

# REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-A-13

Subject: Is Obesity a Disease?  
(Resolution 115-A-12)

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Referred to: Reference Committee D  
(Douglas W. Martin, MD, Chair)

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## 1 INTRODUCTION

2  
3 Resolution 115-A-12, “Obesity Should Be Considered a Chronic Medical Disease State,”  
4 introduced by the Illinois Delegation at the 2012 American Medical Association (AMA) Annual  
5 Meeting and referred by the House of Delegates, asks:

6  
7 That our AMA: (1) recognize obesity and overweight as a chronic medical condition (de facto  
8 disease state) and urgent public health problem; (2) recommend that providers receive  
9 appropriate financial support and payment from third-party payers, thus ensuring that providers  
10 have an incentive to manage the complex diseases associated with obesity; (3) work with third-  
11 party payers and governmental agencies to recognize obesity intervention as an essential  
12 medical service; and (4) establish a comprehensive ICD code for medical services to manage  
13 and treat obese and overweight patients.

14  
15 Reference Committee A recommended referral of Resolution 115-A-12 to clarify the first resolve.  
16 AMA Policy H-150.953, “Obesity as a Major Public Health Program,” already urges improved  
17 coding and payment mechanisms for the evaluation and management of obesity (Appendix).  
18 Additionally, both the ICD-9-CM and ICD-10-CM contain diagnosis codes for overweight and  
19 obesity, as well as body mass index (BMI). Therefore, this report addresses only the first resolve  
20 of Resolution 115-A-12.

21  
22 The Council on Scientific Affairs (CSA) previously addressed this issue.<sup>1</sup> Based on its  
23 interpretations of definitions of disease in common use, the Council argued that it was premature to  
24 classify obesity as a disease, citing the lack of characteristic signs or symptoms due to obesity, as  
25 well as evidence of any true causal relationships between obesity and morbidity and/or mortality.  
26 The resultant Policy D-440.971, “Recommendations for Physician and Community Collaboration  
27 on the Management of Obesity,” recommends that our AMA “work with the Centers for Disease  
28 Control and Prevention to convene relevant stakeholders to evaluate the issue of obesity as a  
29 disease, using a systematic, evidence-based approach” (Appendix). No formal meeting with the  
30 Centers for Disease Control and Prevention (CDC) and other stakeholders was ever held.

31  
32 This report examines the definitions of obesity and disease, the limitations of those definitions, and  
33 arguments both for and against the classification of obesity as a disease. The possible implications  
34 for provider reimbursement, public policy, and patient stigma also are considered. Of central

1 interest is the potential impact of classifying obesity as a disease on improving patient care and  
2 health outcomes. This report does *not* address food addiction, binge eating disorder, or other  
3 psychological disorders that may result in obesity, as the currently prevailing definitions of obesity  
4 do not specify its underlying causes.

## 5 6 CURRENT AMA POLICY RELATED TO OBESITY

7  
8 The AMA has more than 20 policies that specifically refer to obesity. Most do not define or  
9 describe the term, but among those that do, obesity is referred to as a: “complex disorder” (Policy  
10 H-150.953), “urgent chronic condition” (Policy D-440.971), “epidemic” (Policy D-440.952), and  
11 “major health concern” and “major public health problem” (Policy H-440.902). AMA policy does  
12 not clearly define obesity as a disease, although policy D-440.980 directed our AMA to convene a  
13 task force to “recommend measures to better recognize and treat obesity as a chronic disease”  
14 (Appendix).

## 15 16 METHODS

17  
18 English language reports were selected from searches of the PubMed and Google Scholar databases  
19 from 2004 to January 2013 using the search terms “obesity as a disease,” “obesity a disease,”  
20 “obesity should be considered a disease,” “what is disease,” and “definition of disease.” Additional  
21 articles were identified by manual review of the reference lists of pertinent publications. Websites  
22 managed by federal agencies and applicable professional and advocacy organizations also were  
23 consulted for relevant information.

