Have you ever seen *My 600lb Life*?

It’s on TLC—the erroneously named *Learning Channel*—and it does a pretty good job at showcasing some of the types of patients that I deal with. The kind of people that I see on a daily basis as a bariatric specialist aren’t *always* quite as far gone as some of the people on that show, but it gives an… *okay*… representation to some of the ones that are. There’s some sensationalism involved, but hey, that’s television.

But what they really hit home (again, most of the time) is the fact that a lot of our jobs is to understand the psychology behind the eating habits of our patients. Whether they’re two hundred and fifty pounds looking to curb a growing problem or if they’re six hundred and fifty pounds and we’re their last resort, I would say a good forty percent of our job is getting to the root of *why* our patients feel the need to overeat.

Most anyone whose had one will tell you that a surgery is only a temporary solution. It just makes it so that a patient *can’t* overeat, at least not without consequences. Giving them the tools to manage and control their weight on their own is simple enough, but making sure that they follow through and don’t relapse in their eating habits is easily the hardest part of our jobs.

And yes, I’m counting the surgery in that.

A lot of *my* patients, now these are the people who walk into *my* office, are advised against WLS as a first resort because of the harm that it can cause their bodies in the long run. I’ve always been a big proponent of doing whatever we can through therapy and group meetings, because it creates a sense of community to help hold the patient up even when (I’d like to say *if*, but more often than not it’s often *when*) they stumble in their weight loss journey.

If they rush into any surgical options and fail—as so many unfortunately do—then they haven’t learned things like meal preparation, proper diet, and self-control. Without those necessary tools, they almost invariably wind up gaining back some to all, and sometimes *even more* of their weight and have to start from scratch all over again.

A lot of what I’m doing with my patients basically amounts to therapy and counselling, with some slight medication here and there for pesky pre-existing conditions and extra-strength appetites that have to be dosed down until they get a hold of it themselves.

However, sometimes, we get patients that need a little more help than others.

It was my idea, if you can believe that, to start having a sort of “pre-screening” session before we agreed to take them on as a patient. I thought that being able to weed out these more difficult cases so that we could better assign them to doctors who were more equipped to handle them. We’d spend a week or so basically hanging out with them every other day or so, and let them go about their daily lives while we observed and ingratiated ourselves with their daily lives.

To circle back around, watching *My 600lb Life* is actually where I got the idea. But we won’t tell my Clinic Manager that.

Anyway, since it was my idea, I was the one who was put on the assignment along with two other doctors that were similarly trained with backgrounds in psychology.

So the goal was to sit down with three or four prospective patients when I could, sitting down and getting to know them. What they were from, their home lives, any pre-existing conditions that might steer them towards weight gain, and most importantly how they viewed their relationships with food.

The problem with this was, and in hindsight I see this now, most people who require our specialty in the medical field view social events as an unspoken call to include food. It’s one of the most common symptoms of an eating disorder, and it was something that—consciously—I planned for.

In practice it worked out to me outsourcing my Tuesday and Thursday office hours so that I could go and meet with some of these prospective patients, either in their homes or at restaurants close by, and I would often sit down and have a meal with them.

Since I was actively trying to gauge how much they ate, I would insist that they try not to (pardon the pun) fudge the numbers so to speak, and have just a regular breakfast/lunch with me.

*Think of it like your last chance to eat without thinking of me breathing down your neck*.

That was how I advertised it, jokingly. And a lot of my patients *did* still try to fib to me. On some level, most bariatric patients (especially if they’re actively seeking medical attention) are at least a little ashamed of how much they eat, and it’s only natural that they’d try to hide the truth from me so that I wouldn’t think the worst of them. But, given their complex relationship with food, their ideas of a “normal” lunch were often still pretty big.

Well, they were either slight exaggerations, or they were just comically small—I once had a teenaged girl who could barely leave her house try to tell me, with a straight face, that *of course* all she ate for lunch were two cans of chicken soup and a Coke. *Those* kinds of stories are were always my favorites because, well… at least they were entertaining.

Anyway, I’m getting ahead of myself.

So the idea behind this idea was that I would observe them and get to know them and be able to discern whether or not they would be better suited as my personal patients or if I would be able to assign them “softer” doctors like Dr. Kim or Dr. Glick. While we ate (again, two times a week) I would take notes and ask questions about their lives, but it was also a chance for me to… you know, get some lunch.

