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Discussion

Audience Question #1:
Thank you very much. Great talk. I'm interested in your view as to why obesity is skyrocketing in 100 years. As the first speaker said, it was 1%, it's going to 40%, it's surely not evolution, nor genes. So maybe we should tackle things as a society from the outset. Is it the availability of food? Is it the addictive food in food companies? Is it some change? Is it a brain disorder? Because I agree, once they get obese, it's really hard. And we send them to dietitians, we tell them it's your fault, or maybe it's not your fault so now take a medication. But something has gone wrong in this 100 years.

Dr. Deanfield:
I'm going to ask both the speakers – of these two speakers, Naveed first.

Dr. Sattar:
Well, I mean, I think you made most of the relevant points. Clearly, the environment is much more obesogenic. We can easily overeat much cheaper, you know, calories are abundant. Our physical activity is substantially reduced. We all know this. We all know and actually, even in Scotland, for example, we're now starting to think about, can we actually really change environment? It's a very tough ask. No country has achieved that. Yet they're trying, small ways. But for me, the big, big issue, I think the major issue, is probably a bit of both, but the major issue, I think, is just far too many calories in society. Companies can make cheap, fat, salty foods. They sell them really cheap. They make massive profits. They don't care. So either we go legislate, but that then affects economic factors in terms of food, you know, food industry. And some people, cheekingly say, 'Are we just going to move the profits from food industry to these drug companies?' You know, so those are the kind of things that are happening in society.

The reality is, the food environment isn't going to change very quickly, very fast. I mean, there's still many people living with obesity that we need to treat, but we've got to do both. We've got to try and treat people. Maybe that will also help change the environment in a certain respect, but we've also got to apply pressure politically to change the food environment, and voluntary agreements just don't work. It's got to be both legislation and we've got to try and make it easier for people to live healthier lives without much subconscious effort to improve the environment in terms of walkability and less cars and more cycling. So Martha, I'll pass to you.

Dr. Gulati:
Yeah, that, you know, I agree with everything that you said. We are definitely also a more sedentary environment. You know, sedentary population as a whole. We see children not doing as much physical activity, being taken away from their schools, at least in the United States, where they don't even have physical education anymore, where they have some time. And I think that that's part of it. And the food availability, of course, is another thing that is creating all these problems and the type of foods that people are choosing.

But I live in Los Angeles, where literally nobody walks. So there's more cars there than any place I've ever seen. And just an example, I'm somebody who decided to not have a car moving to Los Angeles, and I'm probably the only person who walks to work. And we don't make our environments easily walkable, like we're not ensuring that sidewalks are good and safe, and they should be safe, you know, for people who are older as well. We need to do things infrastructure wise, so that there's more green space and more places that people can be active.

But right now, we've really grown in a different way, and I think it's going to really ultimately come down to how we choose our leaders and legislators, that they start changing that for the future, because we definitely don't want it to continue.

Dr. Deanfield:
So I think I was going to say, I'm just going to comment on that, just for the moment, to say that actually we are making some progress in these areas, and at least engaging with politicians and the like. In the UK, it's been done by transferring the debate from being just a health debate to being a wealth debate and workforce productivity and the health of the younger people who are generating the income for the economy. So that's what's changed, and I think we will get there, but it's going to take quite a long time to do that. And in the meantime, we're going to have to tackle this weight epidemic, if you like, with a combination of this traditional medical approaches to lifestyle, which are important but not successful, and these new drugs and how we're going to introduce them.

Audience Question #2:
Thank you. Thank you for the wonderful presentations. Actually, I would emphasize on a point that obesity, as other top list in the WHO list of mortality top, they are all socially modifiable. Most of them like smoking. But I think that the education of doctors doesn't emphasize on lifestyle because we're educated that we perceive medicine as drugs, drug intervention or implantations, operations, and mechanical interventions. And we face the same problem in people who drop out from rehabilitation; they don't comply with the exercise regimes. And we should possibly educate more our doctors and I don't mean the cardiologist who is interested on prevention, but the average cardiologist considers as why are they intervened by mechanical interventions, or we should give drugs. And for example, with semaglutide, when you are going to stop, you have already addressed this. And then are we really kind of creating addicts, if semaglutide is going to be the next Xanax pandemic, for example. Thank you.

Dr. Deanfield:
So those are very wise comments, and we could have a whole session on the role of the doctor in these sort of environmental-related medical health issues. We're all ologists. We sit at the end of the life cycle, and we wait for people to come to us with their particular disease, and they're exposed over 50 years to the bad environment, the bad behaviors, the risk factors that we don't do very well in tackling. Our healthcare systems are designed to pick up the pieces of the consequence of that in later life, but we don't do much to prevent the diseases.

Dr. Sattar:
John, can I just add – I think you're right also that actually what we've done wrong in health advice, we've made it far too complex. We give people books of diets. We tell them to go and do 150 minutes. That's just rubbish. What we need to say, 'Look, can you make one change? Here is how you make the change. And here is the journey.' And once they gain confidence that they can make one change, we try something else. We step by step by step. I think we can help people improve their lifestyles. And you know, for example might be, 'Can you walk an extra 5 minutes a day, an extra 500 steps per day, and try and do that regularly.' So we can do these things, but we just don't do it well enough. And the point is, the drugs alone do not make people generally happier. Lifestyle, improved lifestyle, can help people improve their muscle mass, their, you know, many other aspects of their life that is going to give them a healthier lifestyle going forward.

Audience Question #2- Response:
And we know that obesity has to do with psychology, very much, so a kind of mind/heart team might be important also for managing.

Dr. Sattar:
No, I – possibly, yes, but let's make it simpler and make it easier for people to actually grasp. And it's teamwork. It's, you know, the drugs will get you half the way, but lifestyle for the patient has to get the other half. And we've got to try and give them the messaging in the way that they fully understand, and allow more people to try and at least make a try at making lifestyle changes. John?

Audience Question #3:
Well, thanks a lot. I think a very important session. Just a little word of criticism about this conference, you don't have a single presentation about nutrition. And actually you can change nutrition. And the second, what we have learned from other weight loss trials is people can lose weight. That's not the big problem with low calorie diets. Keeping them off, but the point is, you have to keep them under supervision to maintain it. And I think it's not the doctor, it's more the nutritionist, or so the nurse who has to give them regular advice. So this is something, while there are a lot of studies, and I think you know best as an epidemiologist, which shows that.

Dr. Deanfield:
What we've learned today, for me, is that this is tractable now in clinical practice. We do have new treatments, which we now have to learn to employ to the benefit of our patients. And we don't do that well enough yet, and the data is going to come out in the next 2 or 3 years, it's going to be compelling that this represents something we should be thinking about much more in our clinical practice, whether

we're cardiologists, endocrinologists, nephrologists, or the like.

Importantly, though, that's not going to be enough. We have to do these societal changes have to happen in the background, targeting environment, targeting health policy, and the like, and we're not going to be able to be able to do that on our own. But as the medical profession or the healthcare profession largely represented here, I think what we've learned is that we now have to be advocates for this. We really have to push this to our healthcare providers, our politicians, and the like. And the way we do that is going to frame this debate over the next few years. We have to treat our patients better, but we also have to support what are clearly the right comments that have been coming back from the audience here, that this is not just simply a medical problem.

So very exciting now we have treatments that work. They will reduce weight sustainably and predictably. And we now have to use them in terms of really a change in approach to this incredibly important risk factor for the population.

And I think we can end there by thanking you for coming here today and go away and think about this in your medical practice, but also in your healthcare systems. Thank you very much.