## 24 25 BACKGROUND

26  
27 Opinions within the medical profession have been divided for a number of years on whether or not  
28 obesity should be considered a disease, rather than a condition or disease risk factor. Those in favor  
29 of classifying obesity as a disease argue that excess body fat, which results from myriad genetic,  
30 behavioral, and other environmental factors, impairs a number of normal body functions. While the  
31 adverse health consequences and healthcare costs associated with obesity are generally well-  
32 recognized even in the absence of a disease label, proponents argue that neither provider  
33 reimbursement nor research into effective treatments will be adequate until obesity is considered a  
34 disease. Those opposed to classifying obesity as a disease argue that excess body weight increases  
35 risk of morbidity and mortality, but does not guarantee it. Concerns also exist about labeling 1/3 of  
36 Americans as “ill” and increasing stigmatization of obese individuals. However, others argue that  
37 classifying obesity as a disease will actually decrease stigma. These issues, and others, are  
38 discussed in more detail below.

## 39 40 WHAT IS OBESITY?

41  
42 The World Health Organization (WHO) defines overweight and obesity as “abnormal or excessive  
43 fat accumulation that may impair health.”<sup>2</sup> The WHO, as well as the Centers for Disease Control  
44 and Prevention (CDC)<sup>3</sup> and the National Heart, Lung, and Blood Institute (NHLBI),<sup>4</sup> describe  
45 overweight and obesity in adults using body mass index (BMI) categories (Table 1). The NHLBI  
46 additionally recommends measuring waist circumference in adults with BMIs below 35 kg/m<sup>2</sup>, to  
47 further assess disease risk.<sup>4</sup>

48  
49 *While Simple and Inexpensive, BMI is a Limited Measure of Body Fatness*

50

1 Both the WHO and NHLBI guidelines recognize that BMI is an indirect and imperfect measure of  
 2 body fatness, although more accurate than body weight alone.<sup>4</sup> Originally designed as a rough  
 3 population-level indicator of obesity, BMI has been widely recommended as an inexpensive  
 4 clinical screening tool to help assess disease risk, in addition to other indicators such as blood  
 5 pressure and blood lipids.<sup>5</sup> Associations between BMI and adiposity (as well as disease risk,  
 6 described below) vary by age, gender, ethnicity, socioeconomic status, stature, and athletic  
 7 training. These variations generally reflect population-specific differences in body composition, fat  
 8 distribution, causes of overweight, and genetic susceptibility.<sup>5</sup> As a screening tool for obesity, BMI  
 9 demonstrates low sensitivity, particularly at BMIs below 30.<sup>6</sup> For example, some people with BMIs  
 10 < 25 may have excess adipose tissue and proinflammatory cytokines, as well as metabolic  
 11 disturbances associated with obesity, such as insulin resistance, hyperinsulinemia, dyslipidemia,  
 12 hypertension, and cardiovascular disease (CVD).<sup>5,6</sup> On the other hand, some individuals with BMIs  
 13 greater than 30 may not have excess body fat; however, even if they do, they may exhibit high  
 14 insulin sensitivity and normal blood pressure and lipid levels.<sup>5,6</sup> Due to the limitations of BMI,  
 15 some argue that BMI should be excluded from the definition of obesity when deciding whether or  
 16 not obesity is a disease.<sup>7-8</sup>

17  
 18 NHLBI is currently developing new guidelines on overweight and obesity in adults as part of its  
 19 development of cardiovascular risk reduction guidelines for adults.<sup>9</sup> These new guidelines will be  
 20 based on rigorous and standardized systematic reviews of the scientific literature, which may  
 21 clarify some of the uncertainties around the assessment and management of obesity in clinical  
 22 practice. The release date of the new guidelines is currently unknown, but their availability for  
 23 public comment is expected later in 2013.

#### 24 25 *Obesity as Measured by BMI is Associated with Increased Morbidity*

26  
 27 Despite the limitations of BMI, a substantial body of literature has found increased BMI to be  
 28 associated with myriad diseases and conditions, including: type 2 diabetes, coronary heart disease,  
 29 stroke, hypertension, dyslipidemia, several cancers, gall bladder disease, osteoarthritis, asthma,  
 30 chronic back pain, sleep apnea, pregnancy complications, stress incontinence, and depression.<sup>5-6,10</sup>  
 31 The nature of the relationships between BMI and these conditions is generally similar across  
 32 population groups, although the specific level of risk at a given BMI often differs by age, gender,  
 33 ethnicity, and/or socioeconomic status.<sup>5</sup>