I would purposefully not eat breakfasts on days that I would go eat with my clients, because I (of all people) knew the risks of overeating. Not only that, I had known from both psychological study and personal experience that food had a nasty way of finding its way into your mouth when you weren’t paying attention. *Especially* if someone else was eating in front of you.

But our clients didn’t get to be the sizes that they were by eating large portions of otherwise healthy food.

So I was spending two days a week with at least two to three clients (one almost invariably wound up getting cold feet or cancelling) surrounded by food and spending my time at dinner tables while we talked about things that were potential triggers for my clients’ appetites.

And I can’t stress enough how easy it is to lose track of just how much food goes into your mouth when you’re focusing on other things. Life, raising children, hanging out with friends… or even when you’re interviewing potential trouble-case bariatric patients and trying to make sure that you do a good job so that you can hopefully write that article you’ve been dying to try and submit it to a medical journal.

It wasn’t like I just started binging at the first opportunity. It was a pretty gradual thing, I guess is what I’m saying.

I had probably put on a good fifteen pounds before I realized what was happening. And, you know, I thought *office job* first thing. A lot of my work is sedentary, I’m getting older… the sort of excuses that anyone might make when faced with a higher reading on the scale. But the fact of the matter was that I was eating a whole bunch of unhealthy food that my body wasn’t prepared for. It was another twenty pounds after that an more than a few busted khakis before I realized *why* it was happening.

It hadn’t occurred to me—we smart types have a tendency of overlooking the simplest answers—that spending time so much time around people who were addicted to food could have affected me so strongly. Surrounding myself with all that temptation on a regular basis, slowly eroding away at my willpower while I was focused on my patients and my career and…Ugh, just *life*, you know?

Anyway, I took quick action and abdicated from my part of the project. I got some of the interns, people who were hungry in a whole different kind of way, to take over the interviewing process for potential applicants and quickly resumed my regular schedule of working in the office of examining dietary habits and nutritional analysis with the occasional therapy session and pharmaceutical consultation.

But the damage was done.

Years of study and due diligence had gone out the window in just the space of a few months as I quickly fell into the same habits that I’d gently steered my clients against for the entirety of my career. I found myself at the vending machines twice, three times a day. I was sneaking meals under my desks to avoid the scornful, judgmental eyes of my colleagues, unable to fight my cravings for fast food and thick, greasy burgers…

Suffice it to say, even without my clients’ negative influence penciled in to my schedule, I absolutely ballooned.

By the time I hit two hundred and fifty pounds, I was eating four times a day. One in the morning, two “small” lunches throughout the day, and then a big pig-out either at home or on the way. It wasn’t long before it was two regular sized lunches (one before the standard lunch period and then another to help get me until after five) and a little something from the drive-thru either in addition to my order or in preparation for a big, fattening dinner… and the less said about dessert the better.

My fellow doctors all knew that I was getting fat, but that was the kind of talk that you reserve for other patients rather than respected colleagues. Sort of like a therapist letting another therapist’s idiosyncrasies slide in the name of friendship. However, as I kept gaining weight and fooling myself into thinking that everything was fine, falling deeper and deeper into denial, they were the ones who eventually helped me with an intervention.

Just as I crested north of three hundred pounds, they helped me realize that my weight had spiraled out of control. I was at my biggest weight ever, they were worried about me, and they were fully intent on helping ground me back to the set of core principles that we defined ourselves by at the clinic.

Unfortunately, I had maybe picked up more than eating habits from the troubled clients that I had ingratiated myself with, and proved rather difficult to work with myself.

My weight only continued to climb, and at a seemingly faster rate now that I was aware of my problem. Three hundred became three fifty, which soon begat four hundred and a disability case opened after I broke one too many office chairs. Out of work and basically getting paid to do paperwork from home, it all sort of melted together in a blur of daytime TV and DoorDash…

The more I ate, the bigger I got. The bigger that I got, the less that I wanted to leave the house. The less I wanted to leave the house, the more I ate.

It really was a vicious cycle—and being aware of it every heaving step of the way only made it that much more agonizing to experience first-hand.

And it’s been a long road, getting to where I am today. Life often doesn’t make things easy for any of us, most especially the obese. But I’m proud to say that I’m finally ready to return to the clinic and resume my work in the field.

It’ll just take some time on the other end of the desk, as a patient.

So for the meantime, these little meetings will have to do. I hope that you won’t be biased towards me just because I helped *create* this whole little… *thing* we’re doing. The pre-screening process is rigorous enough, but don’t go soft on me!

Look at me, going on and on while I stuff my face—you must think I’m absolutely hopeless.

Would you like some?