatremia. The symposium, however, not only prepared us for the plethora of injuries, it again fulfilled its primary goal of ensuring quality care at the Marine Corps Marathon.

We hope to see you in attendance next year!

Dr. Francis O'Connor, who has been involved with the AMAA Sports Medicine Symposium at the Marine Corps Marathon since 1991, was profiled in the spring/summer 2003 issue of the AMAA Journal.

Editorial

Continued from page 4

on, can it not be said that on balance that person is healthy (7)? This indeed is precisely what is meant by "Health at Any Size," isn't it?

This argument reflects the third leg of the tripod, fleshed out. We should, in my view, cast away that which is not an equal leg of the movement, but rather can be seen as a crutch supporting inaction: "Everything's ok with obesity; the research is faulty." That crutch can get in the way of any kind of health-promoting behavioral change among the bulk of the overweight/obese population, thus contradicting the true essence of the HAAS movement.

We should rather stand on two firm legs: the present first one, "Weight loss is really tough," and (for those other than the morbidly overweight) the present third one, "You can truly be healthy at any size," by engaging in health-promoting behaviors other than weight loss. Our principal focus

should now be on helping overweight people do just that. It appears that certain elements of the HAAS side should stop fighting a fruitless battle against data and get on to promoting health for the overweight/obese population.

REFERENCES

1. Ernsberger P., Koletsky R.J. Part 2: Rationale for a Wellness Approach to Obesity. *Healthy Weight Journal* 2000; 14:20.
2. NHBLI Obesity Education Initiative Expert Panel on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults*. Bethesda, MD: National Institutes of Health, NIH Pub. No. 98-4083, 1998.
3. Allison D.B., et al. Annual Deaths Attributable to Obesity in the United States. *Journal of the American Medical Association* 1999; 282:1530-1538.
4. Mokdad A.H., et al. The Spread of the Obesity Epidemic in the United States. *Journal of the American Medical Association* 1999; 282:1519-1522.
5. Must A., et al. The Disease Burden Associated with Overweight and Obesity. *Journal of the American Medical Association* 1999; 282:1523-1529.
6. Jonas S., Konner L. *Just the Weigh You Are*. Boston, MA: Houghton Mifflin/Chapters Publishing, 1998.
7. Jonas S., *Talking About Health and Wellness with Patients: Integrating Health Promotion and Disease Prevention into Your Practice*. New York: Springer Publishing Co., June 2000.

Cardiovascular Drugs

Continued from page 11

pulmonary complications leading to severe pulmonary insufficiency.

2. Pacemaker – should be activity modulated and programmed to react to appropriate levels of exercise to avoid pacer syndrome. Allow an adequate heart rate to be attained at peak exercise.
3. Post-exercise hypotension – all anti-hypertensives exaggerate the post-exercise hypotensive response seen in normal subjects.

Principles to Guide CV Therapy in Patients Who are Moderate to Competitive in Their Levels of Exercise

1. Choose medications that are appropriate both for the patient's diagnosis yet are least likely to limit their activity.
2. Patients must understand that they may need to readjust their exercise levels to ensure safety. That is, heart rate response below angina or production of ST depression. Many times this is the most difficult part of the equation (telling a runner that he or

she needs to slow down).

3. Recommend heart rate monitors to all CV patients who exercise so that they can stay within their acceptable heart rate zone.
4. Recommend that each patient carry an ID card with as much medical information as possible. This may include lists of drugs, miniaturized copy of EKG, etc.
5. Stress the importance of the warm-up and cool-down to avoid precipitation of angina and/or arrhythmia in the early stages of exercise and post-exercise postural hypotension.
6. It may be wise for the patient to have their own blood pressure cuff and frequently check their blood pressure and weight prior to and after exercise. On the morning of a long endurance run, it might be wise to reduce the dosage of daily medications.
7. Balancing exercise levels and CV meds is time consuming and may require frequent visits for serial exercise testing to determine the dosage or choice of these medications.

The cardiovascular drugs that have the most favorable profile would be the class of alpha-blockers, ACE inhibitors and ARBs—venodilators, nitrates and

slow calcium channel blockers (with the exception of verapamil, which may cause a significant decrease in heart rate response at peak exercise. Also, of all the calcium channel blockers, it is more likely to cause muscle spasm or muscle fatigue).

Certainly, we have an obligation to active patients to establish an optimal drug regimen and exercise level. This population of patients is growing and will expect us to have an adequate fund of knowledge to treat this clinical subset. Successfully treating these patients is also extremely rewarding for the physician since it allows the patient to return to reasonable levels of exercise for which they are eternally grateful.

James W. Ziccardi, D.O., FACC, FAACVPR, is the Director of Cardiac Rehabilitation at Shore Memorial Hospital in Somers, NJ, as well as a marathoner who takes cardiovascular drugs.

REFERENCES

1. Chintanadilok J., Lowenthal D. Exercise in the Prevention and Treatment of Hypertension. Thompson, P. (ed.): *Exercise and Sports Cardiology* McGraw-Hill, 2001, pp. 402-429.
2. Gyllestad L., Hallen J., Medbo J.L., et al. The effect of Acute vs. Chronic Treatment with Beta Adrenoceptor Blockade on Exercise Performance, Haemodynamic and Metabolic Parameters in Healthy Men and Women. *Br.J. Clin Pharmacology* 1996; 41:57-67.