#### 34 35 *The Obesity Paradox*

36  
 37 While co-morbidities generally increase as BMI increases, a number of research studies report no  
 38 effect--or even slightly protective effects--of overweight and obesity on mortality risk (i.e., J- or U-  
 39 shaped associations).<sup>5-6,11</sup> A number of factors beyond the inherent limitations of BMI may explain  
 40 these seemingly paradoxical associations, including inadequate control (both under and over) for  
 41 potential confounders and/or factors in the causal pathway (e.g., nutritional status, cardiorespiratory  
 42 fitness, hypertension), and/or more aggressive screening and treatment efforts in individuals  
 43 classified as overweight or obese.<sup>5,11-15</sup> In addition, the causes of death at low and high BMIs  
 44 differ.<sup>5,14</sup> Nevertheless, most research indicates that individuals at the highest end of the adiposity  
 45 spectrum are at increased risk of mortality.<sup>5,13</sup>

#### 46 47 **WHAT IS A DISEASE?**

48  
 49 This seemingly straightforward question lacks a single, clear, authoritative, and widely-accepted  
 50 definition.<sup>8,15-17</sup> CSA Report 4-A-05 identified some common precepts in the definitions of disease  
 51 provided by several dictionaries and encyclopedias (Table 2).<sup>1</sup> Similar attempts have varied in their

1 conclusions about what constitutes a disease, particularly in relation to obesity.<sup>8</sup> However, even the  
 2 same definitions can yield varying conclusions. For example, the American Association of Clinical  
 3 Endocrinologists (AACE) recently utilized the same disease criteria put forth in the previous  
 4 CSA report and concluded that obesity does, in fact, meet those criteria.<sup>7</sup> AACE's conclusion  
 5 appears to be based less on new knowledge about obesity than on differences in their interpretation  
 6 of the definition of disease.

7  
 8 In evaluating the variety of disease definitions currently in use (Table 2), some have noted that no  
 9 one definition would encompass all diseases currently accepted as such (e.g., some definitions  
 10 would exclude tuberculosis, stroke, alcoholism, some psychological disorders, or diabetes).<sup>8</sup>  
 11 Indeed, the medical community's definitions of disease have been heavily influenced by contexts  
 12 of time, place, and culture as much as scientific understanding of disease processes.<sup>16</sup> Given the  
 13 often significant social and economic consequences of the dividing line between disease and  
 14 "natural state" or "condition,"<sup>8,16</sup> it is imperative to consider the potential advantages,  
 15 disadvantages, incentives, and obligations of the disease label for patients, clinicians, employers,  
 16 third party payers, policy makers, and society as a whole.<sup>8</sup> Thus, rather than trying to determine if  
 17 obesity meets arguably arbitrary disease criteria, the more relevant question is "would health  
 18 outcomes be improved if obesity is considered a chronic, medical disease state?"<sup>8</sup>

#### 19 20 WOULD CLASSIFYING OBESITY AS A DISEASE IMPROVE HEALTH OUTCOMES? 21

22 Various individuals and organizations have referred to obesity as a disease dating back to at least  
 23 the 17th century, and possibly earlier--Hippocrates recognized the increased mortality risk of being  
 24 overweight.<sup>8</sup> However, members of both the general public and the medical community remain  
 25 divided on this issue.<sup>8,15</sup> While some arguments focus on whether obesity meets or does not meet  
 26 the criteria for a specific definition of disease, other arguments directly address financial incentives  
 27 for research and patient care, as well as the ability to offer treatment (Table 3). The financial and  
 28 treatment arguments are particularly pertinent to the discussion of how classifying obesity as a  
 29 disease might improve health outcomes; these arguments are considered in more detail below,  
 30 along with arguments related to public policy, prevention programs, public perceptions and patient  
 31 stigma.

#### 32 33 *Maybe Yes* 34

35 More widespread recognition of obesity as a disease could result in greater investments by  
 36 government and the private sector to develop and reimburse obesity treatments.<sup>7,8</sup> Some argue that  
 37 the Food and Drug Administration (FDA) would face increased pressure to approve medications  
 38 for obesity, and would therefore reframe their approval process to focus on the ability of  
 39 pharmaceuticals to decrease adipose tissue rather than to improve other markers of metabolic  
 40 health, such as blood pressure and lipid levels.<sup>8</sup> There is current interest in developing a "limited  
 41 use" approval pathway that could facilitate the clinical review and FDA approval of prescription  
 42 drugs. Antibiotics and drugs to treat obesity have been identified as appealing candidates for such a  
 43 pathway. More effective medications on the market would likely spur physicians to prescribe, and  
 44 patients to expect, pharmaceutical interventions for obesity.<sup>8,18</sup> In turn, third party payers would be  
 45 harder pressed to deny coverage.<sup>8</sup>

46  
 47 Public policy and prevention programs related to obesity may benefit from the greater urgency a  
 48 disease label confers. More funding for obesity-prevention programs, particularly for children and  
 49 adolescents, could lead to improved health outcomes for years to come.<sup>8</sup> It is likely that a number  
 50 of public policies related to healthy eating and physical activity, such as funding and regulations  
 51 for K-12 meal programs and physical education, would receive greater attention and resources.

1 Employers may be required to cover obesity treatments for their employees and may be less able to  
2 discriminate on the basis of body weight.<sup>8</sup>

3 Public perceptions may shift as a consequence of more extensive recognition of obesity as a  
4 disease, with greater appreciation of, and emphasis on, the complex etiology of obesity and the  
5 health benefits of achieving and maintaining a healthy weight.<sup>8</sup> Lack of self-control, laziness, and  
6 other detrimental character attributes might be less likely to be associated with obese individuals,  
7 and in turn reduce stigmatization.<sup>8,19</sup> The disease label also may provide greater motivation for  
8 some individuals to lose weight or maintain a healthy weight.<sup>8</sup> While increased emphasis on  
9 obesity may increase stigma (see below), some have argued that such consequences would oblige  
10 the medical community to take greater action to protect patients' rights.<sup>8</sup>

11  
12 *Maybe No*

13  
14 Concern exists that more widespread recognition of obesity as a disease would result in greater  
15 investments by government and the private sector to develop and reimburse pharmacological and  
16 surgical treatments for obesity, at the expense of clinical and public health interventions targeting  
17 healthy eating and regular physical activity.<sup>18</sup> "Medicalizing" obesity could intensify patient and  
18 provider reliance on (presumably costly) pharmacological and surgical treatments to achieve a  
19 specific body weight, and lead to prioritizing body size as a greater determinant of health than  
20 health behaviors.<sup>18,20</sup> Given the limitations of BMI (discussed above), this could also lead to the  
21 overtreatment of some people, such as those who meet the criteria for obesity, (i.e., BMI > 30) but  
22 are metabolically healthy. A similar concern is that obese individuals who improve their eating,  
23 physical activity, and sleeping habits, yet fail to lose enough weight to change their BMI  
24 classification, would still bear the "diseased" label and be pressured to receive medical treatment  
25 by clinicians, health insurers, and/or employers—even though their improved lifestyle behaviors are  
26 significant factors in preventing, delaying, and reducing the severity of obesity-associated  
27 outcomes. While some argue that BMI should be excluded from the definition of obesity in  
28 deciding whether or not obesity is a disease,<sup>7,8</sup> the fact remains that BMI is currently the prevailing  
29 clinical measure of obesity.

30  
31 It is possible that public policy and prevention programs related to obesity may be diminished if  
32 increased government financing of research into medical treatments reduces funds available for  
33 public health prevention programs.<sup>18</sup> Similarly, the medicalization of obesity could detract from  
34 collective social solutions<sup>20</sup> to environmental forces that shape people's behaviors and impact a  
35 number of conditions beyond just obesity.<sup>19</sup> Thus, public efforts to enhance the built environment  
36 to make healthy eating and physical activity choices easier may receive less attention, despite  
37 providing substantial health benefits at every body weight;<sup>18,20</sup> in turn, this could slow the  
38 improvement of health outcomes for all Americans. In addition, employers may raise health  
39 insurance premiums, limit hiring of obese individuals, and/or curtail employee wellness programs  
40 that incentivize weight loss or maintaining a healthy weight.<sup>8</sup>

41  
42 Public perceptions may shift as a consequence of more extensive recognition of obesity as a  
43 disease, but not in a manner that improves health outcomes. For instance, some individuals may  
44 conclude that health behaviors matter little in disease development and management, which may  
45 decrease their motivation to eat healthfully and be physically active.<sup>8</sup> In addition, an increased  
46 clinical emphasis on obesity could potentially offend or otherwise alienate some obese individuals,  
47 particularly if the emphasis is on achieving an ideal weight rather than healthy eating and physical  
48 activity behaviors.<sup>19</sup> Assuming the current BMI cut-points remain the primary clinical indicator of  
49 obesity, such stigma would likely also impact people who are otherwise healthy, but who  
50 nevertheless meet the criteria for obesity (BMI > 30).

1 AREAS REQUIRING FURTHER RESEARCH

2  
3 If obesity is to be considered a disease, a better measure of obesity than BMI is needed to diagnose  
4 individuals in clinical practice. Further research is also warranted into the physiologic mechanisms  
5 behind why some obese individuals (e.g., the metabolically healthy obese) do not develop adverse  
6 health outcomes related to excess adipose tissue.<sup>21</sup> This is particularly relevant given the difficulties  
7 most people have in achieving sustained weight loss. In addition, much more research is needed to  
8 develop effective and affordable obesity prevention and management strategies at both the clinical  
9 and community levels.

10  
11 SUMMARY AND CONCLUSION

12  
13 Without a single, clear, authoritative, and widely-accepted definition of disease, it is difficult to  
14 determine conclusively whether or not obesity is a medical disease state. Similarly, a sensitive and  
15 clinically practical diagnostic indicator of obesity remains elusive. Obesity, measured by BMI, is  
16 clearly associated with a number of adverse health outcomes, with greater consistency across  
17 populations at the highest BMI levels. However, given the existing limitations of BMI to diagnose  
18 obesity in clinical practice, it is unclear that recognizing obesity as a disease, as opposed to a  
19 “condition” or “disorder,” will result in improved health outcomes. The disease label is likely to  
20 improve health outcomes for some individuals, but may worsen outcomes for others.

21  
22 What is clear is that a better measure of obesity than BMI alone is needed. NHLBI’s forthcoming  
23 guidelines on overweight and obesity in adults may help clarify clinical uncertainties regarding the  
24 best means of measuring obesity, at least in reference to cardiovascular risk. In the meantime,  
25 better clinical and public health strategies are warranted to assist individuals in improving their  
26 lifestyle behaviors and in reducing adverse outcomes associated with obesity.

27  
28 RECOMMENDATIONS

29  
30 The Council on Science and Public Health recommends that the following statements be adopted  
31 in lieu of Resolution 115-A-12 and the remainder of the report be filed.

- 32  
33 1. That Policies H-150.953, “Obesity as a Major Public Health Program,” and H-440.866,  
34 “The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the  
35 Diagnosis and Management of Adult Overweight and Obesity,” be reaffirmed. (Reaffirm  
36 HOD Policy)  
37  
38 2. That Policy H-150.953, “Obesity as a Major Public Health Program,” be re-titled “Obesity  
39 as a Major Public Health Problem.” (Modify Current HOD Policy)  
40  
41 3. That Policy D-440.971, “Recommendations for Physician and Community Collaboration  
42 on the Management of Obesity,” be rescinded. (Rescind HOD Policy)

Fiscal note: No significant fiscal impact

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**TABLE 1. National Heart Lung and Blood Institute Classifications of Overweight and Obesity by BMI and Waist Circumference in Adults<sup>4</sup>**

Classification	BMI (kg/m <sup>2</sup> )	Risk of type 2 diabetes, hypertension, and CVD <i>relative to normal weight and waist circumference*</i>	
		Men ≤ 40 in Women ≤ 35 in	Men ≥40 in Women ≥ 35 in
Underweight	< 18.5	---	---
Normal weight	18.5 – 24.9	---	---
Overweight	25.0 – 29.9	Increased	High
Obesity (Class I)	30.0 – 34.9	High	Very High
Obesity (Class II)	35.0 – 39.9	Very High	Very High
Extreme obesity (Class III)	≥ 40	Extremely High	Extremely High

\*NHLBI guidelines note that increased waist circumference can indicate increased disease risk even in individuals considered normal weight.

**TABLE 2. Examples of disease definitions**

<b>Definition of disease</b>
<p>All 3 of the following criteria must be met:</p> <ul style="list-style-type: none"> <li>a) “An impairment of the normal functioning of some aspect of the body</li> <li>b) Characteristic signs or symptoms; and</li> <li>c) Resultant harm or morbidity to the entity affected”<sup>1</sup></li> </ul>
<ul style="list-style-type: none"> <li>1) Based on biostatistical theory: “Deviation from species-typical functioning; disease is deviation from the average.” -or-</li> <li>2) Based on evolutionary functions: “Disease occurs when an organ is not performing the job that allowed it to evolve via natural selection.”(quoted in <sup>8</sup>)</li> </ul>
<p>All 4 of the following criteria must be met:</p> <ul style="list-style-type: none"> <li>a) “A condition of the body, its parts, organs, or systems, or an alteration thereof;</li> <li>b) Resulting from infection, parasites, nutritional, dietary, environmental, genetic, or other causes;</li> <li>c) Having a characteristic, identifiable, marked, group of symptoms or signs;</li> <li>d) Deviation from normal structure or function (variously described as abnormal structure or function; incorrect function; impairment of normal state; interruption, disturbance, cessation, disorder, derangement of bodily or organ functions).”<sup>22</sup></li> </ul>
<p>“Damage to an organ, part, structure, or system of the body such that it does not function properly (e.g., cardiovascular disease), or a state of health leading to such dysfunctioning (e.g., hypertension); except that diseases resulting from essential nutrient deficiencies (e.g., scurvy, pellagra) are not included in this definition.”<sup>23</sup></p>
<p>“An impairment of the normal state of the living animal or plant body or one of its parts that interrupts or modifies the performance of the vital functions, is typically manifested by distinguishing signs and symptoms, and is a response to environmental factors (as malnutrition, industrial hazards, or climate), to specific infective agents (as worms, bacteria, or viruses), to inherent defects of the organism (as genetic anomalies), or to combinations of these factors:”<sup>24</sup></p>
<ul style="list-style-type: none"> <li>1. “An interruption, cessation, or disorder of a body, system, or organ structure or function.</li> <li>2. A morbid entity ordinarily characterized by two or more of the following criteria: recognized etiologic agent(s), identifiable group of signs and symptoms, or consistent anatomic alterations.”<sup>25</sup></li> </ul>

**TABLE 3. Arguments For and Against Classifying Obesity as a Medical Disease State\***

Yes, Obesity is a Disease	No, Obesity is <i>Not</i> a Disease
<p>Obesity meets disease criteria (e.g., outlined in CSA Report 4-A-05<sup>1</sup>):</p> <p>a) <i>Impairment of normal functioning of the body:</i> “Appetite dysregulation, abnormal energy balance, endocrine dysfunction including elevated leptin levels and insulin resistance, infertility, dysregulated adipokine signaling, abnormal endothelial function and blood pressure elevation, nonalcoholic fatty liver disease, dyslipidemia, and systemic and adipose tissue inflammation.”<sup>7</sup></p> <p>b) <i>Characteristic signs and symptoms:</i> Increase in body fat has both anatomic sequelae (e.g., joint pain, immobility, sleep apnea) and metabolic sequelae (progression to type II diabetes and cardiovascular disease).<sup>7</sup></p> <p>c) <i>Results in harm or morbidity to the entity affected:</i> Obesity is directly associated with increased mortality and morbidity due to a number of factors, and weight loss improves obesity-related morbidity and mortality (e.g., improved glycemic control in diabetes and reduced risk of type II diabetes, CVD, some cancers, and alleviation of symptoms of osteoarthritis, sleep apnea, etc.).<sup>7</sup></p>	<p>Obesity does NOT meet disease criteria (e.g., outlined in CSA Report 4-A-05<sup>1</sup>):</p> <p>a) <i>Impairment of normal functioning of the body:</i> Excess adipose tissue is not necessarily an impairment; rather, it is a biological adaptation that can have beneficial effects. In fact, it is normal for the obese body to resist weight loss efforts.<sup>1</sup></p> <p>b) <i>Characteristic signs and symptoms:</i> There are no specific symptoms of obesity and the only sign is increased weight and body fat, which is the definition of obesity.<sup>1</sup></p> <p>c) <i>Results in harm or morbidity to the entity affected:</i> True causality has not been established in the literature, as obesity has only been associated with morbidity and mortality.<sup>1</sup></p>
<p>Obesity is similar to other diseases (e.g., hypertension, diabetes, lung cancer) that result from a combination of genetics and environmental factors (including behaviors).<sup>7</sup></p>	<p>Simply because other diseases share similarities with obesity does not mean obesity is a disease.<sup>8</sup></p> <p>Obesity results from personal choices to overeat or live a sedentary lifestyle, not an illness.<sup>7</sup></p>
<p>All diseases work through pathways and mechanisms; simply because obesity’s anatomic and metabolic sequelae include already recognized diseases does not mean obesity is not also a disease.<sup>8</sup></p>	<p>Obesity is a modifiable risk factor - it increases risk of morbidity and/or mortality only by causing other diseases.<sup>8</sup></p>
<p>The disease label (i.e., “medicalization”) would help improve attitudes and financial support to expand: a) research into prevention and treatment, and b) resources for patient care.<sup>7</sup></p>	<p>“Medicalization” of obesity is intended to drive financial gains of certain providers/interests.<sup>8</sup></p>
<p>Most experts agree obesity is a disease.<sup>8</sup></p>	<p>Just because most experts agree (if true) does not mean obesity meets the criteria for disease, and some experts disagree.<sup>8</sup></p>
<p>Obesity is treatable in at least some individuals but a lack of treatment should not be a criteria for considering obesity a disease.<sup>8</sup></p>	<p>There is no effective, well-established treatment for obesity.<sup>8</sup></p>

\*Arguments listed were discussed in the cited references, but do not necessarily reflect those authors’ views.

## **APPENDIX.**

### **Current AMA policies relevant to the issue of obesity as a chronic medical disease state**

#### **H-150.953 Obesity as a Major Public Health Program**

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12)

#### **H-440.902 Obesity as a Major Health Concern**

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients. (Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12)

#### **D-440.980 Recognizing and Taking Action in Response to the Obesity Crisis**

Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-

establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) provide a progress report on the above efforts to the House of Delegates by the 2004 Annual Meeting. (Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07)

**D-440.971 Recommendations for Physician and Community Collaboration on the Management of Obesity**

Our AMA will: (1) work with the Centers for Disease Control and Prevention to convene relevant stakeholders to evaluate the issue of obesity as a disease, using a systematic, evidence-based approach; (2) continue to actively pursue measures to treat obesity as an urgent chronic condition, raise the public's awareness of the significance of obesity and its related disorders, and encourage health industries to make appropriate care available for the prevention and treatment of obese patients, as well as those who have co-morbid disorders; (3) encourage physicians to incorporate body mass index (BMI) and waist circumference as a component measurement in the routine adult physical examination, and BMI percentiles in children recognizing ethnic sensitivities and its relationship to stature, and the need to implement appropriate treatment or preventive measures; (4) promote use of our Roadmaps for Clinical Practice: Assessment and Management of Adult Obesity primer in physician education and the clinical management of adult obesity; (5) develop a school health advocacy agenda that includes funding for school health programs, physical education and physical activity with limits on declining participation, alternative policies for vending machines that promote healthier diets, and standards for healthy a la carte meal offerings. Our AMA will work with a broad partnership to implement this agenda; and (6) collaborate with the CDC, the Department of Education, and other appropriate agencies and organizations to consider the feasibility of convening school health education, nutrition, and exercise representatives, parents, teachers and education organizations, as well as other national experts to review existing frameworks for school health, identify basic tenets for promoting school nutrition and physical activity (using a coordinated school health model), and create recommendations for a certificate program to recognize schools that meet a minimum of the tenants. (CSA Rep. 4, A-05; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 1, A-08; Reaffirmation I-10; Reaffirmed: BOT Rep. 21, A-12)

**H-425.994 Medical Evaluations of Healthy Persons**

The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) *Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs.* (6) Continued investigation is required to determine the usefulness of

test procedures that may be of value in detecting disease among asymptomatic populations. CSA Rep. D, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

**H-90.974 Opposition to Obesity as a Disability**

Our AMA opposes the effort to make obesity a disability. (Res. 412, A-09)

**H-440.866 The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity**

Our AMA supports: (1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m<sup>2</sup>; (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks. (CSAPH Rep. 1, A-08)

**D-440.952 Fighting the Obesity Epidemic**

1. Our AMA Council on Science and Public Health (CSAPH) will critically evaluate the clinical utility of measuring body mass index (BMI) and/or waist circumference in the diagnosis and management of overweight and obesity, with input from leading researchers and key stakeholder organizations, with a report back at the 2007 AMA Interim Meeting. 2. Our AMA will consider convening relevant stakeholders to further examine the issue of incentives for healthy lifestyles. 3. Our AMA Council on Medical Service and CSAPH will collaborate to evaluate the relative merits of bariatric surgery and the issue of reimbursement for improving health outcomes in individuals with a BMI greater than 35. (BOT Rep. 9, A-07)